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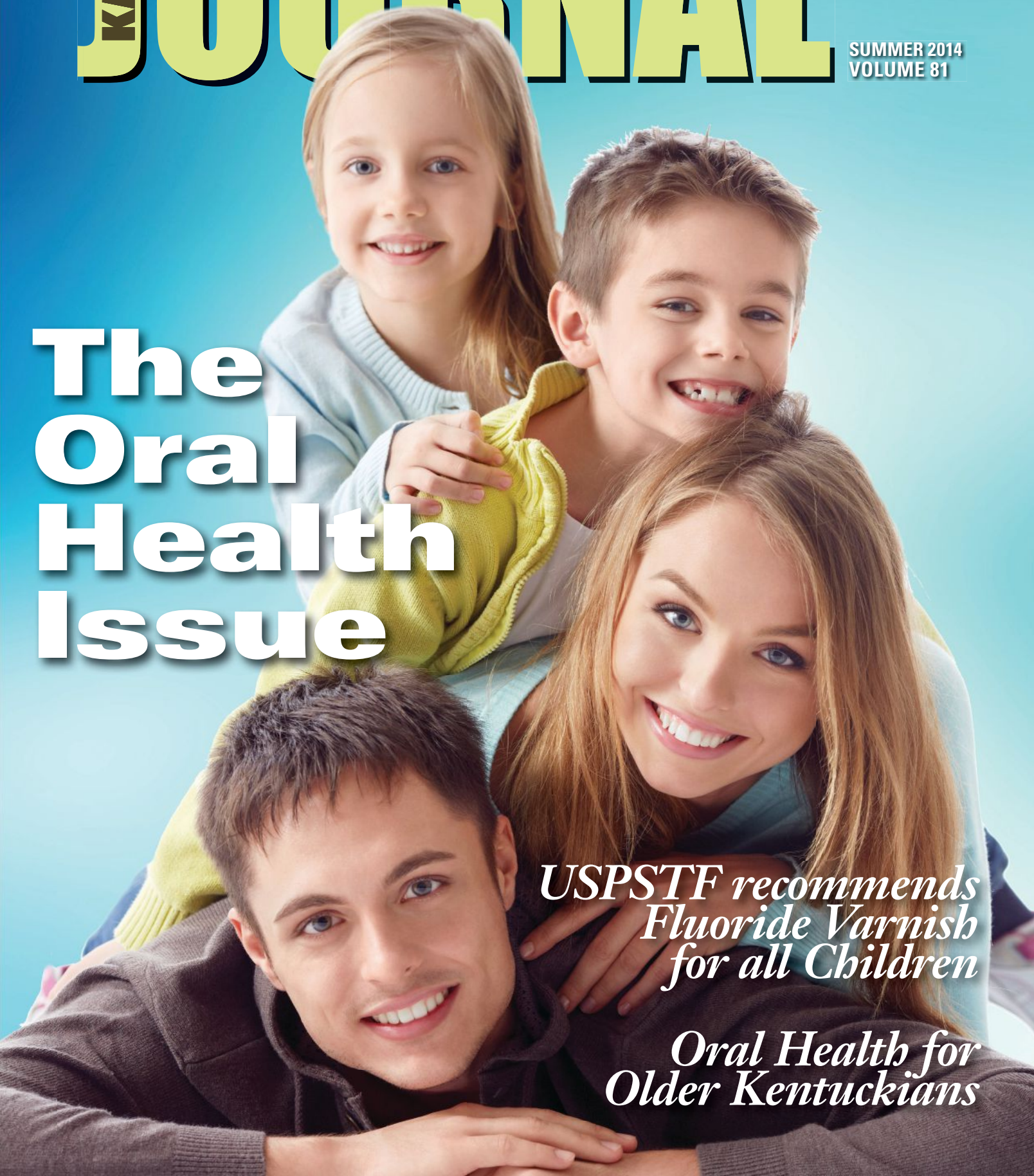

The Oral Health Issue

USPSTF recommends Fluoride Varnish for all Children

Oral Health for Older Kentuckians

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message from Your PRESIDENT

Something to Smile About

One of the ways I see Family Medicine differing from other primary care specialties is being aware of and treating multiple problems and diagnoses. In the Emergency Room, we are called upon by providers to evaluate patients with labs and x-rays, then make a disposition to admit or send home or transfer, to make the arrangements for their continued care, to straighten out their medicines, etc. Rarely does our ER get referrals from the Family Docs practicing in our community. We have been trained in multiple specialties and can integrate different organ systems into one total patient. Being able to apply a knowledge of multiple complex medical problems as well as our patients' social situations aids us in making a holistic plan of treatment that addresses nutrition, medications, exercise, activities of daily living that includes family members and other caregivers. Other specialties rely on Family Docs to do this. Can we handle it all? No, not every time but, in general, Family Medicine gets the big picture of our patients' health. This journal issue is emphasizing an area that we tend not to think about until something goes wrong but one that influences multiple aspects of our patients' healthcare. Let's give our patients more to 'smile' about in regards to their health.

Yes, this issue will put the 'bite' back into our management of dental disease (or for those of you approaching life from the positive, oral health). 'Chew' a while on all the systems and pathologies that can be affected by the mouth and its contents. Who would have ever linked gum disease as an etiology for cardiac concerns? How many patients have complained about dry mouth and when it wasn't addressed, simply became non compliant with the offending medicine without our knowledge, thus affecting their blood pressure control or diabetes or heart failure? Poor dentition also causes nutritional concerns, especially in our elderly population. Bacterial gum disease puts patients at risk for aspiration pneumonias. Did you know simple oral care interventions led to a 90% reduction in ventilator associated pneumonias? The effect of inflammation from oral diseases such as periodontitis has a causal link with diabetes, obesity, CAD, H. pylori and even adverse pregnancy outcomes. In the patient presenting to our offices and ER's with fevers for which we don't find an obvious source or diabetics with hyperglycemia and no apparent infectious cause, don't forget to look for

MMM, I'M TELLING YOU NOW, THE GREATEST THING YOU EVER CAN DO NOW, IS TRADE A SMILE WITH SOMEONE WHO'S BLUE NOW.....

dental abscesses, sinusitis or gum disease. Promoting oral health and the prevention of dental disease is a very important part of caring for our patients.

Patients are now obtaining dental care more often through their medical providers or through ERs. This is from a lack of dental coverage as well as economic conditions that put dental care at the bottom of priorities like food, housing and other necessities. It also stems from a decrease in the number of dentists available to see patients, long waiting lists for free dental clinics and from a general lack of education and emphasis on preventing dental problems. Using the ER for care is the most expensive way to provide dental treatment which contributes to the exponential growth of health care costs. Not to mention that emergent care is usually only a temporary treatment until definitive care with a dentist can occur.

I have seen several patients present to the ER repeatedly with dental pain and oral problems that served as the start of their narcotic addiction and the many other sequellae that result from that addiction. Many of our "frequent flyers" present with a chief complaint of toothache or dental pain. And like back pain, it is difficult to assess how painful that dental problem really is and what the best treatment would be. If you've ever had a toothache you certainly know how that pain can ruin your day and make you feel 'down in the mouth'. Ever have a patient tell you their chest pain is worse than a toothache?

Of course "meth mouth" is a clue for us to look closer at the patient suffering from addiction and to provide counsel and encourage treatment for their problems before families and lives are devastated. Once, I was covering an ER and a patient was brought in by the local police. He was suspected of dealing crack cocaine but the evidence was nowhere to be found. Did he swallow cocaine and put himself at risk of serious medical problems and would he be able to go to jail safely? A thorough exam found that he was hiding rocks of the crack cocaine in the spaces left from his missing teeth. Perhaps if he'd had better dental care the evidence would have been a little more obvious!

