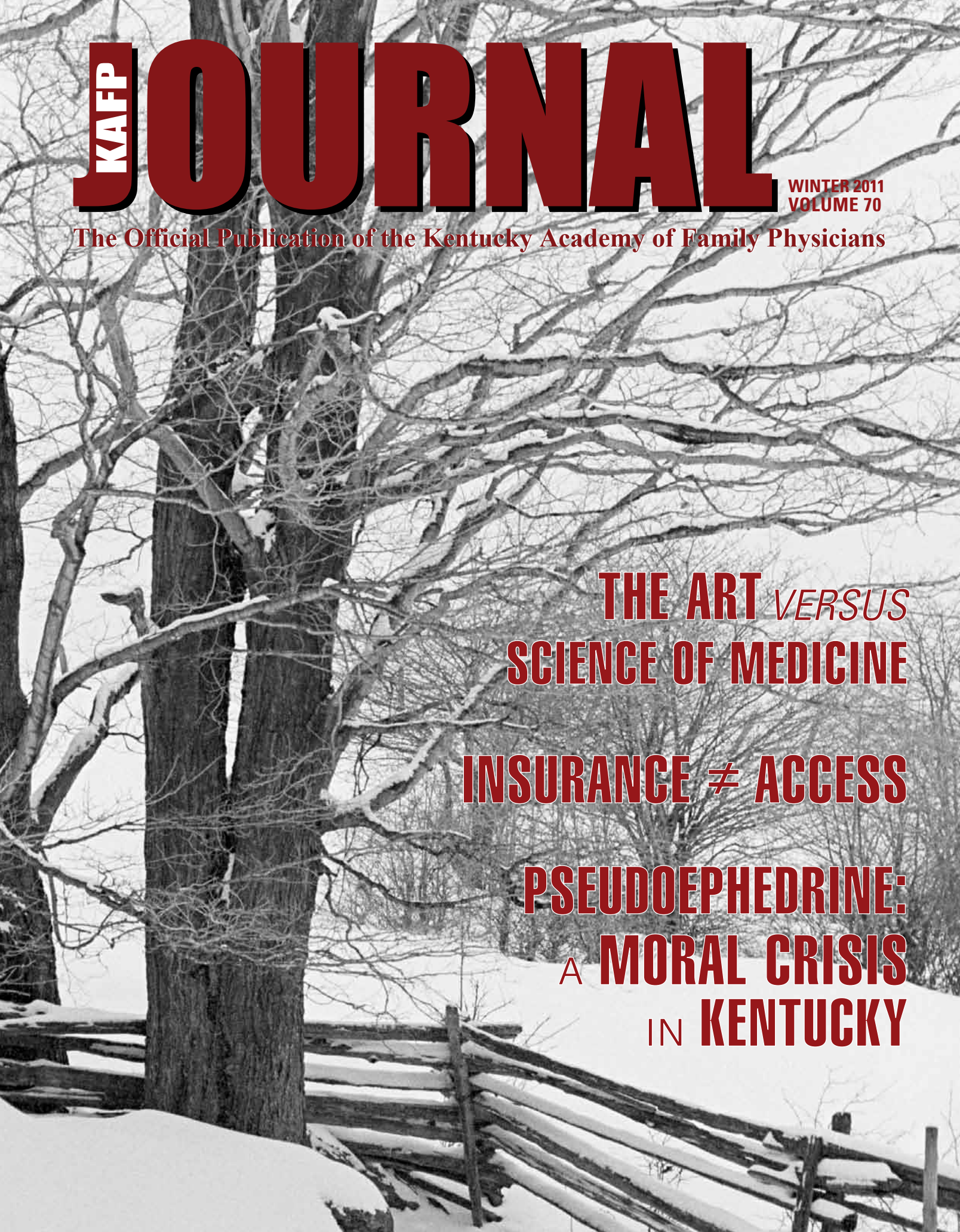

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message from the PRESIDENT

Over the past two months I have attended the AAFP Scientific Assembly and the Tennessee Academy Scientific Assembly. Both had numerous evidence-based lectures that were excellent in content, but the data presented has caused a lively debate within me that I thought I would share with the rest of you.

In Denver, one of the presenters discussed the evidence-based data with regards to PSA testing and digital prostatic exams. The gist of the discussion was that the evidence does not support such testing as being of benefit. In Gatlinburg, one of the presenters claimed evidence-based data currently does not support breast self exams or physician exams as being of benefit. In each case, the data suggests that these modalities could be adverse to one's health.

PERHAPS I AM GETTING TO BE ONE OF THOSE "OLD DOCTORS" CLINGING TO RELICS OF THE PAST, BUT I DON'T THINK THAT IS THE CASE.

Now the debate that this touched off has to do with the physical exam aspect of the data. One could extrapolate many aspects of the physical exam lack sufficient evidence to continue to advocate for their inclusion in health care delivery. Does pulmonary auscultation provide benefit in the absence of respiratory symptoms? What about the cardiac exam? Does listening to the heart really make a difference in patients without known cardiac disease? How about funduscopic exams? Given the guidelines for all diabetics to receive yearly dilated eye exams, do we really need to look into the eyes of our patients? I could go on ad infinitum to each of the various aspects of the exam, but I think you get the point. Does the physical exam really provide any evidence-based benefit?

Perhaps I am getting to be one of those "old doctors" clinging to relics of the past, but I don't think that is the case. Even in a world populated with technologic advances that enable us to see more and know more about our patients before we examine them, I still believe the physical exam remains a critically important part of health care delivery. The mere act of performing an exam requires one to touch the patient. It is this connectedness that forms the core of the physician-patient relationship. How many times have I heard patients lament the ER physician "never laid a hand on me?"

While elements of evidence-based medicine provide significant advances in our understanding of health and disease, there are three critical flaws in advocating blind adherence to these guidelines. One is EB guidelines are based on population studies, but the patient on our table is an individual, not the population. While a population study may indicate little overall value from a certain modality, that modality may be critically important to a specific patient. Like the story of the starfish, it makes a difference to "this one."

The second flaw is how do you account for the "hunch," or intuition? Any M.D. who has been out for awhile has stories of diagnoses made or successful treatment based

THE ART VERSUS SCIENCE OF MEDICINE

more on divine revelation than evidence-based fact. Intuition probably is rooted in the mature experience of the veteran clinician. But, isn't that the value of experience, knowing when it is important to break the rules because the rules don't cover every situation?

Finally, EB medicine does not account for the significant effects of faith in healing. How does one account for the placebo effect? What about the true medical miracle - where does that fit into the evidence-based algorithm? I can acknowledge these may occur rarely, but that doesn't mean they don't exist.

I am not advocating getting rid of EB guidelines as much as I am defending the necessity for protecting the place of art in medicine. Medicine has always been part art and part science. While science has improved medicine, raw science devoid of compassion, absent touch, without faith and unable to appreciate the awe inspiring things we are privileged to see as healers is medicine that can be packaged, formatted and performed by machine.

