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April 27-28, 2012
Crown Plaza, Lexington, KY

MARK YOUR CALENDAR FOR UPCOMING MEETINGS!

• Rheumatoid Arthritis: Effective Management Strategies for Patient-Tailored Care

Join the GAFP and Antidote for a webinar on **January 24th at 12:15 ET** as rheumatologist Stanly Cohen, MD and family physician Louis Kuritzky, MD discuss the diagnosis and treatment of Rheumatoid Arthritis. From initial assessment and classification to referral and treatment, Drs Cohen and Kuritzky will discuss ways of find the most appropriate treatment options to develop a plan for patient-tailored care. Learn more and register today at: http://antidotecme.com/RA

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message from the PRESIDENT

Family physicians for ALL KENTUCKIANS

As physicians, we uniquely understand the importance of vision in our patient's lives. Vision is such an important sense in our understanding of the world. All four Gospels mention Jesus' healing of a blind man, but it is the Greek physician Luke who best tells this parable.[1] As Jesus approached Jericho, a blind man was sitting by the roadside begging. The man began to scream and cry out for mercy as Jesus passed. Jesus asked the man "What do you want me to do for you?" The man replied, "Teacher, I wish to see." Jesus said to him, "Your faith has healed you." Instantly, the blind man could see. He followed Jesus, looking at everything as he went!

At our Strategic Planning meeting in November, we developed a vision statement for the Kentucky Academy of Family Physicians: **Family physicians for all Kentuckians!** What an eye opening, bold and powerful statement. Can you see it? Unlike the somewhat generic vision statement of the AAFP, "To transform healthcare to achieve optimal health for everyone," our vision is personal. Can you imagine what it would be like if all Kentuckians had a personal family physician to manage their healthcare? I cannot envision any better way to provide the quality care and valued care our citizens deserve, now, and into our future.

Great vision statements are inspiring words that clearly and concisely convey the direction of the organization. I think we hit a home run! "**Family physicians for all Kentuckian**s" powerfully communicates our intentions and will hopefully be an attractive common vision for our members. Our success in achieving this vision will be determined by our shared values and our mission. At the Strategic Planning meeting, we also redesigned our mission statement and strategic priorities. "**Improving the health of Kentuckians, promoting the value of family medicine, and serving the needs of our members in a**

supportive professional community" is our proposed new mission statement. We have identified five key strategic priorities to help us meet our mission:

1. **Health** = promoting a healthy commonwealth
2. **Advocacy** = advocating for the rights of members and their patients
3. **Community** = creating an open professional community for sharing practical and clinical knowledge
4. **Practice enhancement** = assisting our members with resources to enhance their practices
5. **Workforce** = developing interest and support for the future family medicine workforce

Each strategic priority has several potentially achievable projects or activities that will allow us to measure our success. Two short-term priorities emerged from the discussions: developing a "community" of family physicians, starting with updating our web site, making it more interactive and investigating social media opportunities; and working with like-minded organizations with initiatives that will help us reach our goal of increasing the number of family physicians in Kentucky.

CAN YOU IMAGINE WHAT IT WOULD BE LIKE IF ALL KENTUCKIANS HAD A PERSONAL FAMILY PHYSICIAN TO MANAGE THEIR HEALTHCARE? I CANNOT ENVISION ANY BETTER WAY TO PROVIDE THE QUALITY CARE AND VALUED CARE OUR CITIZENS DESERVE, NOW, AND INTO OUR FUTURE.

Our strategic priorities will focus the activity of the KAFP staff and leadership. Promoting, advocating, creating, assisting and developing are our action verbs. Like in the parable of the blind man, it will take faith to reach our vision. It will also take a lot of hard work. In a Peruvian desert in April 2002, artist Francis Alys enlisted the help of 1000 volunteers (about the size of the KAFP!). Equipped with shovels, they formed a single line in order to displace by ten centimeters a five hundred meter long sand dune from its original position. This team of volunteers literally moved a mountain. It made for a visually memorable scene captured in the video "When faith moves mountains".[2]

A lot of time and hard work went into the Strategic Planning meeting. I would like to thank the following people for their participation: Eddie Prunty, Ron Waldridge, II, Sharon Colton, Melissa Zook, John Darnell, Buki Adelola, Brittany Sullivan, Mont Wood, Jim O'Brien, Michael King, Nancy Swikert, Chuck Thornbury, Ken Crabtree, Andrea Adams (KPCA), Gerry Stover and Janice Hechesky. Witnessing the wisdom and highly functional communication skills of these individuals during the meeting was awe-inspiring. "**Family physicians for all Kentuckians**" is a vision I can see and believe in. If you have any ideas or wish to get more involved, please give me a call or send me a text. Mark your calendar for our Kentucky Academy of Family Physicians 61st Annual Scientific Assembly in Lexington, April 27 – 28. I look forward to seeing you there.