Isn't it nice to be on the receiving end of a healthy smile? It's almost as good as the 'just had my teeth cleaned' feeling. Make a concerted effort this summer to promote oral health and educate patients on the importance of dental care. Make sure to have a relationship with the dentists in your community- it helps our patients if we can refer them to a dentist we trust and can collaborate with on the many facets of our patients' health. There's more to dental care than knowing when and how to prophylax with antibiotics for valvular heart conditions. And there are many advances in oral health care that we need to learn and provide for our patients. The program Smiles for Life at www.smilesforlifeoralhealth.com is a great resource and also provides AAFP CME. KAFP's own Wanda Gonsalves and Steve Wrightson were involved in the development of this curriculum. Led Zeppelin says it best in the song "Friends":

Mmm, I'm telling you now, the greatest thing you ever can do now,
Is trade a smile with someone who's blue now…..

Have a great summer and don't forget to floss.

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The State Academies of Family Medicine are pleased to invite you to attend a FREE webinar on Extended-Release/Long-Acting Opioids: Achieving Safe Use While Improving Patient Care. We have scheduled 6 webinars during the next several months -- one of them should be perfect for your busy schedule.

These 90-minute webinars meet the FDA requirements for ER/LA opioid risk evaluation and mitigation strategies [REMS], and include a wide range of topics relevant to your practice and patients:

- Appropriate assessment, risk evaluation and use of the agents;
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The webinar includes the latest evidence-based information and practical tools you will put immediately to use, and much more. A post-activity assessment will help you gauge your increase in knowledge and competency. Upon completion of the assessment and evaluation you will receive 1.5 AAFP Prescribed credits and we'll send you both the faculty slides and additional resources you can use to improve your care of patients.

Full Schedule:

Activity	EST	CST	PST	REGISTRATION LINK
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June 24 – Tuesday	12:30-2:00 pm	11:30 am-1:00 pm	9:30-11:00 am	http://bit.ly/1n9sSmH
September 23 – Tuesday	1:30-3:00 pm	12:30-2:00 pm	10:30 am-12:00 pm	http://bit.ly/1kY9g4S
September 25 – Thursday	7:00-8:30 pm	6:00-7:30 pm	4:00-5:30 pm	http://bit.ly/1l3Djnu
November 11 – Tuesday	3:30-5:00 pm	2:30-4:00 pm	12:30-2:00 pm	http://bit.ly/1qFc862
November 13 - Thursday	9:00-10:30 pm	8:00-9:30 pm	6:00-7:30 pm	http://bit.ly/1n9t0T8

If you have any questions, feel free to contact srodrigues@familydocs.org.

Collaborative for REMS Education

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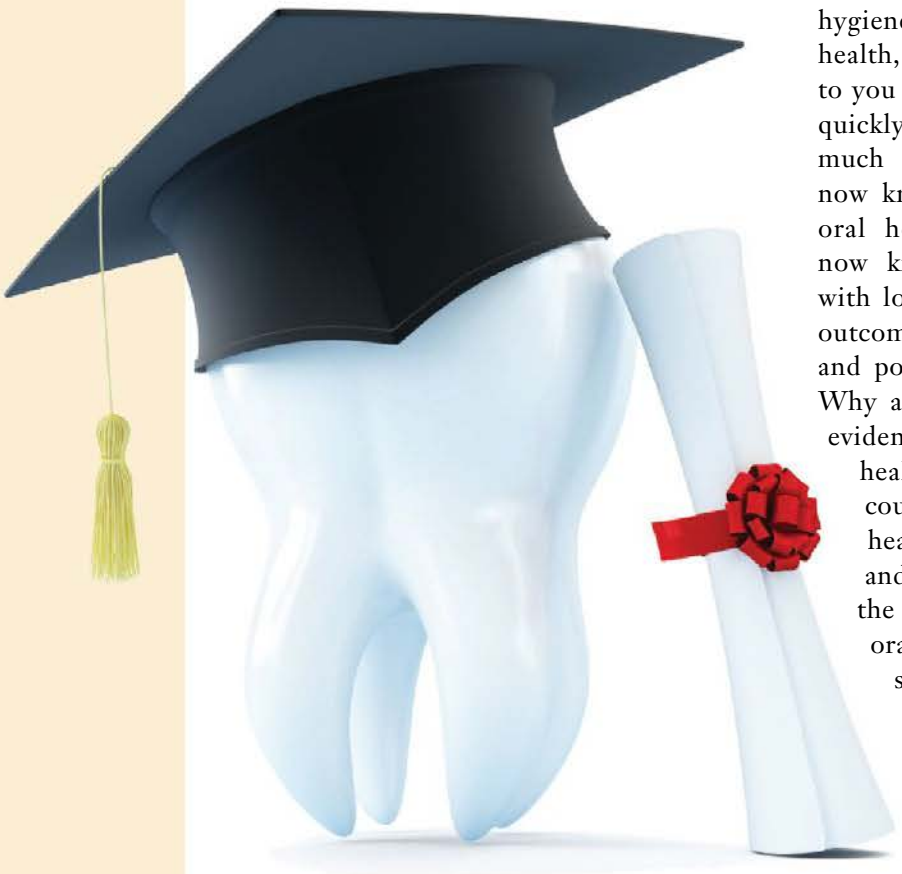
BY WANDA C. GONSALVES, M.D.

WE'RE STILL NOT WHERE WE NEED TO BE IN **Oral Health Education!**

It's really hard to believe that as of this past May 2014 it has been THIRTY YEARS since I graduated from medical school. I entered my class after completing a Bachelor of Science in Dental Hygiene from the University of Louisville. I had worked for only five years in the profession when I realized I wanted to be a physician. No, not a dentist. A physician!



It had been way too difficult finding a dentist to hire me. I was African American and their patients were white. Few African American dentists could afford to hire a dental hygienist. A few white dentists I interviewed with were concerned about how their patients would feel having an African American dental hygienist. I decided afterward to leave the dentistry field and become a physician. In medical school, I quickly learned that primary care was an area in which I could educate my patients and make a difference in the lives of all ages. I became a family physician.

In medical school there were no lectures in dental health. The mouth was not a part of the body and counting the dentition was unheard of. There was no mention of poor hygiene or periodontitis as it relates to oral health, and if there were a patient who came to you with some sort of a mouth lesion, you quickly referred to a dentist. I don't think much has changed in practice, except we now know there is a systemic link between oral health and good overall health. We now know that periodontitis is associated with low birth weight infants, poor diabetes outcomes, cerebrovascular disease, obesity, and possible coronary artery disease[1, 2, 3, 4, 5]. Why are we still so far behind the medical evidence in terms of our practice of oral health education? Why aren't more of us counseling our patients about good oral health and the link between oral health and systemic illness? Why aren't we using the tools that are available to learn about oral health so that we can educate our students, residents, physician assistants and nurse practitioners?

After 10 years of practice, I went into academics at the University of Kentucky. In academics, I find joy in making a difference not only in patients, but in the young minds that will follow me. In academics, I found colleagues that were also passionate about oral health. In 2000, Dr. David Satcher's *Oral Heath in America*, *the Surgeon General Report*[6] was a call to physicians and other medical professionals to collaborate with dental professionals to decrease the oral

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health disparities that affected the poor, minorities and the elderly. Oral health was felt to be one of the most unmet health needs of the 21st century[6]. Physicians and other medical professionals could educate themselves, and in the process, help reduce the oral health disparities by educating patients, recognizing oral diseases, and referring to their dental colleagues. As a family physician, I may see a child and the caregiver seven times or more before the child turns 3 years old, when most dentists see children for the first time.