The true value of the physician isn't that they know the guidelines and algorithm that give the highest likelihood of successfully treating any presenting ailment, but that they are able to put a human perspective on that ailment.

As we continue the inevitable march towards medicine that is completely evidenced-based, driven by a master that demands accountability, there will come a tipping point in which we will no longer need to worry about those ancillary providers who desire to chip away at what we as physicians do, for the entity that will replace us all will be a program, a keyboard and a monitor. There will be those who see this as the advancement of medicine and science. I will see it as the reduction of a once great profession.

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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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HEALTH CARE REFORM AND THE PRIMARY CARE WORK FORCE

Today, an estimated 45 million Americans are uninsured. Over the next five years, the recently passed health care reform acts will use private insurance reform, public program expansion, and both individual and employer mandates to decrease the number of uninsured people by more than two-thirds. But insurance coverage is not the same as access to care.

"Meaningful access depends not only on insurance coverage but the terms of that coverage and the availability of services in the community," says Joseph E. Smith, executive director of the Kentucky Primary Care Association (KPCA). "Is the health care infrastructure adequate? Are there enough primary care providers? How are those providers distributed geographically?"

The health care reform package expands programs that have proven to increase access to primary care in underserved areas: National Health Service Corps, community health centers and community-based residencies. The Acts even take a stab at payment reform for primary care through a 10 percent Medicare bonus, temporarily raising Medicaid reimbursement rates for select primary care services to equal Medicare reimbursement rates, and a series of demonstration projects aimed at transforming both the care delivery system and payment mechanisms.

"In essence, I think this bill puts a spotlight on the importance of primary care in the delivery of health care to our nation and emphasizes the role of primary care," says Dr. Samuel Matheny, of the Department of Family and Community Medicine at UK's Chandler Medical Center.

Will these measures be enough to treat health care's worsening chronic condition – the shortage and maldistribution of primary care physicians?

Work Force Supply and Distribution are Critical to Health Care Access

Among the most stubborn problems creating barriers to care are the shortage and uneven distribution of health professionals – particularly primary care physicians. Kentucky's health professional shortage areas give a snapshot of the problem. Of 120 counties, 91 have a current shortage designation which can be in primary care, mental health or dental services. Thirty-four counties have one shortage; 42 counties have two shortages; and 15 have shortages in all three health professions. To eliminate these shortages, Kentucky needs to recruit and correctly deploy 79 primary care physicians, 104 mental health professionals and 17 dentists. These shortages are determined based on 30 -year-old methodologies and may seriously underestimate the demand for primary care in a post-reform environment.

What will happen to access under health care reform? In 2006, Massachusetts enacted health reform legislation that is structurally similar to the Obama Health Care Reform package: the percentage of uninsured dropped from over 10 percent in 2006 to under 3 percent by 2008, wait times for appointments increased, and many physicians closed their panels to new patients. There are 129.4 active primary

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THE HEALTH CARE REFORM PACKAGE EXPANDS PROGRAMS THAT HAVE PROVEN TO INCREASE ACCESS TO PRIMARY CARE IN UNDERSERVED AREAS: NATIONAL HEALTH SERVICE CORPS, COMMUNITY HEALTH CENTERS AND COMMUNITY-BASED RESIDENCIES.

care physicians per 100,000 Massachusetts residents. By contrast, Kentucky has only 77 active primary care physicians per 100,000 residents. (1) It would appear that Kentucky will have even more difficulty absorbing the expected surge in demand for primary care, particularly in underserved areas.

In Massachusetts, increased coverage released pent-up demand for primary care and overwhelmed the primary care delivery system. How will increased coverage play out nationally? Some people will enter the insurance market as a result of private insurance reforms beginning as early as this year. However, the major expansions in coverage won't happen until 2014. With fewer and fewer medical students choosing primary care specialties, an aging population, and significant expansion in insurance coverage in 2014, what does the health care reform package offer to increase access to primary care?

National Health Service Corps

The high cost of medical education is one factor that influences medical students to select more lucrative subspecialties over primary care. The health care reform package attempts to redress this imbalance by guaranteeing funding for the National Health Service Corps (NHSC), which offers loan repayment to primary care clinicians who commit to practice in underserved areas. The $1.5 billion NHSC allocation is expected to place approximately 15,000 primary care providers in underserved areas over the next five years. By comparison, in the 38 years since its inception in 1972, the NHSC has assisted some 30,000 clinicians.

Primary Care Reimbursement

The health care reform package improves primary care reimbursement in at least two ways. First, from 2011 through 2015, Medicare will pay a 10 percent primary care bonus for select HCPCS codes provided by primary care practitioners. For physicians, eligibility for the bonus depends on primary specialty designation (family medicine, internal medicine, geriatric medicine, or pediatric medicine) and the percentage of allowed Medicare charges for primary care services in a prior period (at least 60 percent of the allowed Medicare charges must be for primary care services). Covered codes include 99210 through 99215, 99304 through 99340, and, 99341 through 99350. [Title V Subtitle F Section 5501(a)(2)(A) of the Affordable Care Act.] Unlike the current HPSA bonus, eligibility for this payment does not depend on geographic location. (2)

SOME PEOPLE WILL ENTER THE INSURANCE MARKET AS A RESULT OF PRIVATE INSURANCE REFORMS BEGINNING AS EARLY AS THIS YEAR.

Second, in 2013 and 2014, Medicaid programs will be required to reimburse select primary care codes for services provided by primary care doctors at rates equal to Medicare. Eligible physicians are those with a primary specialty designation of family medicine, general internal medicine or pediatric medicine. Eligible codes include Evaluation and Management HCPCS codes covered by Medicare and certain codes related to the administration of immunizations (90465 through 90468 and 90471 through 90474). [Title I Subtitle C Section 1202 of the Reconciliation Act of 2010.] Kentucky's current Medicaid rates are approximately 80 percent of the Medicare level.

"(W)e continue to have a deficit of around 40,000 primary care physicians in the United States, with newly insured patients entering the system over the next few years, we will expect the primary care shortage to worsen," says Dr. Matheny, "but the bill does address this concern in that one of the most important factors in consideration of career selection by medical students in choosing the specialty is payment. So, by addressing the primary care payment rates, we hopefully will be able to increase interest on the part of medical students in primary care."

Community-Based Residencies

"Teaching Health Centers." For some time now, residency programs have shown that physicians tend to practice in settings similar to where they trained. To address the distribution of primary care clinicians, the health care reform package creates two new programs to increase the number of primary care clinicians being trained in community settings: development grants to create Teaching Health Centers (THCs) and Graduate Medical Education (GME) payments from the Department for Health and Human Services (DHHS) paid directly to THCs.