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[1]Luke 18, vs 35-43. NIV.
[2]www.nytimes.com, video clip "When Faith Moves Mountains" 5/1/11, accessed 11/28/11.

message from the ASSOCIATE EDITOR

I would like to take this opportunity to introduce myself, as this is my first issue as associate editor, and my first contribution to the journal. I am an assistant professor here at University of Louisville in our Department of Family and Geriatric Medicine. I have been here now for just over a year, and what a year it has been. Our Newburg Clinic has moved sites and I am the new Medical Director. I have become involved with the residency as an Assistant Director. And my wife and I welcomed our first son into the world just over three months ago. But that is skipping a few major details that may help to round out the story. If you will, let me share with you my journey to this great state.

My voyage to Kentucky has been a long one, one that began in Pennsylvania where my father was attending medical school. Upon graduation we picked up and moved to Sacramento, CA, for his Family Medicine residency. After residency, my father's love for rural communities and taking care of the underserved lead him to the National Health Service Corps. From California, we moved to Morehead, KY and he started a three-year stint in Menifee County. I remember fondly my days in Morehead, swimming at Cave Run Lake and chasing fireflies – something we never had on the west coast.

Once my father's obligation was fulfilled, he and my mother decided to move us out to Oregon, an area of the country they had always wanted to see. We loved it out there, and he had a thriving private practice for over 25 years. I often rounded with him in the hospital on the weekends, dreaming of the day when I might follow in his footsteps. After college I applied to medical school at the University of Kentucky, hoping to rediscover some roots and get a change of pace. I was quite sure that it would be a short four-year trip as I was now a "west coast kid". But my father knew better. He assured me that I would fall in love with a bluegrass woman and lay down some roots of my own. But what did he know?

I met my wife on the first day of medical school. We were anatomy partners and I was a goner from the get-go. We couples-matched at University of Virginia, and spent five wonderful years in Charlottesville – three as residents, and two more for a fellowship in academic development with an emphasis in Evidence-Based Medicine and Information Mastery.

THE OVERALL IDEA OF INFORMATION MASTERY IS THAT WE AS PHYSICIANS MUST LEARN TO WADE THROUGH THE ENORMOUS AMOUNTS OF INFORMATION WE FACE EVERY DAY AND QUICKLY GET TO THOSE THINGS THAT ARE IMPORTANT TO US AND OUR PATIENTS. WE MUST LEARN TO SIFT THROUGH DISEASE-ORIENTED STUDIES TO FIND ONES THAT MEASURE PATIENT-ORIENTED OUTCOMES.

My introduction to the (relatively) new concepts of Evidence-Based Medicine and Information Mastery was at the hands of David Slawson. I was immediately fascinated by and drawn to this new science of medicine. Here now was a way to help quantify, or at least qualify, how well we know what we know. I found it freeing to be able to give my patients reassurance about treatments that have been well tested and shown to help, and useful to be able to share with them the uncertainty we have for other things. I saw this as a perfect complement to the art of medicine that my father taught me growing up.

The overall idea of Information Mastery is that we as physicians must learn to wade through the enormous amounts of information we face every day and quickly get to those things that are important to us and our patients. We must learn to sift through disease-oriented studies to find ones that measure patient-oriented outcomes. It can be a liberating idea – that we are allowed to ignore much of what is presented to us and instead concentrate on the information that necessitates a change in practice, or that will improve the lives and health of our patients. It is a philosophy of "work smarter, not harder" that I think intuitively appeals to most physicians, especially those in a field that is as broad as our own. And now there are a multitude of online resources that offer predigested information designed for point-of-care use, thereby delivering EBM to your fingertips at the time of a patient encounter.

This is not to say that the evidence supplants the individualized care that we pride ourselves in giving. But it does offer a default for when we are not sure of the right direction to take. Instead of guessing, we can often rest assured in that we are offering proven therapies that have been shown to help large groups of patients in ways that are important to them.

Perhaps my favorite example of the power of point-of-care EBM is in counseling a patient with heart disease, hypertension, and hyperlipidemia who smokes. Sound familiar? If I pull up a Framingham or ATP III calculator, I can quickly show him that despite what I can do about his blood pressure or cholesterol with medications, no one factor will impact his health like smoking cessation. And I can show him the numbers to prove it, which can be quite powerful. This data then helps us prioritize his health problems and identify those that need the most time and effort presently.

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All of this led me to my present position as a family physician at an academic center. Academics appeals to me as it affords me the opportunity to help shape the young physicians who will hopefully end up taking care of the people of this great state. And in a state so desperately in need of more primary care, I am honored to aid in the training of family physicians. I have always believed, and continue to believe that family medicine is necessarily the cornerstone upon which our medical system is built, and recent changes in the health care system in this country have reinforced that. As family physicians, we have the ability to bring the most cutting-edge information to all those in need, and deliver it with the compassion and sensitivity that is the trademark of our specialty.

There has been quite a lively discussion about the art and science of medicine lately, both in this journal and in the country at large. There is fear that the personal care we cherish as patients and physicians will disappear in the shadows of "socialized" medicine and large health care organizations. But I do not see it that way. I know for a fact that my residents are taught the art of medicine. And I am working to teach them how to be Information Masters.

As associate editor of this journal, I hope to continue the dialogue. I see this publication as a forum for us to mull over these coming changes and to work together to find ways to adapt. I want to keep our young physicians involved, to help them see the path that others have laid out before them and help them to appreciate the task at hand. I would also like to announce that I will be working with Drs. Crump and Wrightson to develop a series of EBM case reviews, drawing from the patient encounters of our members. Look for the first of this series in the next issue. And if anyone out there has a case for us, or something else they would like to see addressed in these pages please let myself, or Dr. Crump, or Dr. Wrightson know.