Shortly after the Surgeon General's Report, grant funding by the U. S. Health Resources Services Administration (HRSA) inspired faculty across the country to develop an oral health curriculum, hence *Smiles for Life*. *Smiles for Life (SFL)*, developed in 2005 by myself and several other faculty members across the country and now in its third edition, is a ready, comprehensive web-based tool for educators, students and practitioners to learn about oral health. Smiles for Life can be accessed at www.smilesforlifeoralhealth.org. Since its inception, SFL has gained an audience in many professions. Its latest usage report from January 2014 through March 2014 by the *National Interprofessional Initiative on Oral Health*, an oral health advocacy organization, showed that there were 228,000 cumulative site visits by nurses (30%), physicians (24%), Physician Assistants (21%), dentists (11%) and others (11%). Of those registered users of SFL, 59% were students. I'm especially happy to know that students are now learning more about oral health. But, what about the faculty and practicing clinicians that will need to know more about oral health in order to reinforce what students are learning? The report showed that only 3% of the registered users were educators.

You'd have to be living under a rock if you have not heard or read about interprofessional education (IPE) that is advocated by the Institute of Medicine (IOM), the Association of American Medical Colleges (AAMC), and other medical organizations. IPE is critically important for providing quality health care and meeting the complex tasks needed by medicine today. Oral heath education can be the bridge that brings two or more disciplines together to learn about, from, and with each other. Examples of programs utilizing oral health education as an IPE vehicle can be found in several medical institutions across the country. This journal includes a piece, "Oral Health Concerns in Older Kentuckians" from Pamela Stein, DMD, from the department of Public Health Dentistry at the University of Kentucky. Her co-author, Whitney Dietz, will soon complete her dentistry degree and hopes to join a General Practice Dentistry residency. This additional training, not unlike Family Medicine, will allow her to care for more complex oral health issues in children and adults. We welcome this collaboration with our dental colleagues to address the difficult, multi-layered issues surrounding oral health in Kentucky. As educators and practicing clinicians, let's all be advocates for oral health education to help reduce the most unmet health need in our country. A good place to start is www.smilesforlifeoralhealth.org.

IPE IS CRITICALLY IMPORTANT FOR PROVIDING QUALITY HEALTH CARE AND MEETING THE COMPLEX TASKS NEEDED BY MEDICINE TODAY. ORAL HEALTH EDUCATION CAN BE THE BRIDGE THAT BRINGS TWO OR MORE DISCIPLINES TOGETHER TO LEARN ABOUT, FROM, AND WITH EACH OTHER.

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Wanda Gonsalves, MD graduated with a BS in Dental Hygiene from the University of Louisville. She received her MD degree from the University of Kentucky College of Medicine, where she stayed to complete her residency training in Family Medicine. After 10 years in private practice, Dr. Gonsalves entered academic family medicine at the University of Kentucky and later the Medical University of South Carolina in Charleston, SC. Most recently, she returned to Lexington as Vice Chair in the Department of Family and Community Medicine. Her passion has been service learning at both institutions where she has helped medical students in the development of student run free clinics. She is an original steering committee member for Smiles for Life: a National Oral Health Curriculum.

BY A. STEVENS WRIGHTSON, M.D.

FLUORIDE TREATMENTS IN THE PRIMARY MEDICAL CARE OFFICE: Newly Recommended by the USPSTF

Dental caries is the most common infectious disease of childhood especially in young children age 2-5.[1] For years, nondental primary care clinicians, particularly family physicians and pediatricians, have been asked to help address this issue in 2 major ways: counseling on appropriate preventive techniques and prescribing fluoride supplements in children who do not have adequate access to water fluoridation. Despite these steps, the incidence of caries in children has risen, especially in the last 20 years.[2]

In Kentucky, we are particularly hard hit with dental disease, especially in our children.[3] Nikki Stone, DMD, Dental Director for the UK North Fork Valley Community Health Center in Hazard, Kentucky has spent the last 10 years traveling to schools in the four county region around Hazard (Letcher, Knott, Perry, and Leslie). Her initial findings were disheartening.

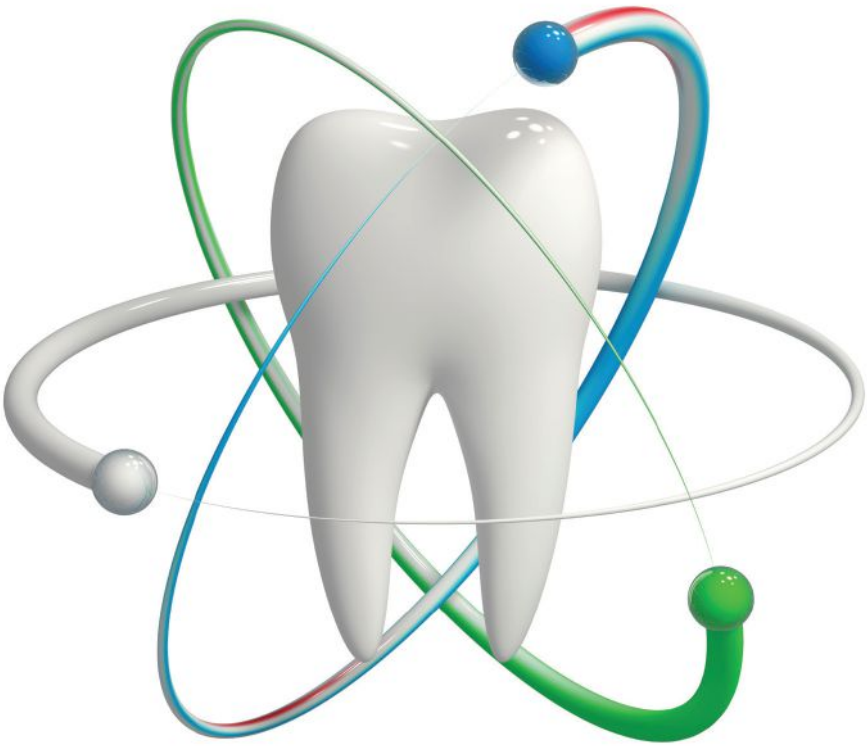
> "Nearly 5,000 children were seen that first school year (2005), and the baseline data was disturbing, especially when compared to national data and the HealthyPeople 2010 goals. **A staggering 58% of Head Start children and almost 70% of elementary school children had untreated tooth decay, and nearly 20% had urgent dental needs (pain/infection/rampant decay).** At nearly every Head Start center visited over the four-county area, at least one child in each center had all 20 baby teeth grossly decayed with multiple abscessed teeth. Compared to national data, the children in this service area turned out to have the **2nd highest untreated tooth decay rates in the nation,** second only to the isolated Alaskan Native/Native American populations."

In addition, Dr. Stone's work revealed several interesting findings. Schools she visited that had the **lowest** rate of untreated decay were also the schools with the **highest** test scores. Children can learn and perform better if they are not dealing with dental pain and disease.[4,5] Dr. Stone also found, not surprisingly, that Medicaid utilization rates for dental visits remains alarmingly low. This means that even though Medicaid covers dental care, and has done so for years, many children still do not access care. In 2011, across Kentucky there were 113,000 children age 0-4 enrolled in Medicaid. Of those, 65,000, or 57%, received dental services. In 2012, despite an increase in enrollees in this age group to 147,000, only 57,000, or 39% accessed dental services.[6] All age groups show a decline in utilization up to age 70, though the 0-4 age group is the most dramatic. These children, as evidenced by Dr. Stone's findings, are especially vulnerable to lack of dental care.