Teaching Health Centers are defined as community-based, ambulatory patient care centers that operate primary care residency programs. To be eligible for DHHS GME payments, the THC must be listed as the sponsoring institution by the entity that accredits the residency program. In other words, the THC itself would have to be accredited rather than being the continuity clinic for a university-based residency. This sets a very high bar for the THC. Because the development grants were authorized but not appropriated, the health care reform package does not offer resources to offset the costs of developing and accrediting the THC's residency program. However, for those THCs that qualify, up to $230 million is appropriated over fiscal years 2011 through 2015. [Title V Subtitle F Section 5508 of the Affordable Care Act.]

Enough?

The combination of expanded training opportunities, increased reimbursement and more loan repayment opportunities may help attract more medical students to primary care. Again, will these measures be enough to ensure adequate access? A May 2010 Health Affairs article casts doubt on the ability of small payment increases and student loan repayment to significantly shift the specialty choice of medical students. Comparing the income and wealth accumulation potential of primary care physicians (general internists and family physicians) with specialists (cardiologists), Vaughn et al found that:

continued >>

Over their lifetimes, primary care physicians earn lower incomes – and accumulate considerably less wealth – than their specialist counterparts. This gap influences medical students, who are choosing careers in primary care in declining numbers. ... The wealth gap is substantial; narrowing it would require substantial reductions in specialists' practice income or increases in primary care physicians' practice income, or both, of more than $100,000 a year. Current proposals for increasing primary care physician supply would do little to lessen these differences. (3)

"We have to look at how we value primary care," says Smith of the KPCA.

Conclusion

Health care reform is a "down payment" on health system transformation. The health care reform package takes several ambitious steps toward improving the American health care system: reforming private insurance markets; expanding public insurance; mandating individual and employer participation; and, emphasizing prevention, quality and primary care. However, provider shortages, uninsured and underinsured patients, and the undervaluing of primary care will continue to stand in the way of true health system transformation. "The Health Care Reform Act is not a panacea for universal access," says Smith of the KPCA. "It is a beginning. It is not the end."

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2. The Health Care Reform Package is comprised of two Acts: the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) which amends the Affordable Care Act. A Compilation of Patient Protection and Affordable Care Act as amended through May 1, 2010 is available at:http:/docshousegovenergycommerceppacaconpdf. For more information: The Health Care Reform Package is extensive and complicated. For detailed summaries and a timeline, I recommend the Henry J. Kaiser Family Foundation website: http://healthreform.kff.org/
3. Vaughn, Bryan T., et al (May 2010) "Can We Close the Income and Wealth Gap Between Specialists and Primary Care Physicians?" Health Affairs 29:5 pp.933-940.

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SO WHAT'S THIS ABOUT **MEANINGFUL** USE?

LIKE IT OR NOT, AND A GOOD NUMBER OF PROVIDERS ARE IN THE "NOT" CATEGORY, THE ELECTRONIC RECORD IS NOT ONLY HERE TO STAY, BUT IS PRODDING US INTO THE NEXT DIMENSION.

I never knew when I went to medical school that I'd have to be a typist! How many of us are nostalgic for the good-ol' days when "electronics" were the Christmas presents that had those little springs on a board that you connected to all those little colored wires. Or perhaps, "Operation." Now that was electronic! If only Milton Bradley knew he was so futuristic, and the patient looks quite representative too.

Alas, here we are in the era of modern medicine. Unfortunately, it's not enough to evaluate, diagnose and treat entities such as CREST or SIADH. Now the provider must make room upstairs for a totally different alphabet soup: EHR, ONC, CMS, HHS, HIT, M-O-U-S-E! Where does it stop? Uh… it doesn't!

Like it or not, and a good number of providers are in the "not" category, the electronic record is not only here to stay, but is prodding us into the next dimension. I know some of you are thinking, "You can't push a string!" Let me take this opportunity to inform you that our government is using electrons to drive us in the direction they think medical documentation should go.

In order to make it easy to transition from the manila world to the virtual world, we now have incentives. As an example, but not necessarily my favorite, we will all LOSE Medicare reimbursement to the tune of 1 percent per year starting in 2015 up to 4 percent per year by 2018 for NOT having an electronic record. Feeling incentivized yet? Maybe just prodded?

There is the promise of either $44,000 (for Medicare providers) or $63,750 (for Medicaid providers) per provider paid out over a number of years for having an Electronic Health Record (EHR) and using it in a meaningful way. (See Table 1) The details can be studied at https://www.cms.gov/EHRIncentivePrograms/. Note: Law school may be beneficial before reading this series of documents. Thankfully, a number of good summaries are available. More importantly, if you select a product from the Certified Health Information Technology (HIT) Product List (CHPL) and practice medicine the way you were taught, you will be able to report meaningful use (MU) and thereby be eligible for the government incentives.

So, what's the catch? Not all EHRs are on the CHPL. There are only three organizations certified by the Office of the National Coordinator (ONC) for Health Information Technology (HIT) to test and certify products for meeting regulatory standards. Believe it or not, these are decided by the Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB).

The three ONC-ATCBs, as of the writing of this article, are 1) Certification Commission for Health Information Technology (CCHIT) in Chicago, Ill., 2) Drummond Group, Inc. in Austin, Texas, and 3) InfoGard Laboratories Inc, San Luis Obispo, Calif. A complete list of the Certified Health IT products is available at http://onc-chpl.force.com/ehrcert. Selecting a product from this list is supposed to guarantee the applicable reporting criteria to meet meaningful use.

So, what is meaningful use? (No, not the next Mel Brooks movie, but a good guess.)

In order to answer this question, we must go back to July 28, 2010, and implementation of "The Final Rule" of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law. 111–5). The ARRA contains the Health Information Technology for Economic and Clinical Health (HITECH) Act that was signed into law on Feb. 17, 2009. HITECH provides the U.S. Department of Health and Human Services (HHS) with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of Health Information Technology (HIT), including electronic health records and electronic health information exchange.

By now, we all must conclude that the United States is destined for an EHR. The government has implemented incentives for providers who adopt an EHR as well as penalties for those who do not. On the surface, the criteria for taking advantage of the incentives may seem cumbersome. In fact, the requirements for eligibility can be allowed to slide from your consciousness simply by selecting an approved product.

The Final Rule implements the provisions of the ARRA that provide incentive payments to eligible professionals (doctors of medicine or osteopathy, dental medicine or dental surgery, doctors of podiatric medicine, doctors of optometry and chiropractors) and eligible hospitals (acute care hospitals and critical access hospitals) participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology. It definitively outlines all the specifics of Stage 1 meaningful use and clinical quality measure reporting to receive the incentive payments in 2011 and 2012. As a note, there will be a separate Final Rule issued by the Office of the National Coordinator for Health Information Technology (ONC) that will define an initial set of standards, implementation, specifications, and certification criteria for electronic health records.

The Recovery Act specifies three main components of meaningful use: 1) the use of a certified EHR in a meaningful manner, 2) the use of certified EHR technology for electronic exchange of health information to improve quality of health care, and 3) the use of certified EHR technology to submit clinical quality and other measures.