Practice Committed to Quality

St. Elizabeth Physicians in Williamstown is Kentucky's First Level 3 Patient-Centered MEDICAL HOME

When it comes to demonstrating a commitment to quality and evidence-based medicine, St. Elizabeth Physicians in Williamstown has been leading the pack among Kentucky's primary care medical practices. In June, the Williamstown office became the first practice in Kentucky to achieve a level 3 rating as a patient-centered medical home (PCMH) from the National Committee for Quality Assurance (NCQA). Level 3 is the highest level possible in NCQA's PCMH program.

The practice previously was recognized as Kentucky's first PCMH back in 2010, when it achieved a level 2 rating.

The NCQA describes the PCMH as a healthcare setting that facilitates a partnership between the patient and the patient's personal physician and, when appropriate, the patient's family. Care is facilitated by patient registries, information technology, health information exchange and other means to ensure that patients get the care they need in an appropriate and timely manner.

In addition to the level 3 PCMH rating for the practice as a whole, physicians in the Williamstown office have achieved distinction in NCQA's Diabetes Recognition Program, which recognizes clinicians who use evidence-based measures and provide excellent care to patients with diabetes.

The accolades highlight the culture of quality improvement and service to patients that the Williamstown practice is building, says Denise Page, RN, CPC, Director of Quality and Compliance for St. Elizabeth Physicians

Patients clearly benefit from the changes the practice has made on the road to becoming a PCMH, says Page.

"The best indicator of how PCMH affects our patients is feedback from the

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THE CHANGES WE MADE BENEFIT NOT ONLY OUR PATIENTS, BUT OUR PRACTICE AS WELL. WE'VE SEEN INCREASED STAFF MORALE, IMPROVED REIMBURSEMENT, AND HIGHER LEVELS OF PATIENT SATISFACTION AND HEALTH ACROSS THE BOARD.

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patients themselves," she says. "During a focus group we conducted, one patient said she loved our practice because she could call in the morning to get an appointment for later that day. She would then use her lunch hour to see the doctor, go to the pharmacy, get lunch and still have time to eat before clocking in for the afternoon's work. To me, that is the true meaning of patient access."

While transforming into a PCMH can result in outstanding patient service, the process is definitely not easy, says Ford Threlkeld, MD, one of the physicians at the Williamstown office. "Our journey required hard work from everyone involved -- brainstorming, following through with our processes, and finally checking to make sure they were working and getting the desired result."

Dr. Threlkeld says the most difficult tasks were maintaining detailed tracking efforts and hurdling many time-intensive projects. "By exceeding goals and implementing our electronic medical record system, we were able to move from our starting point as a level 2 PCMH to our current level 3 rating," he says. Furthermore, he says, "all of that hard work has paid off tenfold. The changes we made benefit not only our patients, but our practice as well. We've seen increased staff morale, improved reimbursement, and higher levels of patient satisfaction and health across the board."

MORE INFORMATION

To learn more about NCQA's PCMH recognition program, visit www.ncqa.org. If you would like to ask questions or visit St. Elizabeth Physicians, contact Denise Page at 859-344-3711 or denise.page@stelizabeth.com.

LETTER TO THE EDITOR:

Dear Sirs,

I have recently received the "important letter from Medicare" outlining penalties incurred by those physicians not complying with electronic medical records. Several hardship situations were cited for exemptions. However, there is no exemption for those physicians who are near the end of their careers and in solo practice.

I recently joined my husband's practice after the multispecialty group in which I worked closed. I had used electronic medical records in my previous practice and therefore continued with them in my new location (since I would be starting with new charts). I was not able to easily access the records from my previous practice to do this and was required to hire personnel to individually record each record on a hard disc in order to access it in my new practice. Unfortunately when switching EMR companies it is impossible to simple transfer information electronically without paying huge sums of money to one or the other company.

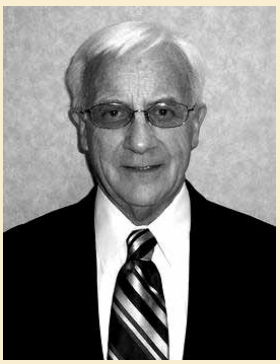
My husband, also a family physician, has been in solo practice for the past 30 years. He may be retiring in the next 5 or 10 years, depending on how the practice environment goes for physicians. For him to switch 30 years of patient records into electronic form would likely cost over $150,000 in staff time. He will face a drop in efficiency of around 30% or alternately an additional 20-25 hours a week on completing medical records after office hours, adding to an already long work week. Then there are the start up costs of the hardware and software, as well as the monthly fees associated with upgrades and tech support. He has already seen firsthand what it involved when I switched to electronic records in 2004. I have yet to see the $40,000 promised by the government for all of this.

Electronic records would probably make sense for a new physician, just out of training. He/she would not have old records to convert. Their training would involve electronic records and therefore they would be proficient in operating the programs from the start. They would not have the daily patient volume yet to slow them down.