But there is a bright spot. Dr. Stone has shown with regular monitoring, appropriate use of fluoride varnish and dental sealants, and a tight collaboration with Pediatric Dental specialists, she can make a difference in these children's lives. Dr. Stone's program reports a decrease in the incidence of untreated dental decay in elementary age kids from 60% to 53% in the last 6 years. Likewise, for Head Start children, there has been a decrease from 58% to 42% in untreated decay over the past 6 years. She partners with a Pediatric Dentist who travels an hour to Hazard once a week to see children with urgent needs, rather than making the children and their family travel that distance. This means that she has seen an increase in completed care (all decayed teeth treated appropriately), from 8% to 64% by removing this additional barrier.

In 2013, the Robert Wood Johnson Foundation did a nation-wide search for workforce innovations in the provision of preventive oral health services. The dental outreach program in Hazard was one of 25 programs identified by RWJ as one of

those promising preventive programs. This is indeed encouraging, but also highlights the need to expand dental preventive services beyond its historic silo. Many children in our state are still unable to access dental care, let alone preventive dental services. In the Fall 2009 edition of this KAFP journal, Dr. Stone and I wrote about and encouraged the use of fluoride varnish by primary care clinicians, stating, "Because many children do not see a dentist, it is up to clinicians in a child's medical home to initiate counseling about good oral health habits as well as providing treatments, such as fluoride varnish, that can reduce early childhood caries."[7]



Providing fluoride varnish to the primary teeth of children from the time of tooth eruption until age five can reduce the risk of early childhood caries. More importantly, this procedure can be performed in a primary care clinician's office with essentially no risk to the child and minimal cost in time and supplies to the clinician. In May 2014, the US Preventive Services Task Force gave a B recommendation for fluoride varnish application twice a year to all children by medical primary care providers. Thus, there is evidence to support the findings that fluoride varnish application ***by medical providers*** reduces the incidence of childhood caries. This recommendation is directed at primary care clinicians, not dentists. For high risk children, those with a personal or family history of dental decay, those lacking adequate water fluoridation, or those with dietary habits that put them at risk (see the sippy cup with apple juice or soda), fluoride varnish should be applied more frequently, perhaps every 3 months. Those high risk children, likewise, need closer follow-up in a dental home. Let me emphasize, however, that all children, not just those at high risk for dental disease, should establish a dental home at 12 months of age. As medical providers, we should advocate for ways that would increase dental care utilization to better care for these children's oral health needs. For many counties in Kentucky, following these steps could impact the lives of more than half of the children living there.

More information about fluoride varnish application can be found at www.smilesforlifeoralhealth.org. This free, interactive web site provides the only national oral health curriculum designed for primary care providers. Along with the eight learning modules are interactive cases, videos and additional resources. Two of the modules focus on child oral health needs, including a stand-alone fluoride varnish module. The materials are endorsed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP),

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and the American Dental Association (ADA) among other national and international organizations.[8]

In March 2014, Governor Beshear released a list of health goals for Kentucky titled **kyhealthnow**. These goals are meant to create healthier citizens and a more productive workforce, attributes obviously needed for Kentucky to compete economically with other states. These goals can be found at http://governor.ky.gov/healthierky/kyhealthnow/Pages/default.aspx and will require innovative partnerships and strategies to achieve. They include:

- Reduce Kentucky's rate of uninsured individuals to less than 5%
- Reduce Kentucky's smoking rate by 10%.
- Reduce the rate of obesity among Kentuckians by 10%.
- Reduce Kentucky cancer deaths by 10%.
- Reduce cardiovascular deaths by 10%.
- **Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%.**
- Reduce deaths from drug overdose by 25% and reduce by 25% the average number of poor mental health days of Kentuckians.[9]

Why is oral disease a prominent goal? As stated on the kyhealthnow website, "Kentucky's dental problems have long been a source of ridicule, and have real and detrimental impacts on schoolchildren, the workforce and families. In fact, Kentucky ranks 41st in annual dental visits, 45th in the percentage of children with untreated dental decay (34.6%), and 47th in the percentage of adults 65+ missing 6 or more teeth (52.1%)." Increasing the provision of oral health services in the medical home, particularly fluoride varnish application for children is an important step in meeting one of the Governor's major goals.

I am truly encouraged by the progress that Dr. Stone has made in her communities in Eastern Kentucky, but imagine the scale of impact that **could** occur if family physicians and pediatricians in the area started applying fluoride varnish and providing oral health anticipatory guidance from the eruption of the first tooth. Better yet, what if the mothers of those children received proper oral care prenatally, in order to further diminish the transmission of caries causing bacteria from mother to child, and both parents received encouragement to set an example of good oral health? Then we would really see a cultural shift, with the recognition that dental disease is just that, a disease that can be controlled and, perhaps, eliminated.

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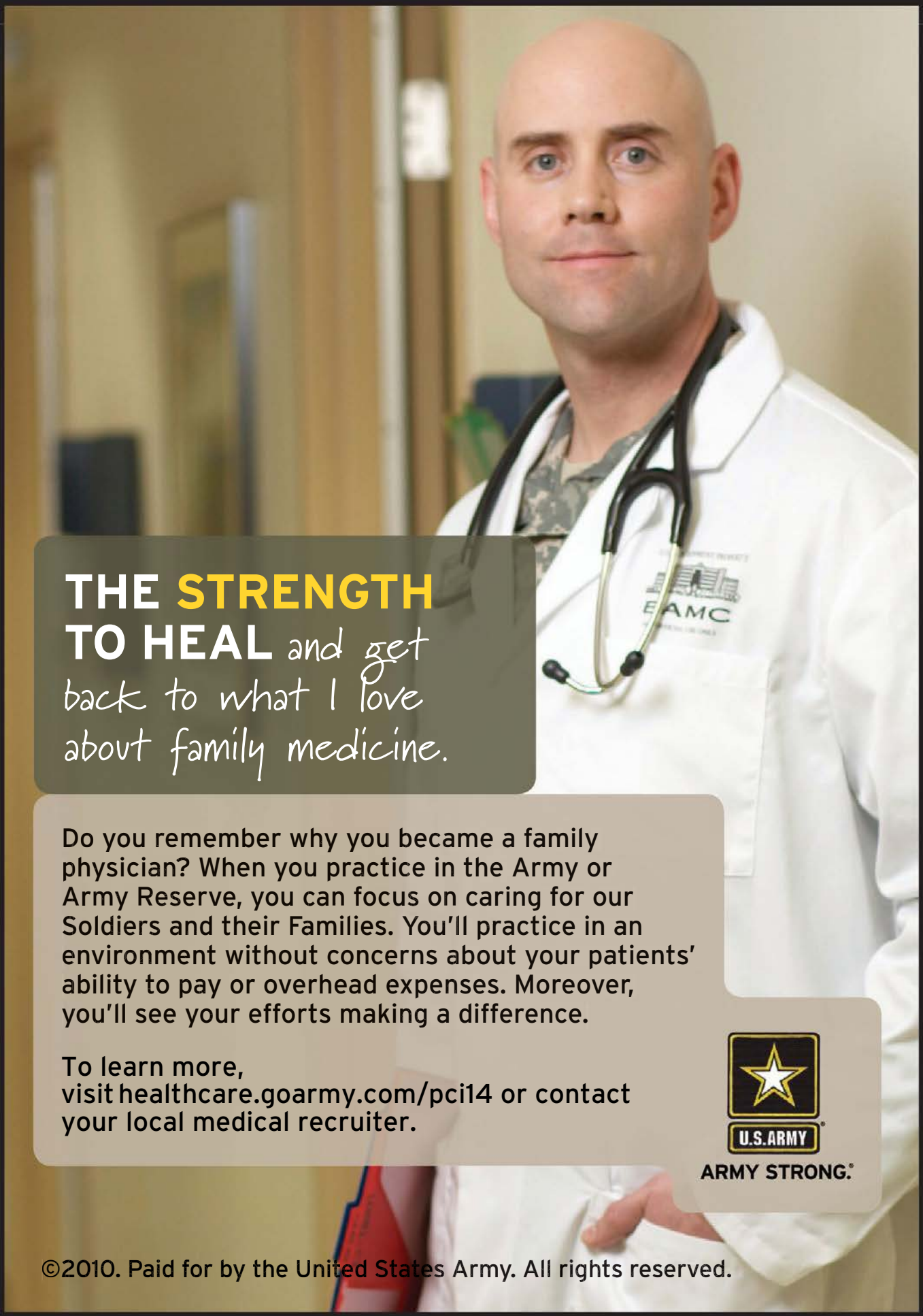