To realize improved health care quality, efficiency and patient safety, the criteria for meaningful use will be staged in three steps over the course of the next five years. Stage 1 sets the baseline for electronic data capture and information sharing. Stage 2 (2013) and Stage 3 (2015) will continue to expand on this baseline and be developed through future rule making. Stages 2 and 3 have not been conceptualized.

As of now, two regulations have been released. One defines the meaningful use objectives that providers must meet to qualify for the bonus payments. The definition includes the reporting of clinical quality measures. The second identifies the technical capabilities required for certified EHR technology. The full document can be viewed at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

The specifics of Stage 1 of meaningful use includes three required quality control measures (if your practice does not

MEANINGFUL USE OF A CERTIFIED EHR IN				
Paid in	2011	2012	2013	2014
2011	$18K	-	-	-
2012	$12K	18K	-	-
2013	$8K	$12K	$15K	-
2014	$4K	$8K	$12K	$12K
2015	$2K	$4K	$8K	$8K
2016	$0	$2K	$4K	$4K
2017	$0	$0	$0	$0
TOTAL	$44K	$44K	$39K	$24K
HPSA	$48.4K (=10%)	$48.4K (=10%)	$42.9K (=10%)	$26.4K (=10%)

Table 1: As shown above, Medicare payments are increased by 10% for providers located in a Health Professional Shortage Area (HPSA).
Reference: Meaningful Use, Centers for Medicare and Medicaid Services. http://www.cms.gov/EHRIncentivePrograms/99._Meaningful_Use asp Accessed 11/20/2010.

continued >>

encompass these patient characteristics, there is an alternate list) and both a core set and a menu set of objectives that are specific for eligible professionals and hospitals. For eligible professionals, there are a total of 25 meaningful use objectives. A total of 20 of the objectives must be completed to qualify for an incentive payment. These 20 are divided into 15 core objectives that are required, and the remaining five objectives may be chosen from the list of 10 menu set objectives. For hospitals, there are a total of 24 meaningful use objectives. These 24 are divided into 14 core objectives that are required, and the remaining five objectives may be chosen from the list of 10 menu set objectives.

The three required quality control measures are:

1) Hypertension; Blood pressure measurement
2) Preventive care and screening measures pair; Tobacco use assessment and tobacco cessation intervention
3) Adult weight screening and follow up

The 15 core objectives for eligible professionals are:

1) Computerized physician order entry (CPOE)
2) E-Prescribing (eRx)
3) Report ambulatory clinical quality measures to Centers for Medicare and Medicaid Services (CMS)
4) Implement one clinical decision support rule
5) Provide patients with an electronic copy of their health information, upon request
6) Provide clinical summaries for patients for each office visit
7) Drug-drug and drug-allergy interaction checks
8) Record demographics
9) Maintain an up-to-date problem list of current and active diagnoses
10) Maintain active medication list
11) Maintain active medication allergy list
12) Record and chart changes in vital signs
13) Record smoking status for patients 13 years or older
14) Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
15) Protect electronic health information

The menu set objectives for eligible professionals are:

1) Formulary checks
2) Incorporate clinical lab test results as structured data
3) Generate lists of patients by specific conditions
4) Send reminders to patients per patient preference for preventive follow up care
5) Provide patients with timely electronic access to their health information
6) Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
7) Medication reconciliation
8) Summary of care record for each transition of care/referrals
9) Capability to submit electronic data to immunization registries/systems
10) Capability to provide electronic surveillance data to public health agencies

To qualify for the incentive, all eligible providers are required to:

1) Register with the government via the EHR Incentive Program website.
2) Be enrolled in Medicare FFS (Fee for Service), MA (Medicare Advantage), or Medicaid (FFS or managed care).
3) Have a National Provider Identifier (NPI).
4) Use certified EHR technology to demonstrate meaningful use.

The EHR Incentive Program Timeline is:

- January 2011 – Registration for the EHR Incentive Program begins
- January 2011 – For Medicaid providers, states may launch their programs if they so choose
- April 2011 – Attestation for the Medicare EHR Incentive Program begins
- May 2011 – EHR incentive payments begin
- Nov. 30, 2011 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FFY 2011
- Feb. 29, 2012 – Last day for eligible providers to register and attest to receive an incentive payment for CY 2011
- 2015 – Medicare payment adjustments begin for eligible providers and eligible hospitals that are not meaningful users of EHR technology
- 2016 – Last year to receive a Medicare EHR incentive payment; Last year to initiate participation in Medicaid EHR Incentive Program
- 2021 – Last year to receive Medicaid EHR incentive payment

What's the bottom line?

If you select an approved product and use the product as intended and designed, you will be able to meet the criteria of meaningful use and submit the reports, thereby ensuring eligibility for the incentives. Will the dollars be available? Well, that is the Forty-Four Thousand Dollar question.

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The Care of the Hispanic Patient: A COMMUNITY HEALTH CENTER'S APPROACH

Lessons from our Hispanic patients

Juan is an eight-year-old boy brought to the Bluegrass Community Health Center (BCHC) in Lexington, Ky., by his mother for an earache. He has been a patient of BCHC for the last three years since he and his parents moved to the U.S. Juan has been attending public school in Lexington since kindergarten. His English is fluent and even has a slight accent that belies, not his Mexican origins, but his time here in Kentucky. He is smiling and playful with the medical assistant who calls him back to the examination room. Her name is Lulu, and she is also from Mexico. Juan's mother speaks to Lulu in Spanish as she gives the history of his earache over the last several days. She has been treating him with cebolla caliente (hot onion), which she puts in his ear to remove the aire frio (cold air) that she believes is causing his pain. She has also given him some aguitas (herbal teas), hot treatments for this cold illness.

Lulu briefs the physician on her conversation with Juan's mother and explains the cultural context of hot and cold in relation to illness and treatment. She also reminds him that two of the most common American home remedies - orange juice and chicken soup - are considered to be cold and are, therefore, inappropriate for this type of illness. If these treatments are recommended, the patient's mother may disregard the recommendation for fear of worsening the illness. Together they go in to talk with the patient and his mother, with Lulu providing interpretation.

Upon inspection, Juan is healthy and his earache appears to be due to a serous rather than an acute suppurative otitis media. The decision to defer antibiotic treatment and have Juan return in two to three days is explained to the mother through Lulu's interpretation. As part of a comprehensive visit, Juan's immunization record is reviewed. The importance of the Hepatitis A series and a second Varivax is also discussed with Juan's mother, as these two vaccinations are often overlooked since they are not required for school entry. He is given these immunizations as part of the state's Vaccines for Children program, but the seasonal flu vaccine is deferred since he will get this at school. Juan returns in two days, fully immunized and much improved.