In conclusion, for the older physician, especially in solo practice where the overhead would be greatly impacted, it makes no sense to switch to electronic records. I applaud those physicians who wish to pursue it, but for someone near the end of their career it certainly constitutes a hardship. This certainly should be included in the Medicare criteria. Otherwise, these older physicians will be sorry to lose their Medicare patients. The system will be driving out of practice efficient dedicated physicians at a time when we are already short of manpower in our field.

Thank you for listening.
Patricia M. Williams, MD, FAAFP
Mayfield, KY

Patricia Williams, MD, is a long-time resident of Mayfield, KY, and past president of KAFP. She trained in Syracuse, NY, and practiced for a while in Seneca Falls. She was part of a multidisciplinary group in Mayfield for over 20 years and recently moved to a private solo practice. She is a fellow in the AAFP as well as an alternate delegate.



GENERAL PRACTICE *in Ireland*

This past year I had the privilege of spending six months on sabbatical in Ireland. Returning to the country I left 43 years previously was a life changing experience. Ireland had transitioned from a poor country to a wealthy materialistic country but now finds itself in economic decline. These changes caused me to reflect on my role as a physician in the US, especially in comparison to the life of a general practitioner (GP) in Ireland.

Through a grant I received from Atlantic Philanthropies to study the experience of General Practitioners in dealing with Elder Abuse, I was appointed at Trinity College Dublin (founded 1592) in the Department of Medical Gerontology. In reality I spent most of my time at the Adelaide and Meath Hospital down the hall from Dr. Thomas O'Dowd. Dr. O'Dowd is one of the primary authors on a report done in 2005[1] that surveyed the lives of general practitioners. In our many conversations I grew to better understand the transitions that had occurred in the years of my absence.

In 2005 the Irish College of General Practitioners set out to survey all general practitioners (GPs) in the country. This was a repeat of a survey first done in 1982, the results of which when compared to the 2005 results offer a glimpse into the evolving role of GPs in the country. This is especially interesting when contrasted with what has happened with family medicine in this country as many of the same trends hold true.

The island of Ireland is 32,600 square miles or about the size of Lake Superior. It consists of the Republic of Ireland, which accounts for over three quarters of the land mass, and Northern Ireland which is part of Great Britain. Over 6 million people live on the island of which 4.6 million live in the Republic with the remainder in Northern Ireland. There are nearly 4,000 general practitioners (GPs) practicing on the island, of which 3,200 are in the Republic. GPs have provided service in the country for centuries and as part and parcel of every community have retained on-going levels of patient respect and satisfaction. Despite being one of the longest established professional groups, GPs are one of the last disciplines to be embraced by the medical schools. Currently each of the seven medical schools in Ireland has an Academic Department of General Practice with Belfast in Northern Ireland leading the way in 1971. The newest medical school at the University of Limerick has the strongest emphasis on general practice with a model four year graduate medical program.

Most general practitioners from the survey were in the 35-60 age group and compared with previous studies fewer were working after the age of 64 – 3% in contrast with 8% in 1982. Gender changes were notable with 30% of GPs now female in contrast with 12% in 1982. The vast majority of GPs were in full-time practice with only 9% not working full-time. Only 3% of practicing GPs identify themselves as being graduates of non-Irish medical schools.

Formal training programs in general practice are a fairly recent

innovation in Ireland. They are referred to as vocational training programs and last three years. Whereas only 9% of GPs in 1982 had graduated from formal programs, this number had risen to 36% by 2005. Other pathways into general practice include a variety of hospital experiences in medicine, surgery, pediatrics, emergency medicine, psychiatry, etc. Completion of these mini residencies, typically lasting 6 months, usually culminates with award of a diploma in each of those disciplines. Of note, a small percentage of general practitioners who had been on a specialist track and had completed the equivalent of Board Certification but failed to secure an appointment at an academic institution or a regional medical center can only practice in a general practice setting.

The patient population of general practitioners can be divided into two broad categories: private pay patients and General Medical Service (GMS) patients. GMS patients are equivalent to Medicaid patients in this country. The vast majority (96%) of general practitioners provide care to both groups with the remainder providing care exclusively to private pay patients. Most private pay practitioners are located in urban areas. Approximately 60% of GPs have a GMS patient population of 500 to 1500, with approximately 50% of GPs having 500 to 1500 private patients.

A remarkable change has taken place in terms of after-hour calls. Most regions now have contracted physicians who perform the majority of after-hours care, with a smaller contribution by the practice members. Approximately 90% of practitioners work four or fewer nights per month and 22% never work a weekend.

In contrast with the U.S., most GPs in Ireland do not have access to the regional hospitals. They provide care in nursing homes and small local hospitals but the bulk of the care is delivered through ambulatory based offices (referred to as surgeries), and home visits. In addition to providing routine care to the population similar to what might be offered by family medicine in this country, over 80% provide pediatric care, prenatal care, family planning, immunizations, etc. Additional services provided include minor surgery and joint injections, as well as travel vaccinations. GPs also have access to many forms of testing including chest x-ray, skeletal exam, electrocardiograms, and ultrasound. It is interesting to note that almost 65% of GPs use ambulatory BP monitors and 89% of practices are computerized. Sophisticated imaging and other sub-specialty resources are limited and clustered in regional centers and require referral to an outpatient department. This is often very inconvenient for patients and can result in lengthy delays, a frustrating situation for the GP looking to provide a timely diagnosis.