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ORAL HEALTH CONCERNS in Older Kentuckians

By 2050, the numbers of older adults will more than double, with nearly 100 million people 65 years of age and older in the United States.[1] With our aging population, it is imperative that family physicians become proficient in identifying and properly referring diseases that affect older adults, including diseases of the oral cavity. While oral health may seem primarily the responsibility of dentists, only 35.4% of Kentucky adults 65 and older have a dental visit each year.[2] The average number of physician visits for Medicare recipients is 15.4 per year.[3] Only 43.5% of Kentucky elders have dental insurance of any kind (Medicaid or private insurance)[2] compared with 94.7% covered with Medicare benefits.[4,5] Medicare does not provide coverage for routine dental services.

Who, then, is caring for the oral health of our elders who are at increased risk for oral cancer as well as heightened risks for other oral diseases? Nearly one third of Kentucky elders report a current dental problem and 19.3% report existing pain in the oral cavity. Kentucky has the fourth highest percentage of edentulous elders in the nation.[6] Family physicians have greater access to older patients than dentists and can partner with their dental colleagues for the benefit of their older patients. Simply taking a couple of minutes during an office visit to efficiently screen the oral cavity for potential concerns and make appropriate recommendations and referrals would be of great help.

A limited oral examination for elderly patients can be done in a time efficient manner and requires only a few basic steps. First, have the patient protrude the tongue. Grasp the anterior portion of the tongue with a gauze pad and visually evaluate the dorsal and lateral borders, most importantly noting any ulcerations or white or red patches. Secondly, have the patient expose the floor of the mouth by lifting the tongue. Visually examine for any ulcerations, swellings or discolored areas. Palpate the floor of the mouth to detect any abnormal masses. Gently grasp the patient's upper lip and lift to expose the labial mucosa for a visual and tactile exam. Repeat this process for the lower lip. Have the patient open her mouth and visually and tactilely examine the mucosal lining of the cheeks. Finally, visually examine the palate, oropharynx, gingiva and teeth. The totality of the process should take no more than a couple of minutes, but can reduce patient mortality and save thousands in healthcare costs.

What is the significance of a positive physical finding of the oral exam in the elderly?

First, oral cancer may be detected during an oral examination. Dysplasia may present as red, white, red-white mixed, blue or yellow lesions or a raised or ulcerated mass. If a lesion is detected, refer to an oral pathologist or oral surgeon for further evaluation. If a

patient receives regular dental care, involve the patient's dentist in the evaluation and referral. Approximately 94% of all oral malignancies are squamous cell carcinoma. Each year approximately 22,000 patients are diagnosed with squamous cell carcinoma of the oral cavity and 5,300 die with this disease; the highest at risk population for intraoral squamous cell carcinoma is white men over the age of sixty-five.[7] Survival rate of a localized cancer in the oral cavity is 82.7% compared to 36.3% if metastasis has occurred.[8] Highest risk patients include individuals who use tobacco, alcohol, are HIV positive & have had multiple sexual partners.[7]

Second, dental decay may be visible during an oral examination. Decay may present as dark yellow, brown, or black areas on the teeth. Because older adults often have receding gums, decay occurs more often on the roots of the teeth, along the gumline. Untreated decay can lead to pain, poor nutrition and breaking of teeth with possible aspiration. If decay is suspected, the patient should be referred to a dentist for evaluation and treatment. Physicians can help prevent decay by counseling patients to reduce sugar intake and practice daily oral hygiene to include brushing twice daily for two minutes with fluoride toothpaste and rinsing twice daily with fluoride mouthrinse.[9] Topical application of fluoride varnish every three months has been shown to be highly effective in reducing dental decay in older adults.[10]

Third, the tongue and oral mucosa should be assessed for dryness. Signs of dry mouth include dry, cracked lips and dry tongue with a fissured appearance. Dry mouth is uncomfortable and adversely effects eating and swallowing medications. Dry mouth also significantly increases the risk of decay. Although decreased salivary flow is not a direct result of aging,[12] thirty percent of older adults report xerostomia, the subjective complaint of dry mouth.[13] Many medications cause dry mouth including antihypertensives, NSAIDS, antidepressants and sleep medications.[14] Alzheimer's disease, Parkinson's disease, diabetes, Sjögren's syndrome, and head and neck radiation therapy also cause dry mouth.[15-16] If dry mouth is noted, pharmacists may provide insights regarding substituting medications that are less drying to the mouth. Frequent sips of water should be recommended as a palliative measure, as well as over-the-counter salivary substitutes such as Oralbalance® Gel (Glaxo Smith Kline) and Biotene® Moisturizing Mouth Spray (Glaxo Smith Kline).

Fourth, the patient's gingiva should be evaluated for signs of periodontal disease (redness, swelling and foul odor) during the oral exam. Periodontal disease is an infection of the gums that triggers systemic release of inflammatory products. A recent meta-analysis found periodontal disease increased the risk of stroke.[17] A 2008 study[18] reported periodontal disease increased the risk of diabetes. Glycemic control is more difficult in diabetic patients who also have periodontal disease[19] and death from vascular events is more likely in diabetic patients who also have periodontal disease.[20] Some research suggests periodontal disease may contribute to cognitive decline[21] and increase the risk for Alzheimer's disease.[22] Periodontal disease exacerbates rheumatoid arthritis[23] and treating periodontal disease significantly improves symptoms.[24] A study funded by United Concordia Dental insurance found that treating periodontal disease saves $5,681 in medical costs annually in stroke patients and $2,840 in medical costs annually in patients with diabetes. Hospital admissions were reduced by 39.4% in patients with diabetes who received periodontal treatment.[25]

Elders in long term care (LTC) face additional barriers to adequate oral health. Between 72% and 94% of LTC residents have difficulty providing their own oral hygiene.[26] An observational study revealed that certified nursing assistants brushed residents' teeth for 16.2 seconds on average, often without proper infection control, including brushing residents' teeth with

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the same gloves worn while cleaning the perineal area.[27] Lack of daily oral hygiene is a major concern as aspiration of the bacteria involved in dental diseases has been suspected as a primary cause of aspiration pneumonia in LTC residents,[28] and nursing home acquired pneumonia is a chief cause of death among older adults living in LTC facilities.[29] In fact, an additional study has shown nursing home residents who did not receive oral care were more than twice as likely to die from pneumonia compared to their counterparts who did receive oral care.[30] Ensuring appropriate daily oral hygiene is required by law in all long term care facilities that accept payment from Medicaid and Medicare. Because nursing home residents are among the worst of all groups of older adults regarding oral health,[2] it is of paramount importance for primary care providers to examine the oral cavity of these patients, make referrals when appropriate, and provide a medical order for assistance or provision of daily oral hygiene as needed.