Araceli is a twenty-five-year-old mother of two. As part of routine care for all new adult patients at BCHC, she is offered a fingerstick glucose test to screen for diabetes mellitus. Although she is asymptomatic, her glucose is 245mg/dl and her Hemoglobin A1c is 9.8. The doctor and Araceli talk about her family history of diabetes, her personal history of gestational diabetes and the lifestyle changes she has experienced since moving to the U.S. Like many women from rural Mexico, Araceli used to walk a lot and her food was homemade with ingredients bought fresh from the market. She ate meat infrequently, due to the cost. Now she rides the bus to work, has a sedentary job in a factory and eats fast food most of the time. She has gained at least 40 pounds during the past year and notes that during times of stress, she seems to eat even more. She is very worried about her health, given her extensive family history of diabetes and her mother's early death due to diabetic complications. She and her physician discuss the risks and benefits of starting treatment with metformin in addition to the necessary lifestyle changes. She is invited to attend a diabetes group for Spanish-speaking patients at BCHC and scheduled for a series of classes on diabetic education.

Four months later, Araceli returns to the clinic to report that she completed her treatment. However, her Hemoglobin A1c is unchanged, despite her report that she did fill the prescription and take her medication. Upon further inquiry, her physician discovers that she completed only one month of treatment. Without the original prescription, she could not communicate with the pharmacist to request her medication refill and did not have the minimum visit fee of $25 to return to the clinic. Because of these factors, Araceli is scheduled with the BCHC case manager to review her barriers to access and make a plan for her care. She is referred to a Spanish-speaking pharmacist, registered for a walking group with BCHC's Outreach staff and scheduled for a one-month follow up with a nurse educator to review her progress.

The medical experiences of Juan and Araceli provide valuable lessons about the status of health care for Hispanics in the U.S. and the ways that community health centers can help improve the quality of care for this rapidly growing population.

What does it mean to be Hispanic?

The term Hispanic depicts the shared language and a confluence of geography and culture that resulted from Spain's colonial presence in the New World. What it fails to reflect, however, is the diverse culture and

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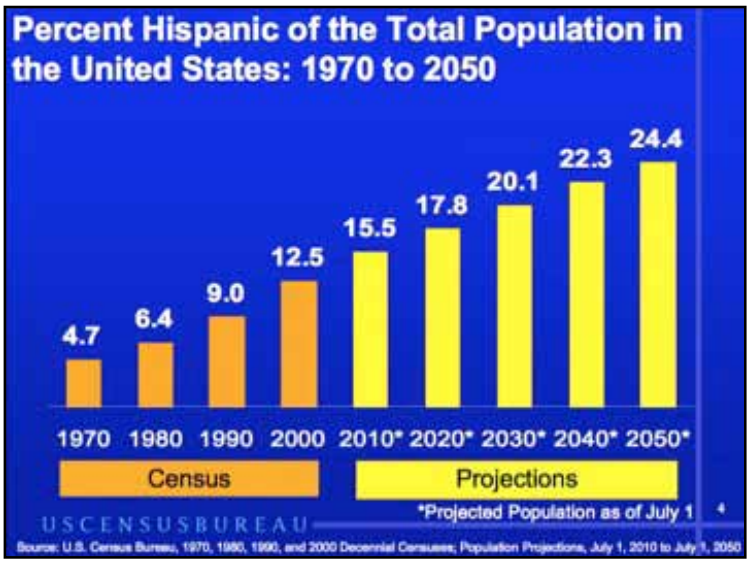
historical origins of the people it describes. The U.S. Census Bureau considers a Hispanic person to be one from Mexico, Central and South America, Cuba, Dominican Republic or Puerto Rico, while another common term, Latino, refers to people from cultures and countries once under Roman rule, such as Spain, Italy and Portugal. While not identical in meaning, the terms Hispanic and Latino are used interchangeably. Hispanic persons are also white, black, Asian or Native American and are not designated as Hispanic when living in their countries of origin. Beyond the ambiguities in nomenclature, the elusive nature of defining what it means it be Hispanic reflects the variability of this group.

As a descriptor, the term Hispanic was not widely used until the 1970s, when it appeared on the U.S. Census form to capture a broader population count of persons with Spanish colonial origins who had immigrated to the U.S. (1, 2) In order to create laws that would allocate funding towards services and programs for the rapidly growing Mexican, Cuban, Puerto Rican and "other" Spanish-descended persons, it was necessary to institutionalize a description and definition of what it means to be Hispanic. Later, use of the term gained momentum in popular culture when the National Council of La Raza, the largest national Hispanic civil rights and advocacy organization in the U.S., and other social advocacy groups sought to create solidarity among immigrants from Mexico, Central and South America by converging around certain social, civil and political causes

Table 1



they had in common. Prior to that, persons of Spanish origin from the Americas identified with and were denoted by their country of origin, as Guatemalan, Colombian or Dominican, for example. Despite their common language, Spanish-speaking individuals come from a variety of national and ethnic backgrounds.

Over the last twenty years, the Hispanic population in the U.S. has grown remarkably. Hispanics comprise only 15.8 percent of the total U.S. population, but have contributed 39 percent of the U.S. population growth since 2000 and are projected to contribute 45 percent from 2010 to 2030. (3, 4) Due to a particularly high birth rate and low infant mortality, an increase in the number of Mexican Hispanics accounts for 34 percent of this rapid growth. Recent estimations of birth rates in the U.S. put Hispanics at about 22.1 per 100,000 as compared to 16.5 for non-Hispanic blacks and 11.4 for non-Hispanic whites. This translates into roughly 2.3 million non-Hispanic whites, 650,000 non-Hispanic blacks and 1 million Hispanics born in 2008. It is estimated that by 2050, the Hispanic population will be the largest minority group in the U.S., comprising anywhere from 25-30 percent of the total population (Table 1).

As of 2009, the Hispanic population in Kentucky was 116,000, or 2.7 percent of the population. The proportion of Kentuckians who are Hispanic is much lower than the national average, despite the perceived density of agricultural work in the area. While agricultural and farm labor brought the initial wave of Hispanic immigrants to Kentucky, many have now settled out into service industries or factory work. Despite the historical concentration of Hispanic populations in the southwestern U.S., increased demand for seasonal agricultural labor has created a migrant stream along the east coast from Florida to Maine, with workers following the crop seasons from one area to the next. The number of Hispanics in the Carolinas has doubled, largely as a result of the increased demand for agricultural labor. In fact, BCHC in Lexington began as the Bluegrass Migrant Farmworker Health Center and still holds the designation of the only migrant farmworker community health center in the state.

The term Hispanic depicts the shared language and a confluence of geography and culture that resulted from Spain's colonial presence in the New World.

A profile of socioeconomic and health characteristics

A common misconception is that the majority of U.S. Hispanics are foreign-born. While the proportion of foreign-born persons is higher among Hispanics than non-Hispanic whites, 62 percent of U.S. Hispanics are native-born. (5) Compared to non-Hispanic whites, U.S. Hispanics are also younger, more likely to be married, have lower income and less education and are more likely to work in low-skilled occupations. (6) They also live in larger households, suffer higher rates of poverty and are disproportionately likely to be uninsured, as compared with non-Hispanic whites.