Most practitioners practice in urban areas with approximately 30% describing their practices as mixed urban and rural, and 21% in rural areas. In contrast with the past where GPs typically practiced out of their homes with perhaps a small space designated as a surgery (office), this applies to only 11% of practices now with the majority having a specially built office or an adapted facility. Over 70% of these facilities are owned by the general practitioner. A decreasing number of general practitioners have an additional practice site, possibly related to better patient access with improved public and private transportation.

Whereas in 1982 greater than 60% of GPs described themselves as being in solo practice, this has now dropped to 35%, with most being in practice situations with multiple partners. Most practices now employ either nursing staff, clerical staff or a practice manager. Of note, there has been a decline in the role of the GPs spouse in the practice. Whereas in the past it was common for a spouse to answer calls and perform a variety of supporting roles, this now occurs in only rare instances. Most GPs have a regular working relationship with a public health nurse and an increasing number now have an appointment system.

Findings on morale and stress were fairly reassuring. In 2005 sixty two percent of respondents reported their morale as being either very good or good, and the majority of practitioners report their stress level as being low or average. Most practitioners plan to retire before age 65 with a small proportion looking at retirement before age 60. Only 16% planned to work beyond the age of 65. There was a significant gender difference wherein about a third of male respondents planned to retire before 65, and almost two thirds of females planned to do so. Those planning to retire earlier cite factors including: potential ill health (28%), financial security (20%), job stress (15%), and job dissatisfaction (14%).

General practice in Ireland is alive and well and is attracting exceptional graduates. The lot of the GP has improved considerably since the solo practice model, with twenty four-seven availability becoming a rarity. Group practice models, with less call and more support, have no doubt been a major factor in current job satisfaction and relatively high morale.

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Clearly there are areas that could use improvement, most notably the discontinuity of care created by the separation between the consultant-heavy regional medical centers and the general practitioner. As in the US, efforts towards better communication between consultant and primary care physician would more fully take advantage of the invaluable background information that could be offered. Despite this the general practitioners provide an invaluable service in every community in Ireland.

It was particularly heartening during my sabbatical in Ireland to see the frustrated responses of sub-specialists when they became aware that some of the best and brightest students were selecting general practice as the preferred specialty, a phenomenon we would love to emulate in this country.

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[1]*O'Dowd T, O'Kelly M, O'Kelly F, Structure of General Practice in Ireland. 1982-2005, Irish College of General Practitioners, Trinity College of Health Sciences, May 2006.*

James G. O'Brien

Dr. James Gerard O'Brien was born in Ireland and completed his Pre-Med and Medical School at University College, Dublin, Ireland. He completed a Rotating Internship at Saginaw Affiliated Hospitals, Saginaw, Michigan and Family Medicine Residency at Saginaw Cooperative Hospitals in Affiliation with Michigan State University. He completed a Geriatric Fellowship at the Center for Study of Aging and Human Development, Duke University, Durham, North Carolina. He was on faculty at Michigan State University, East Lansing, Michigan for 22 years. He has been on the faculty at the University of Louisville for 15 years and in his current position for ten years as Chair of the Department of Family and Geriatric Medicine, University of Louisville, Louisville, Kentucky.