In an evolving world of evidence-based decision-making and patient-centered care, family physicians are able to partner in a much needed intervention to improve the oral health of our Kentucky elders. Physicians are in a position of opportunity to intercept, identify, and appropriately refer a variety of oral diseases. Working collaboratively with their dental colleagues, physicians can improve patient satisfaction and clinical outcomes in the systemic and oral health of their older patients.

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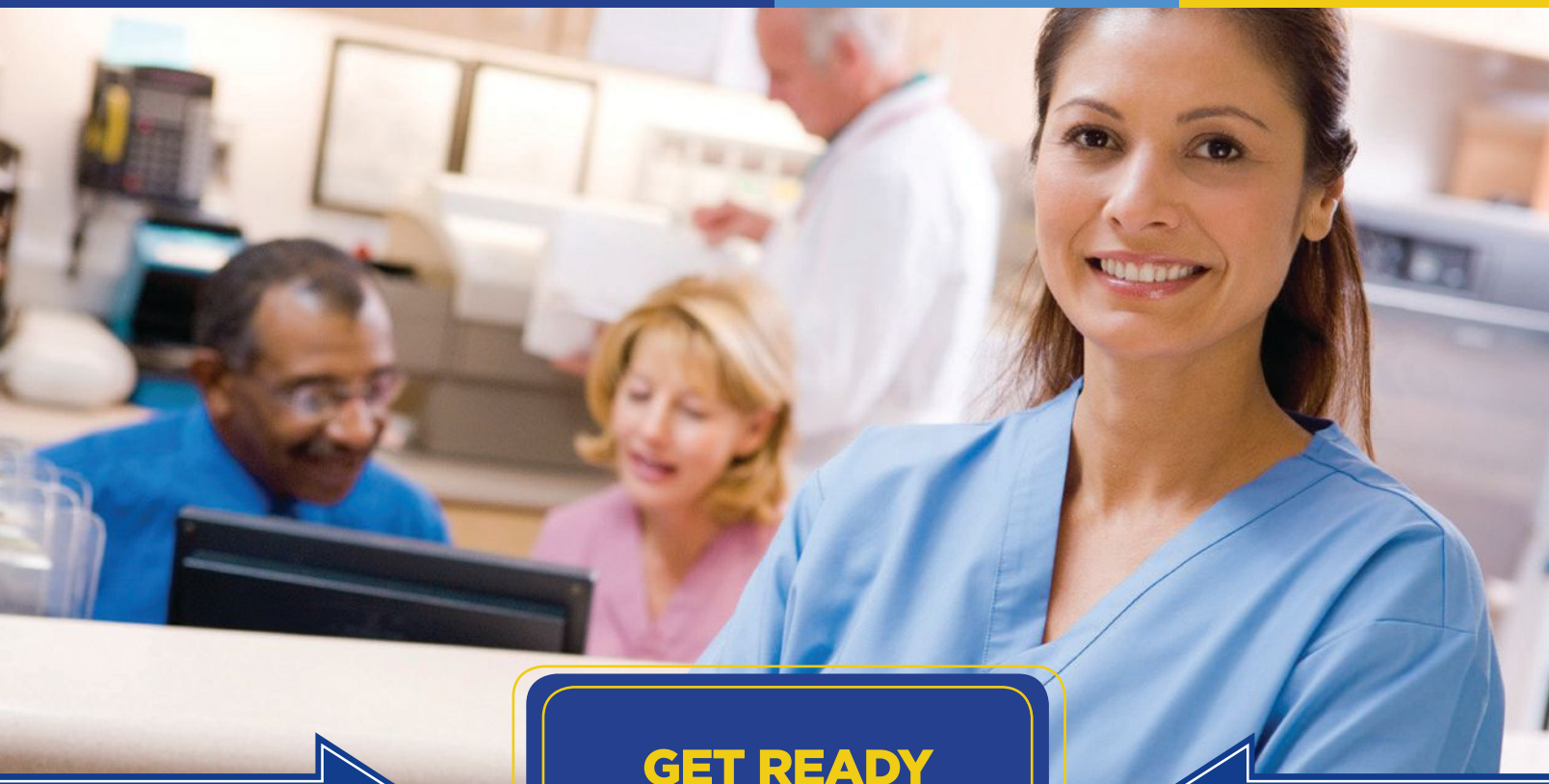
Dr. Pamela S. Stein received her D.M.D. degree in 1990 from the University of Kentucky College of Dentistry and her Masters in Public Health from the University of Kentucky College of Public Health in 2009. She is currently an Associate Professor in the Department of Oral Health Science at the University of Kentucky College of Dentistry. She teaches geriatric dentistry and has conducted research to investigate sustainable solutions to improve the oral health of nursing home residents.

Whitney L. Deitz received her B.S. degree in Biology from Campbellsville University in 2011. She is a D.M.D. candidate for 2015. Whitney plans to attend a General Practice Residency after graduation and then begin a non-profit organization in Kentucky that will provide much needed dental care for vulnerable elders in long term care facilities.



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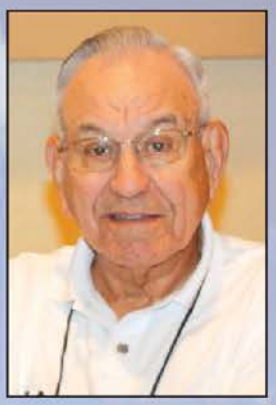

In Memory of Harold D. "Buddy" Haller – First Residency Trained Family Physician in Kentucky

His memory lives on in the patients, colleagues, family and friends that he influenced with his words and deeds.

Dr. Haller was a friend to all and stranger to none. He loved people and enjoyed helping his patients and sharing their lives. As the first residency trained Family Physician in the state of Kentucky and a charter member of the American Board of Family Practice, he exemplified the educational excellence of all Family Physicians in the Commonwealth. First attending the University of Louisville earning a BS in Biology and an MS in Radiation Biology, Dr. Haller was accepted at Bowman Gray (now Wake Forest) Medical School. After graduation from medical school in 1963, Dr. Haller could have pursued residency in any specialty but chose Family Medicine. His wife says this was a decision he never regretted. "In KY, we do Family Practice" he once said when asked why he would select this specialty. After finishing his residency at Baltimore City Hospital where he received the Meade Johnson Award for Graduate Training in Family Practice, Dr. Haller returned to Buechel/Fern Creek area of Jefferson County in Kentucky. Here he joined a practice where he would remain for the next 40 years.

Back in his hometown, Dr. Haller practiced full scope of Family Medicine delivering babies, making hospital rounds and providing outpatient care for his patients. He also served as the medical director of Westminster Terrace Nursing and Retirement Home for 37 years. Believing teaching was part of the commitment to the profession of medicine, Dr. Haller served as an Associate Clinical Professor at the University of KY for 10 years and Assistant Clinical Professor at the University of Louisville for 25 years. Involved in policy and governance, Dr. Haller was a president of both the Jefferson County and KY Academy of Family Physicians. In 1987, he received the Family Physician of the Year award in KY.

Dr. Haller was married to Glenda Papon Haller for almost 56 years. Together they enjoyed traveling, gardening and attending U of L athletic events. His wife shared that one of his favorite trips was to India, China and Thailand.

Harold Haller passed away March 9, 2014. His service to our specialty and state will not be forgotten. His memory lives on in the patients, colleagues, family and friends that he influenced with his words and deeds.

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Svarit Dave, M.D. is moving to Louisville, KY and will be working as a Family Medicine Physician at an out-patient clinic.

Billy Fralish, M.D. is staying with Baptist Health Medical Associates and working as a Family Medicine Physician in Hopkinsville, KY.