In aggregate, prevalence of diabetes in Hispanic adults (11 percent) is almost twice that of non-Hispanic whites (7.1 percent). (7) The risk of death from diabetes is also nearly double (Table 2). While this may be due to their propensity for obesity and being overweight, 38 percent and 70 percent respectively, a genetic link seems likely. Hispanics also suffer a higher rate of death from liver disease and cirrhosis, similar to the Native American population. Of all Hispanics, the Puerto Rican subpopulation fares worst in terms of health care outcomes with high

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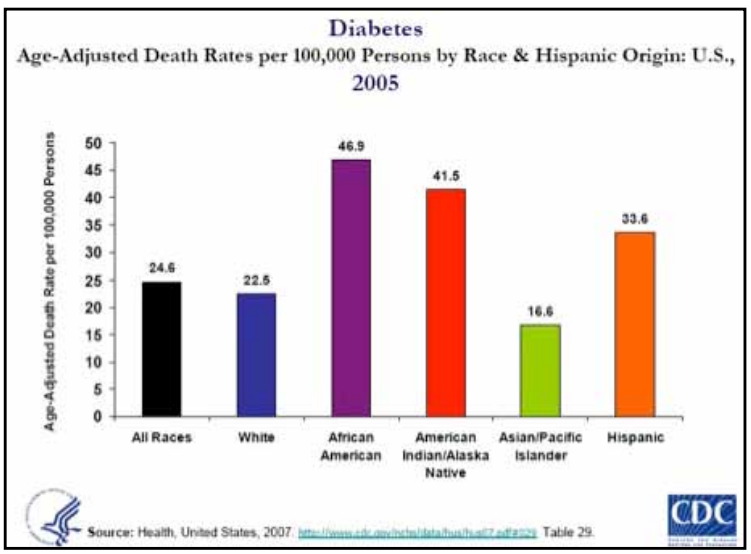
rates of asthma, teen pregnancy and infant mortality similar to those of non-Hispanic blacks. (8)

Maternal and infant mortality are relatively low in the overall Hispanic population. (9, 10) Likewise, mortality from cardiovascular disease is much lower in Hispanics, particularly in the Mexican subpopulation (Table 3). Theories explaining the commonly cited "Hispanic paradox" of lower all-cause mortality despite lower socioeconomic status have been discussed in the literature. (11, 12) First is the "healthy migrant" theory, which argues that these outcomes are an artifact of selection bias – that only healthy persons, usually young and male, undertake and survive the strenuous and treacherous overland journey to the U.S. Another argues that the family structure remains intact despite immigration, providing significant social support and framework for protective behaviors. Finally, it has been postulated that this finding is an artifact of the failure to capture the deaths of individuals who become ill and return home to die. This has been called "the salmon bias." Theories notwithstanding, increasing evidence suggests that barriers to health care access, risk and adoption of U.S. health behaviors upon immigration erode the protective factor of Mexican origin.

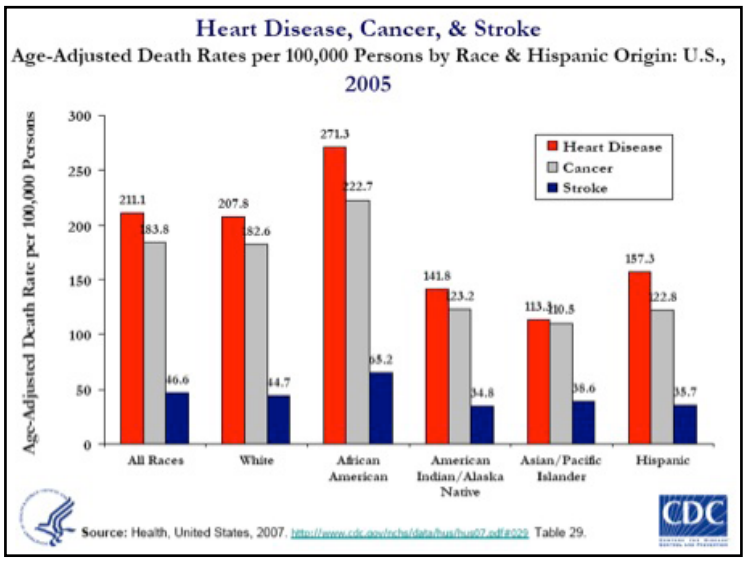
Table 2



Final lessons from our patients

Much like his peers, Juan is just a typical school-aged child at BCHC. He is bright, respectful and able to talk about his earache. Unfortunately, many Hispanic children at Juan's age are put in the position of interpreting for a non-English-speaking parent who is describing his or her own illness, despite the fact that this is neither ethically appropriate nor strictly legal. In this situation, our interpreter, Lulu, provides not only language support for our patients with limited English proficiency but also cultural interpretation for our physician, in order to allow the development of a culturally sensitive treatment plan. Given the inequity in health care access compounded by the increased risk for certain health conditions such as depression and obesity among Hispanic children and young adults,

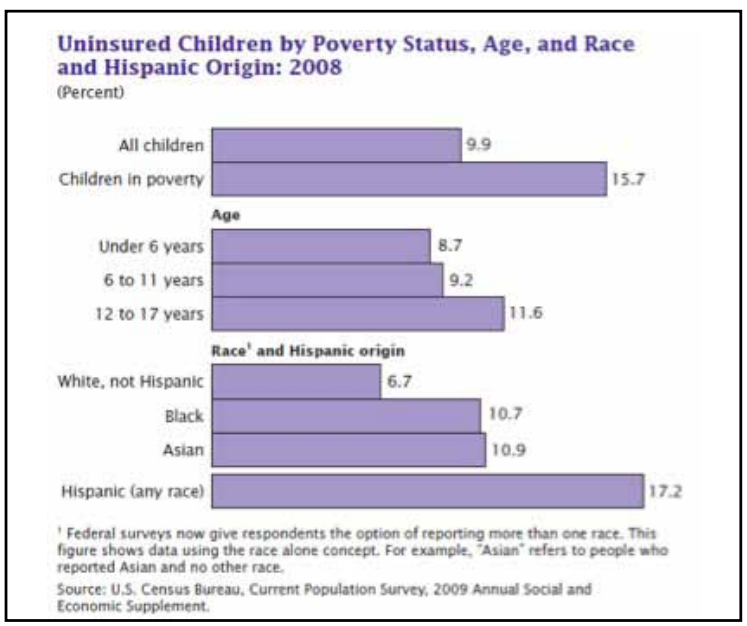
Table 3



clear communication and a thorough understanding of the patient's culture and circumstances are imperative to meeting our patient's needs. By systematically addressing the known health disparities in vulnerable populations, we can promote quality care for children like Juan and their communities. (13, 14)

Araceli presents several issues. Not only is she burdened with early diabetes, but her financial status and low health literacy create further barriers to receiving optimal care. Despite our best efforts, we cannot always anticipate the hurdles our patients will encounter in navigating a foreign system of health care. However, we can continue to learn about and adapt to the challenges of providing meaningful services that include a patient-centered experience. What other cultural influences are involved here? As in many Hispanic cultures, a sense of deference toward the physician may prevent Araceli from revealing that she had difficulty filling her medication or from asking whether

Table 4



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the treatment should have been continued. In establishing a relationship with her patient, the provider must consider the motivation and engagement of her patient in addition to the logistics of following the prescribed plan. As with most patients, Araceli is most likely to engage in her health if she feels that her provider expresses genuine interest in her life and establishes a good rapport - a quality she may describe as personalismo. Another important cultural concept is confianza, or trust in her provider. For most patients, new information will rarely displace existing cultural beliefs about health but may be added to or integrated with what they already know. Ultimately, it is likely the patient's confidence in the abilities and benevolence of her provider which will allow her to believe in a plan of treatment that may be unfamiliar and outside of her cultural scheme.