Thomas O'Dowd

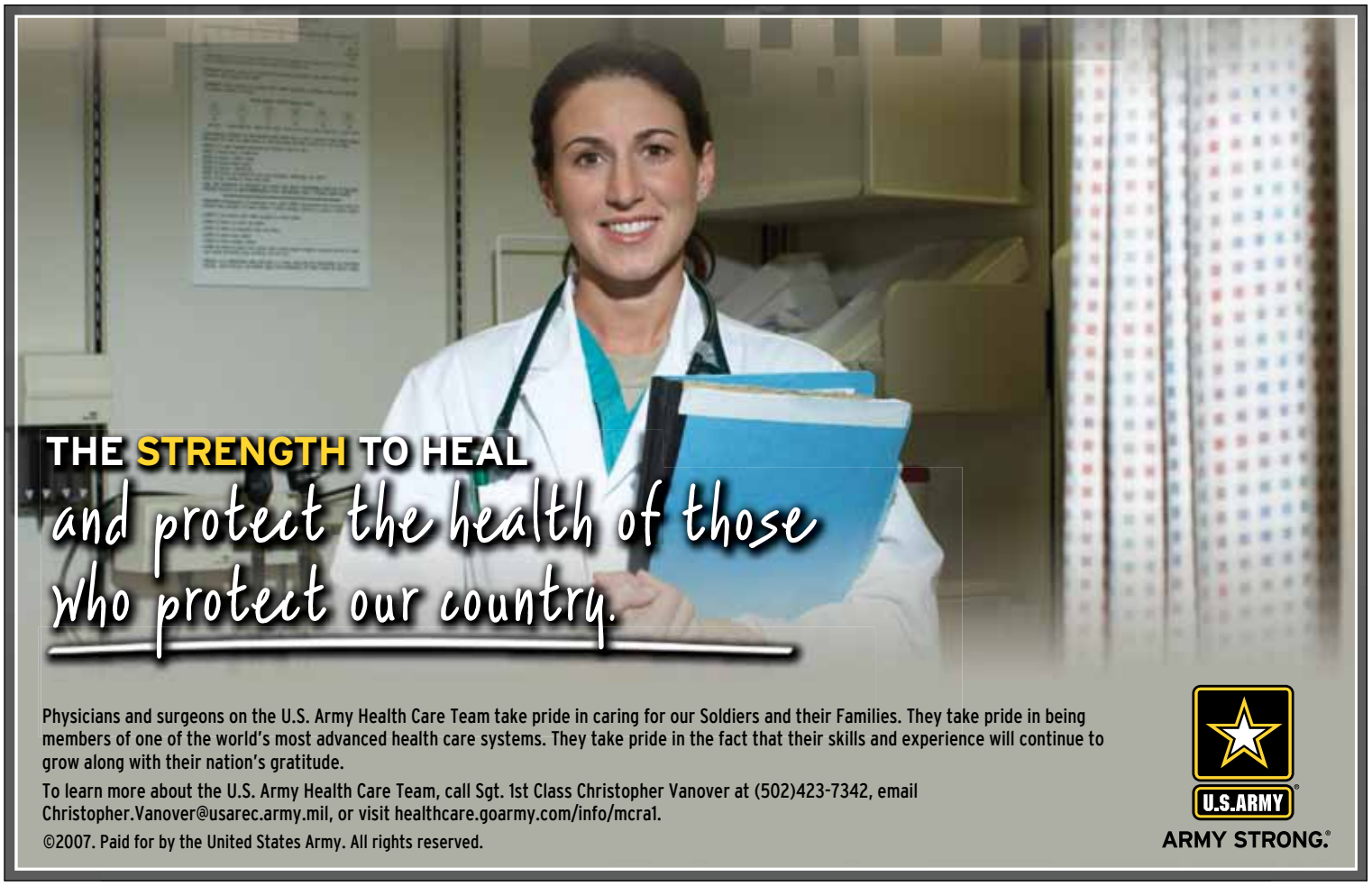
Thomas O'Dowd, MD, is a Professor of General Practice in the Department of Public Health and Primary Care at Trinity College in Dublin, Ireland. He practices at Mary Mercer Health Centre in Dublin where he runs programs in cervical screening and childhood vaccinations, as well as overseeing a methadone program. As Chairman of the Education Committee of the Medical Council he was instrumental in the professionalization of medical education in Ireland. Among his varied research pursuits he is a member of the study team of the National Longitudinal Study of Children in Ireland, a study of 18,000 children.

Vignette: A SPECIAL IRISH GP

"Dr. Paddy", as all in my hometown of 6,000 people, Thurles, County Tipperary, knew him was my hero as a child but also someone I respected and feared and a person with whom I enjoyed a special relationship. As the new GP in our community, I was the first baby delivered by him at home. It was thankfully uneventful but apparently memorable to him. Subsequently I was "a delicate child", a great Irish term, suffering with asthma and bouts of pneumonia. Dr. Paddy was a frequent visitor to our house with the dreaded shots of penicillin and adrenalin. He always exuded calm, patience, and confidence. At age 6, he correctly diagnosed my acute intussusception which fortunately coincided with the weekly visit of the itinerant surgeon with subsequent surgery and a good outcome.

He built the largest practice in the area and covered a large farming community as well. Much of his practice was devoted to house calls which he performed day and night. He performed minor surgery, delivered babies, and worked from dawn to dusk, which eventually resulted in a series of heart attacks with resultant congestive heart failure. I saw him regularly during medical school and then infrequently after emigrating to the U.S. The deterioration in his physical health had little effect on his commitment to provide care to his large solo practice.

When my father became seriously ill and required hospitalization, Dr. Paddy came to our home and according to my mother looked so ill she was convinced he needed more help than my father. To examine my father in an upstairs bedroom, he climbed the stairs sitting on each step as he had such severe dyspnea. My father died after a short hospitalization and shortly thereafter Dr. Paddy died at age 56. He remains a revered figure in my community.



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TODD WOLYNN, M.D.
Medical Director, Atlantic Health Partners

Vaccinate Adolescents for the HEALTH of Your Patients… AND YOUR PRACTICE

The Adolescent: gawky, internet-savvy, likely suffering with acne and at risk for vaccine-preventable disease. The Family Physician: clinically astute, EMR-wary, over-worked and adept at providing immunizations. A match made in heaven??? Well, if you can vaccinate an adolescent AND improve the financial performance of your practice, then hello pearly gates!

As we know, there has been a significant increase of recommended adolescent vaccines. Meningitis, pertussis, human papillomavirus (HPV) and even hepatitis A all have designated vaccines, which can and should be utilized to help prevent these diseases. Preteens and teenagers represent a significant new challenge (and opportunity) to our practices. Compared to infants and children vaccinating adolescents can be difficult:

Why Vaccinating Adolescents is Hard Work	Infant/Child	Adolescent
Regular frequent office visits	Yes	NO
Reliably show-up for vaccination series dose 2 or 3	Yes	NO
Ease of administration without patient interference	Yes	NO
Vaccines viewed as a priority (Parents/Public)	Yes	NO

I will focus on pertussis, meningitis and HPV vaccines in this article to highlight the clinical importance of vaccinating the adolescent and highlighting the keys to making vaccination a financially sustainable (and profitable) service in your practice.