Zeeshan Javaid, M.D. is moving to Pittsburgh, PA and joining MED Express and working as an Urgent Care Physician.

Katarzyna Pisarewicz, M.D. is staying in Kentucky and will be working as a Family Medicine Physician.

Faisal Tawwab, M.D. will be staying in Madisonville, KY and working as an Urgent Care Physician.

CONGRATULATIONS TO OUR 2014 GRADUATES!!

It is with a heavy heart that we bid goodbye to our 2014 graduates. Being a rural training track and small residency program, we develop close relationships with the residents and feel like we are losing part of our family when they graduate and move on. We wish them the very best!

AMANDA RAMEY, D.O.
Dr. Ramey will be staying in Morehead; she will be joining St. Claire Regional Medical Center's Family Medicine – Morehead location as a family medicine physician.

GENA HARRISON, M.D.
Dr. Harrison will be returning to her home state of Michigan to practice as a family medicine physician.

For More Information Contact:
Site Director's : Amy Conley-Sallaz, M.D.
Phone Number: (606)783-6455
Fax Number: (606) 784-2767
Web Site: www.st-claire.org
Email: ajconley@st-claire.org

St. Claire Regional Medical Center
Family Medicine Residency

UNIVERSITY OF LOUISVILLE/ GLASGOW FAMILY MEDICINE RESIDENCY

UNIVERSITY OF LOUISVILLE
GLASGOW

Graduating Class of 2014

Kristin G. Cardona, M.D.
Dr. Cardona will be joining T. J. Samson Community Hospital as a Hospitalist in Glasgow, Kentucky.
Start Date: August 2014

Eric L. Fisher, M.D.
Dr. Fisher will be joining T. J. Samson Community Hospital as a Hospitalist in Glasgow, Kentucky.
Start Date: September 2014

Lindsey K. Whiteman, M.D.
Dr. Whiteman will begin her Sports Medicine Fellowship at the University of Louisville in Louisville, Kentucky.
Start Date: July 2014.

Steven R. Zeller, M.D.
Dr. Zeller will be staying in Kentucky and going into private practice as a Family Medicine physician at Southern Kentucky Primary Care in Bowling Green, Kentucky.
Start Date: July 14, 2014

ST. ELIZABETH FAMILY MEDICINE RESIDENCY

Laura Barczewski MD
St. Elizabeth Physicians
Fort Thomas KY

Marc Curvin MD
Hospitalist
Northern Kentucky

Sean Dillon MD
Undecided at this time

Philip Hartmand MD
St. Elizabeth Physicians
Union KY

Simon LoVasco MD
St. Elizabeth Physicians
Taylor Mill KY

Kruti Patel MD
Undecided at this time

Aleena Slone MD
Private Practice
Kettering OH

Stephanie Stirrat MD
St. Elizabeth Physicians
Taylor Mill KY

St. Elizabeth Family Medicine has maintained the highest standards of excellence for over thirty years in a nationally recognized and respected healthcare system. St. Elizabeth offers time-tested outstanding education in a highly collaborative, unopposed program, teaching broad spectrum Family Medicine with full support and encouragement of our Medical Community. We are very proud to present the graduating class of 2014 and their practice plans:

CONGRATULATIONS!
FROM YOUR FACULTY AND STAFF

DONALD J. SWIKERT, M.D.,
PROGRAM DIRECTOR
St. Elizabeth Family Medicine Center
413 South Loop Road, Edgewood KY 41017
(859) 301-3841 • www.stelizabeth.com

St. Elizabeth HEALTHCARE

UNIVERSITY OF KENTUCKY EAST KENTUCKY FAMILY MEDICINE RESIDENCY PROGRAM

UK UNIVERSITY OF KENTUCKY
EAST KENTUCKY

Veronica Caudill-Engle, D.O.

Melissa Haddix, D.O.

Jenny Faye Mullins, D.O.

The University of Kentucky East Kentucky Family Medicine Residency Program is located in Hazard, KY. The program is dual accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) for four positions each program year. The program currently has a component of 14 residents.

The program's mission is to prepare family practitioners who are dedicated to meeting the health care needs of the people of rural Appalachia. The residents' training is designed to prepare them for meeting the unique demands of a rural practice and for providing quality care in rural settings. Since the program's beginning in 1991, 69 residents have completed their family medicine training.

Drs. Caudill-Engle and Haddix will be joining Hospital Physician Partners. Dr. Mullins will be joining Kentucky River Medical Center in Jackson, Kentucky.

Director's Name: Stacey Johnson, M.D. • Phone Number: (606) 439-3557, Ext. 83565 • Fax Number: (606) 439-1131
Web Site: http://www.mc.uky.edu/RuralHealth/res.asp • Email: scjohnson2@uky.edu.

UNIVERSITY OF KENTUCKY (LEXINGTON) FAMILY AND COMMUNITY MEDICINE RESIDENCY PROGRAM

Over the last 40 years, our residency program has trained 257 graduates, the majority of which practice in Kentucky. Our mission statement demonstrates our three-fold purpose to recruit excellent students, to provide training that is second to none, individualized to the resident's needs, and to graduate family physicians who will become well-respected clinicians in their community. Our training encompasses experiences at the University of Kentucky Hospital as well as providing continuity hospital care in a smaller more patient-centered environment, UK Good Samaritan Hospital within UK Healthcare. We also utilize community sites both in Lexington and in surrounding rural communities, allowing our program to have the best of both worlds and prepare our residents well for a wide variety of patient care needs. We are very proud of our 2014 Graduates!

Director's Name: Michael King, MD, MPH • **Phone Number:** (859) 323-6712 • **Fax Number:** (859) 323-6661
Web Site: http://www.mc.uky.edu/familymedicine • **Email:** jmta226@uky.edu


Abigail Debusk, DO


Karen Frye, DO


Saranne Perman, MD


Hazim Rishmawi, MD


Gretchen Sprouse, MD


Ryan Sprouse, MD

DEPARTMENT OF FAMILY AND GERIATRIC MEDICINE AT THE UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE

The University of Louisville Family Medicine Centers are divisions of the Department of Family and Geriatric Medicine at the University of Louisville School of Medicine. The faculty and residents are committed to providing quality patient care that requires the joint efforts of our patients, their families, and our staff. Our graduating residents for 2014 include: Joshua Bentley, M.D., Jing Bryant, Amy Kim, M.D. and Iosbani Alberteris, M.D. are joining a practice in Louisville, KY. Rimy Brar, M.D. and Becky Popham, D.O. are joining a fellowship in Louisville, KY. David Gilbert, M.D is joining the faculty in the Department of Family Medicine. Cristina Fernandez, M.D. is joining a practice in St. Louis, MO.

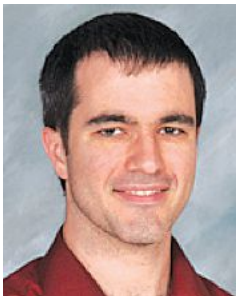

Iosbani Alberteris, M.D.


Joshua Bentley, M.D.


Rimy Brar, M.D.


Jing Bryant, M.D.


Cristina Fernandez, M.D.


David Gilbert, M.D.


Amy Kim, M.D.


Becky Popham, D.O.

The University of Kentucky Department of Family and Community Medicine

BY WANDA C. GONSALVES, M.D.

The University of Kentucky Department of Family and Community Medicine (UK DFCM) strives to improve the health of the people of Kentucky and society at large through excellence in healthcare delivery, education of physicians and other healthcare professionals and the advancement of knowledge through research and scholarship. Our education of medical students and our residency training programs are designed to produce well-rounded physicians, with special emphasis on addressing primary care physician shortages in Kentucky. Our faculty and residents provide care to patients in central and eastern Kentucky via family medicine centers located in Lexington, Hazard, Morehead, Georgetown, and Hindman. Research and scholarship activities in the UK DFCM cluster into three broad areas: health services research, health behaviors research and educational innovations.