What is the role of community health centers in providing health care for Hispanic populations?

Hispanics bear a disproportionate burden of poverty in the U.S. due to historical, environmental and social factors. In particular, immigration status, limited English proficiency and cultural differences create significant barriers for many Hispanics seeking health care. As unskilled, seasonal or temporary workers, they likely will not have the opportunity to purchase an employer-based health insurance plan, and the exorbitant costs of medical care may prevent them from receiving preventive treatments which may delay presentation for significant illnesses (Table 4). Without the health insurance coverage necessary for entry into most ambulatory practices, Hispanic patients may seek care intermittently through urgent care centers or emergency rooms. This discontinuity of practitioners and the lack of a longitudinal source of care have been shown to have an adverse effect on health outcomes, particularly in vulnerable populations. (15)

A viable option for many Hispanic patients is to seek care at grant-funded health centers. BCHC, as one such health center, provides comprehensive primary care services to communities in Fayette County and seven surrounding counties. In order to understand and meet the needs of its population, such as Juan and Araceli, BCHC maintains a bilingual and multicultural staff. With a high regard for the diversification of the U.S. population, BCHC models the road to health equity by recognizing that what was previously described as Hispanic culture is a substantial part of, and may soon be inseparable from, American mainstream culture.

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Alan Stevens Wrightson, M.D. *recently accepted the position as medical director of the Bluegrass Community Health Center in Lexington, Ky. He continues to work with the Department of Family and Community Medicine at the University of Kentucky, teaching residents in the areas of community medicine and oral health. He is one of the founding steering committee members for "Smiles for Life," a national oral health curriculum for primary care providers and students that is endorsed by the Society of Teachers of Family Medicine (STFM) and the AAFP. Dr. Wrightson was born in Kentucky and is a graduate of the University of Kentucky College of Medicine and Family Medicine Residency program.*

WILLIAM C. THORNBURY, M.D.

PSEUDOEPHEDRINE: A **MORAL CRISIS** IN KENTUCKY

Introduction

Pseudoephedrine, once a relatively benign pharmaceutical used as a decongestant, has become a substance of misuse in the United States. When combined with readily available industrial products, it is synthesized inexpensively into methamphetamine intended for abuse. Within the Commonwealth of Kentucky, which carries the dubious distinction of the state with the highest drug diversion in Appalachia (1), its misuse has become an epidemic. Following a presentation by the Kentucky Narcotic Officers Association (KNOA) and the Kentucky State Police (KSP), the Kentucky Academy of Family Physicians (KAFP) Board of Directors deemed it necessary to support a mandate requiring prescription dispensing of pseudoephedrine. This article constructs the history and moral argument supporting this decision.

History of Pseudoephedrine Legislation

In 1976, the U.S. Food and Drug Administration allowed prescription pseudoephedrine to be sold for the first time over-the-counter. Transition from this native form to methamphetamine was relatively easy for chemists, and misuse within the drug population soon followed. Over three decades, it slowly became ingrained within the drug culture; with the advent of readily available industrial products, this rendered a low-technology synthesis within the capability of neophytes. As drug diversion continued to increase, the U.S. Congress in 2006 mandated that the product be returned behind the prescription counter with limits established for daily and monthly quantities given to an individual, and a register kept.

In recent years, annual sales of OTC pseudoephedrine have soared to over $600 million (2) - the logarithmic increase in relation to population and disease prevalence suggests that a majority is for misuse. In Kentucky, initially, misuse declined in 2006 after mandate of the federal registry. To combat this, drug diverters enlisted conspirators to purchase regular, multiple small quantities of the drug, a.k.a. "smurfing." As meth lab incidents began to increase, Kentucky, in 2008, instituted an electronic tracking of drug sales within pharmacies (METHCHECK); however, the incidence of illegal meth labs has continued to increase unabated. Meth lab incidents have steadily climbed in Kentucky: from 302 in 2007, to 743 by 2009; and, by year's end, is expected to pass 1,000 in 2010 - over a 25 percent increase from 2009.

In the fall of 2010, Sgt. Stan Salyards of the KNOA and Major Joe Williams of the KSP presented evidence before the KAFP Board regarding the current state of pseudoephedrine diversion in the Commonwealth. The KAFP Board, and subsequently the KAFP House of Delegates, passed a resolution of support for prescription pseudoephedrine. In September, a companion resolution to the Kentucky Medical Association (KMA) House of Delegates was forwarded by the Barren County chapter after a similar presentation by Tommy Lovings, head of the Warren County Drug Task Force. This resolution passed the KMA with the recommendation to support prescription pseudoephedrine.

Social Consequences

Pseudoephedrine's diversion into methamphetamine has profound social, economic and political consequences. It is beyond this article to present the case for each; however, an overview will be provided to allow the practitioner to appreciate the gravity of these issues to society, and the Commonwealth at large.

The "Meth Project," released in February

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2009 by the Rand Corporation, estimates that methamphetamine abuse costs the U.S. government (all of us) $23.4 billion annually. (3) In Kentucky, Major Joe Williams of KSP stated, "The total cost to KSP last year [2009] to remove 716 meth labs totaled $1,373,825." (4) Of particular note is that we do not have reliable information on the expense to the Commonwealth for burn unit care, emergency room care, child protective services, and other fiscal burdens which one can estimate to be at least as substantial.

The Oklahoma State Police give a fair estimate that the calculable expense of each meth lab is about $350,000. (5) This is inclusive of treatment programs, incarceration, mental health services, toxic waste disposal, child protective services, law enforcement, lost wages, and property damage. Likewise, they are unable to estimate the expense of secondary crime (crime used to procure resources for the drug addiction), health care needs (burn unit/emergency department/primary care), cost to families or the potential needs of unborn children.

The Case for Pseudoephedrine by Prescription

Amid the national despair of rising pseudoephedrine misuse, there have been islands of success. Empirical data from Oregon (6) and Mississippi (2) are available regarding the legislation of prescription pseudoephedrine. In 2006, Oregon enacted a law requiring prescription for all pseudoephedrine products. As a result, law enforcement's response to a meth lab scene for arrest and subsequent clean up has decreased 98 percent from 2004 (472) to 2009 (10). [See Figure 1.] Mississippi instituted a similar statute in July of this year, reporting a 65 percent decrease year-to-date: July-November 2009 (259); 2010 (94).