Why Vaccinate Adolescents and Adults against Pertussis?

For decades we have immunized children 2 mo-5 yr against pertussis. During this same time we used non-pertussis containing "tetanus boosters" to immunize adolescents and adults. What has changed? Research dispelled pertussis myths and showed that:

-Pertussis is not only a disease of childhood

-Pertussis poses significant risk to adolescents/adults

-Adolescents and adults do NOT have life-long immunity to pertussis after they received childhood vaccines

-Efforts to immunize adolescents and adults against pertussis provide significant benefit

-Infants suffer significant morbidity and mortality from

Pertussis and adolescents and adults are THE reservoir for this disease

Over the past two decades there have been a large and rapidly increasing number of reported cases of pertussis, particularly in the past few years. An estimate from J.D.Cherry indicates 800,000 to 3.3 million cases of adolescent and adult pertussis each year in the

The Kentucky Academy of Family Physicians Foundation is pleased to report that the partnership with Atlantic Health Partners, a leading physician vaccine purchasing program, has helped our KAFP members. With the increased burden you face providing a growing number of vaccines to your patients in a fiscally responsible manner, Atlantic may be able to help lower your costs and improve your purchasing terms.

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United States.[1]

Adolescent and adult pertussis is NOT benign.[2] A study reported in the Journal of Infectious Disease in 2000 looked at 664 adolescents and adults with confirmed pertussis and found that cough lasted at least 3 weeks in nearly 100% of patients, and in half the cough persisted for 9 weeks or more. Teens typically missed a week of school and, adults missed 7 days of work, and most suffered extensive disruption to their normal sleep pattern. Additionally, 16% of adolescents and 28% of adults had some type of complication. One of the more serious complications was pneumonia (particularly in older patients). For those 50 years and older, about 6% were hospitalized with a mean stay of 17 days.

The high risk of death and morbidity for infants with pertussis is the driving factor in the push to immunize adolescents and adults. Infants who suffer through a pertussis infection face significant rates of hospitalization, pneumonia, seizures, encephalopathy and even death. The piece that ties this all together is the realization of just exactly who is giving the babies pertussis in the first place. The source of transmission is from adolescents 20% and adults 56% of the time.[3] So adults are primarily the ones who give pertussis to vulnerable infants. Furthermore, mothers are cited as the most common source of exposure to the infant. In this key study reported by the CDC, 32% of the 774 cases of infant pertussis identified the baby's mother as the source of the infection. For this reason many maternity hospitals have chosen to offer and provide Tdap to moms after delivery but prior to discharge.

Vaccinating against Meningitis

A more infamous vaccine-preventable disease is caused by Neisseria meningitidis. This cause of meningitis and meningococcemia strikes real fear in all physicians. As a result of the successful implementations of Hib and Pneumococcus (PCV7) vaccines, the most prevalent cause of bacterial meningitis is now Neisseria meningitidis. This bacteria causes devastating, potentially fatal disease which can be initially difficult to diagnose and progresses rapidly, making prevention paramount. Short of death, severe neurologic sequelae and tissue death with amputations are significant risks.

Since the 1980's we have used a quadrivalent polysaccharide vaccine to protect against this disease. The vaccine was very successful but had many limitations. For the past five years the U.S. standard of care has shifted to a quadrivalent conjugated vaccine (Menactra from Sanofi). The indicated ages for meningococcal vaccination is age 11-12 with a booster dose at 16, as the disease demonstrates a peak in adolescence.

Human Papillomavirus (HPV) is THE cause of cervical cancer.

It's as simple as that! By way of comparison, lung cancer is only associated with cigarettes 70% of the time, but cervical cancer is caused by HPV 100% of the time. Gardasil is Merck's quadrivalent HPV vaccine which protects against HPV types 6, 11, 16 & 18. While you probably have heard the numbers before, it is worthwhile to hear them again. In the United States there are close to 10,000 newly diagnosed cases and 4,000 deaths from cervical cancer each year. While several HPV types are associated with cervical cancer, types 16 and 18 causes the majority of cervical cancer and the Gardasil vaccine has been shown to prevent over 70% of cervical cancers. In addition HPV types 6 and 11 cause almost all anogenital warts and Gardasil reduces these lesions by 90%. Furthermore, Gardasil is the only HPV vaccine also approved and recommended for males for the same 9 – 26 age range as females.

Show me the Money

Ok, so what I just reviewed is very likely familiar information. But just as important to your practice is the ability to provide these vaccines and realize an appropriate profit margin.

The challenges of getting a vaccine into an adolescent per the new vaccine schedules can put a significant strain on our already overstretched office staff and limited resources. For a Primary Care Physician's cash outlay, variable purchase prices and questionable payment have often led to vaccinations being viewed as a financially risky practice.