This academic year has been productive and exciting for the UK DFCM. Each of our residency programs (Lexington, Hazard, Morehead) has a full complement of excellent young physicians in training. Our Sports Medicine Fellowship Program continues to thrive as well and we are still accepting two new fellows each year from a large pool of applicants. These residents and fellows have been quite productive this past academic year in terms of scholarly work, presenting 12 papers at either statewide or national conferences. Among the residents in our Lexington and Morehead programs, six participated in our Global Health Track for residents, and five participated in our Sports Medicine Track. Those in the Sports Medicine Track developed scholarly work leading to presentations at two national Sports Medicine conferences (in San Diego and Indianapolis). We are proud that our Lexington residency program was amongst 1 of 30 residency programs to participate in a volunteer ACGME self-study site visit and the only Family Medicine program within the cohort of 30 participating volunteer programs. The purpose of this visit was to give the ACGME site reviewers an opportunity to formalize their new review process in lieu of the *New Accreditation System* and program requirements. Additionally, our program was able to demonstrate the processes we had developed for critique and feedback. A formal report from ACGME is pending; however, verbal feedback provided at the time of the site-visit was positive and indicative of compliancy and innovation.

The UK DFCM faculty and residents teach and mentor medical students on a daily basis across the curriculum. However, our largest impact, during the past academic year, was with the direct mentoring/teaching of over 103 third year medical students who were completing the required Family Medicine clerkship. Of those 103 students, 84 were mentored directly in a rural AHEC setting. As our third year clerkship greatly depends on our community-based faculty, it would be impossible to mentor students without our community-based faculty involvement– so thank you for your continued support of our third year family medicine clerkship. In addition to our third year clerkship, the DFCM faculty offers a broad array of electives for medical students at all levels of instruction - examples include *Healer's Art*, *Mindfulness in Medicine*, *Leadership in Rural and Underserved Health*, *Salvation Army Student-Run Clinic*, *Introduction to Global Health*, *Interprofessional Teamwork in Global Health*, *Medical Spanish* and *Sports Medicine*.

One of our newest offering (which has now entered its third year) is our *Global Health Track* for medical students. The DFCM has been responsible for the development of this innovative set of electives, which is open to all UK medical students. The global track, electives and related experiences serve to maintain and strengthen student interest in serving people who are most in need. Students who participate in this track have activities available to them that span across all four years of medical school. As you know, there is good evidence reflecting that students who work in resource-limited settings (via global health experiences) are more likely to practice in underserved settings after residency. So far, our students have had primary care experiences in Costa Rica, India, Ecuador, South Africa, Mexico, Israel, and Zambia. Students who successfully complete the Global Health Track (at the end of their four years) receive special recognition at graduation. To date, over 94 UK medical students have enrolled in the *Global Health Track*.

Faculty and residents at all three residency programs remain productive with their research in areas pertinent to our mission, including practice-based quality improvement, chronic care, cancer prevention, sports medicine, complimentary-alternative medicine, community health, and uses of health information technology. The NIH Clinical and Translational Science Award to UK, the Kentucky Ambulatory Network and the UK Centers for Rural Health provide critical infrastructure and support for university-community partnerships in clinical and health services research.

With input from the KAFP and the AAFP, we are making steady progress

toward NCQA Patient Centered Medical Home (PCMH) recognition led in our Lexington office by our new Medical Director, Dr. Jonathan Ballard. Hazard and Hindman offices await rollout of UK's electronic health record, which will occur during the coming academic year. Our progress toward PCMH recognition has been fueled by the excellent leadership of our site-based medical directors and residency program directors, and is partially supported by two grants from the U.S. Health Resources and Services Administration (HRSA).

While each of our sites has specific opportunities and challenges, we are generally making progress. We are taking deliberate steps that will prepare us for value-based reimbursement while operating within the realities of the current fee-for-service environment. These steps include improved billing and coding procedures coupled with attention to systems-based practices that are designed to enhance practice efficiency, communication, access to care, patient activation, evidence-based practice and patient satisfaction.

Our department continues to grow and develop. We have added four new faculty physicians this year; in Hazard, Dr. Robert Atkins, and in Lexington, Drs. Jonathan Ballard, Wanda Gonsalves, Vice Chair, and Roberto Cardarelli, Vice Chair and Community Medicine Division Director. Overall, the UK Department of Family and Community Medicine will continue its exciting work aimed at improving healthcare and the workforce that delivers it, and we look forward to another year of close collaboration with the KAFP.

University of Louisville Department of Family and Geriatric Medicine

BY JONATHAN A. BECKER, M.D.

Since last year's update, our department has seen an incredible number of changes as we have had many faculty move on to exciting new challenges. Most notably, our former department chair, Dr. James O'Brien, stepped down after over a decade of leadership to direct the new Center for Sustainable and Optimal Aging. Our new chair, Dr. Diane Harper, began her tenure in the fall of 2013. Previously on the faculty at Dartmouth, she had spent the last five years as vice chair for research in the Department of Family and Community Medicine at the University of Missouri-Kansas City. She brings a wealth of experience in research and women's health to our department.

Our residency has thrived over the past six years under the leadership of Dr. Mike Ostapchuk. After serving in the interim role for over a year, Dr. Ostapchuk was appointed Associate Dean of Student Affairs in the School of Medicine. It is my privilege to accept the new role of program director at a time when we have such an outstanding group of residents. As I move on to this new challenge, Dr. Jessica Stumbo has become the director of the Primary Care Sports Medicine Fellowship. She has been the Associate Director for the past seven years and been integral to the program's success.

In addition, Dr. Laura Morton is now the director of the Geriatrics Fellowship, the only geriatrics fellowship program in the state of Kentucky.

One of the highlights of the past year has been the National Committee for Quality Assurance recognition of both of our primary training sites – Cardinal Station and Newburg – to be among the first in Kentucky to meet the criteria to earn a level 3 rating as a Patient-Centered Medical Home. The credit for this goes to so many in our department, including our clinic directors, Drs. Eli Pendleton and Renee Girdler, as well as our director of operations, Amanda Padgett, and our Research Lead, Dr. Anne Banks.

Dr. Brent Wright continues to provide senior leadership to the Glasgow/U of L Family Medicine residency program, but has also assumed the Associate Dean for Rural Health Innovation at U of L. He is leading the outreach effort to rural Kentucky for Family Medicine. Dr. Stephen House has assumed the Program Director position for the Glasgow residency.

The U of L School of Medicine Trover Campus just graduated one of the first 3 year medical school program graduates and she has matched in Family Medicine in rural Kentucky.

Some additional major achievements within our local department over the past year:

- Dr. Karen Krigger has been appointed the Director of Health Equities in the Executive Vice President's office at the U of L School of Medicine.
- Dr. Pat Murphy was a National finalist for 2014 Medical Director of the Year by American Medical Directors Association.
- Our residency program manager, Tanya Keenan, has presented on "Building an effective graduate medical education community" at the national ACGME meeting. A related poster won 2nd prize at a regional meeting and she is currently working toward board certification as a Training Administrator of Graduate Medical Education.
- At the recent American Medical Society for Sports Medicine annual meeting, our sports medicine fellow, five residents from Louisville and one from Glasgow had national presentations. Two of the residents will be doing their fellowship here in 2014-2015.

It is an exciting time for our department with so many people in new positions of leadership, but I look forward to our department growing and thriving together.

The Kentucky Academy of Family Physicians
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