A compelling argument can be forwarded for returning pseudoephedrine to prescription drug status in Kentucky given our current understanding of the trends of misuse. As with any malignant process, the diversion and misuse of OTC pseudoephedrine evades any single plan of eradication. The National Methamphetamine and Pharmaceuticals Institute, composed of police and prosecutors, reports that smurfing is presently at epidemic proportions. (7) Analysis of the data, further supported by opinion from the KNOA and KSP, suggests that the present system is inadequate. What may have worked previously has now been rendered inadequate; in effect, the malignancy has mutated. An alternative approach has become necessary in the fight against misuse of pseudoephedrine in Kentucky.

By definition, pseudoephedrine now meets the criteria as a controlled substance, being a product that has potential for public misuse and abuse. One of many options the legislature might consider would be to define the product as a C-III, requiring KASPER reporting, and eliminate the requirement for METHCHECK. This would require physicians, pharmacists and other providers to stand between drug diverters and the legitimate need of the public.

In placing pseudoephedrine in a controlled status, thoughtful consideration must be given to public access to the drug. Primary care (and other) physicians perform this duty on a daily basis with other controlled substances. In point of fact, there are, of course, other alternatives available for symptomatic treatment of sinus disease. An important point not to be lost is that the drug is not generally used for disease treatment itself, rather, for symptomatic relief of discomfort. Further, physicians know and understand their patients and families; access to the product could be appropriately met by our traditional medical system. Substantial inconvenience has not been reported as problematic in the Oregon test case. In short, a critical point has been passed with regard to public safety taking precedent over convenience.

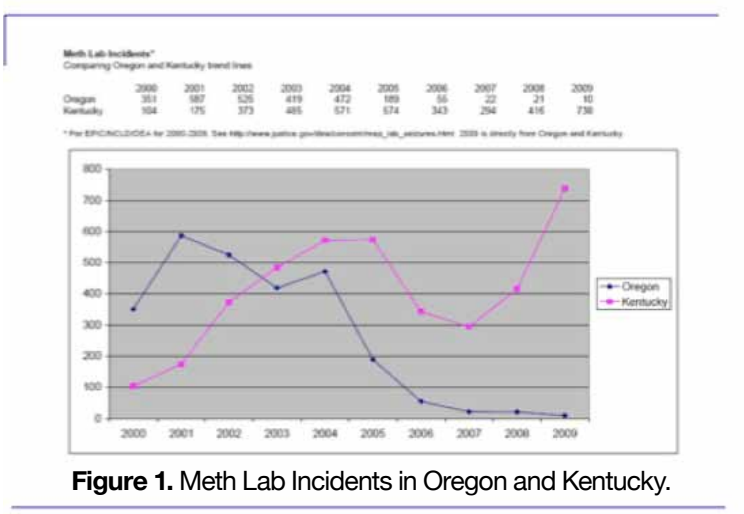

Figure 1. Meth Lab Incidents in Oregon and Kentucky.

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Conclusion

The diversion of OTC pseudoephedrine to methamphetamine has now become a matter of public health and safety. As stewards of the Commonwealth's health, Kentucky's physicians, in particular those serving in primary care, can no longer ignore the totality of health consequences that our current policies enable. While many arguments can be made for intervention, physicians need stand only behind one, and that is morality. In effect, open war is upon us, being prosecuted by a parasitic element of society that has ill-regard for injury to individuals, families or communities. To continue to stand idle in this circumstance places the future of the Commonwealth's health at risk, and this risk is both serious and substantial.

The considerable expense and progressive trend of misuse have begun to impact the Commonwealth's resources. Obligatory items such as incarceration, uncompensated health care and law enforcement allocated to the crisis can be expected to overshadow budgets. Ultimately, it can be expected that the fiscal matter will transition to a political matter when deficit resources lead to forced decision making.

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The war on drug misuse will require action on multiple fronts. In Kentucky, physicians of good conscience have recommended prescription status for pseudoephedrine. On a regional level, surrounding states should consider limiting access similarly in an effort to minimize cross-border access to the drug. On the federal level, government should discuss the elimination of imported pseudoephedrine. Ultimately, our partners in health, the pharmaceutical industry, will need to champion this effort and develop dosage forms, isomers or other novel agents that cannot be synthesized into substances of abuse.

In summary, the recommendations by the KAFP and KMA House of Delegates are not lightly made. The proposal to instill prescription drug status for pseudoephedrine will not be the only solution necessary to combat the assault against Kentucky's public health and safety by drug diversion into methamphetamine. It is, however, the one that is before us as physicians; indeed, we have irrevocably come to a time of action.

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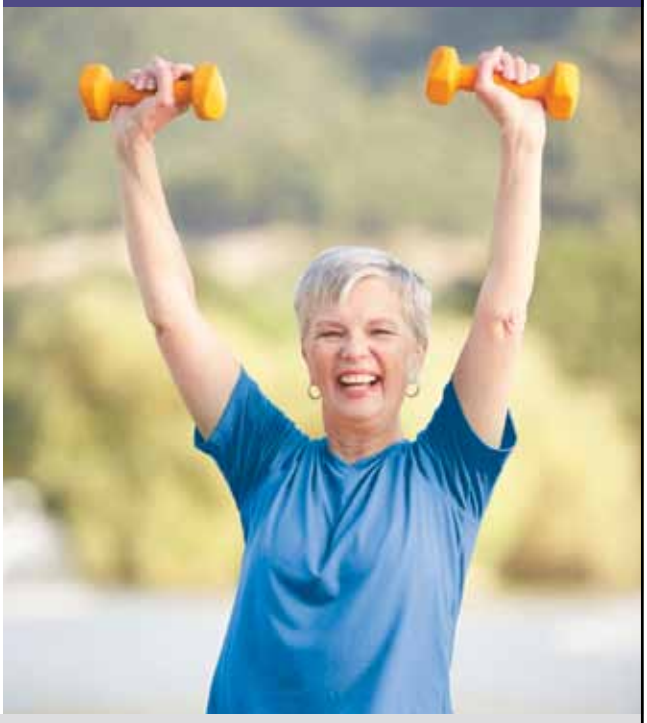

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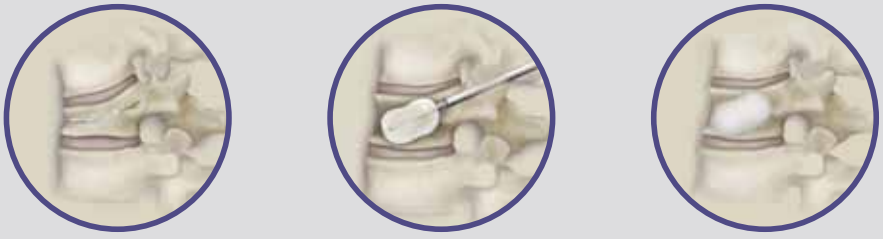

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