If you have not yet done so, I encourage you to read a study by Gary Freed[4] which showed that 21% of Family Practitioners had "seriously considered whether to stop providing all vaccines to privately insured patients" due to the perceived financial strain. This is likely because of the type findings he revealed in another article.[5] To achieve acceptable financial results you must not make either of two mistakes:

1) Ordering vaccines at inflated prices
2) Receiving less than adequate payment for the vaccine OR its administration

Both these points are critical. Vaccine administration payments can vary widely, and while it can be addressed I will leave it for another day and another article. The first point is a much easier fix.

Paying list price for vaccines or obtaining them via a supplier/distributor (great for medical supplies but typically expensive for vaccines) is almost never a

good idea. Furthermore the vast majority of Hospital Group Contracts are not typically oriented to the best available vaccine discounts. A much more favorable way to purchase vaccines is directly from the manufactures, along with an affiliation with a Physician Vaccine Buying Group.

I'll stop here and emphasize my disclosure that I am the Medical Director for Atlantic Health Partners (AHP), one of the largest Vaccine Buying Groups and the only one that is endorsed by over 40 Physician Medical Societies, including the KAFP. AHP helps practices realize nationally best vaccine purchasing prices for pediatric and adolescent vaccines such as Tdap, Meningitis, and HPV so that providing these recommended vaccines can truly benefit your patients and your practice. Furthermore, AHP provides reimbursement support and advocates with payers for fair vaccine payment. If you are not part of a vaccine buying group we encourage you to research available programs to identify one that meets your needs.

Once you confirm that you are obtaining favorable vaccine prices, you can more confidently reach out to your adolescent patients. Adolescents are difficult to track down, but due to the growing number of mandatory vaccines for these older children you have a chance to incorporate them into your regular practice process. Review charts and vaccine records for immunization compliance at all visits. Call families with adolescents behind on their immunizations. Use the opportunity to consider hepatitis A vaccine and HPV for girls and boys. You could be improving patient care and your practice financial performance simultaneously.

If you would like more information about Atlantic Health Partners please contact Jeff Winokur or Cindy Berenson at 800-741-2044 or jwinokur@atlantichealthpartners.com. If you would like to discuss or review clinical aspects of these vaccines please contact me at toddwolynn@gmail.com

[1]Cherry, JD. The Epidemiology of Pertussis: A Comparison of the Epidemiology of the Disease Pertussis with the Epidemiology of Bordetella Pertussis Infection, *Pediatrics*. 2005;115:1422-1427

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GET INVOLVED

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

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

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

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

COMMUNICATION COMMITTEE: *Chaired by* **Bill Crump, M.D.**, with the assistance of **Stevens Wrightson, M.D.**, and **M. Eli Pendleton, 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* **Sharon Colton, M.D.**; this committee is responsible for developing CME that is targeted to the needs of membership.

FINANCE COMMITTEE: *Chaired by* **Treasurer John Darnell, Jr., 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* **Speaker Sam Matheny, M.D. and Vice Speaker John Patterson, 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.

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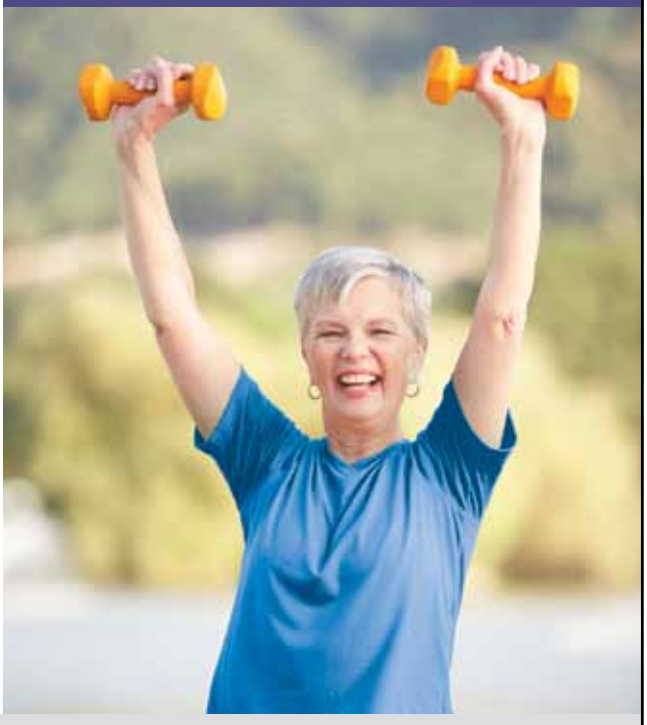

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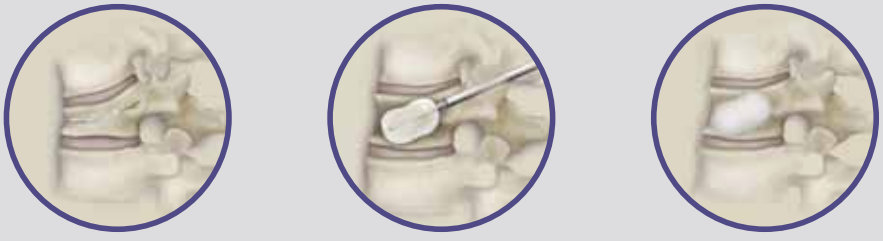

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