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KAFP SCIENTIFIC ASSEMBLY *Awards*

WINTER 2014 · VOLUME 80

KENTUCKY ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR KENTUCKY

THE KENTUCKY ACADEMY OF FAMILY PHYSICIANS

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EDITION 21

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message from Your New PRESIDENT

It takes a lot of people to "grow" a family physician. And all of those people need to be thanked for their support. So in the mode of social media, this is a shout out to my family and supporters for helping me become the physician I am, as well as thanks ahead of time for their understanding over the next year. I would also like to thank the members of KAFP for giving me this opportunity. I hope I can continue the tradition of leadership that we have had from our past presidents.

The only way the KAFP can continue though, is by having other family physicians become active in our membership and activities. As the KAFP, our mission is to improve the health of the families of Kentucky, promote the value of family medicine and serve our members in a professional community. Our strategic plan outlines the ways we will go about achieving this goal and they all require involvement and leadership. We need to encourage other Family Physicians to speak out for the importance of Family Medicine, especially now. A group is easier to work in than going it on our own. And with so many changes happening in medicine now, we need to advocate for our specialty in order to provide better healthcare to our patients.

"NOW'S THE TIME, THE TIME IS NOW."

Immediate Past-President Ron Waldridge, II, M.D. & President Patty Swiney, M.D..

Bruce Bagley, M.D. swearing in Patty Swiney, M.D. as the new KAFP President.

Speaking of advocacy, Drs. Nancy Swikert and Brent Wright continue to work diligently through our legislative committee to advocate for KAFP and our patient's interests. Over the past year, Ron Waldridge, Jr., our immediate past president, has worked with the nurse practitioners' organization to try to ensure a team approach to health care; thus encouraging quality health care for Kentuckians. They need our help to keep family medicine at the forefront and I encourage you to respond to their emails during this legislative session.

The rest of us can't be complacent and let all this good work be for naught. We must step up and be leaders in our practices and communities. In whatever capacity we practice, we should be recognized as family physicians and stand up for our specialty as a better way to serve our communities and patients, and as a better way of providing medical care.

This year's Scientific Assembly offered excellent and needed topics for required CME. It also was a time to learn about these many changes in healthcare. Throughout all these changes and more to come, Family Medicine will continue to be a presence. I encourage more of you to attend next year's Assembly and be a presence in working towards our mission statement and vision.

I will close with some Led Zeppelin lyrics that I think are fitting for Family Medicine, "Now's the time, the time is now". Much better than the "Dazed and Confused" words I could have applied to much of health care today. Thank you again for the opportunities this year to represent the KAFP during Family Medicine's time.

President's Plaque

Dr. Swiney receiving President's Gavel

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2014 KAFP CALENDAR

KAFP BOARD & COMMITTEES CONFERENCE CALL
January 28, 2014 & March 25, 2014
7:00pm EST

2014 TEN STATE MEETING
Feb. 21-23, 2014
Hosted By PAFP
Hersey, PA

WVAFP CHAPTER MEETING
April 3-5, 2014
Embassy Suites
Charleston, WV

2014 FAMILY MEDICINE CONGRESSIONAL CONFERENCE
April 7-8, 2014
Renaissance Hotel
Washington, DC

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FOLLOWING THE LOGGIN' ROAD

If you are from the city or not been a hunter you may not understand the analogy. If you are a country-dweller you will know what I am talking about: If it is not hunting season a deer will follow the "loggin' road".

In the woods there are pathways and old logging roads that have been cleared over time. It is much easier to follow these than it is to force your way through the brambles and saplings as you work your way through the woods. That is why a deer will take the road. Any animal innately takes the easiest route that uses the least expenditure of energy and resources. After the first couple of days of hunting season the deer learn to get off the road and they move into the thickets.

We need to make the path to becoming a family doc "the loggin' road". The universities should have some type of incentive (say it out loud - financial) to make sure that five years out their "primary care" graduates are actually doing primary care and haven't gone into sub-specialties. The universities quote how many pediatricians, internists and med-peds grads they have, but anywhere between 65-80% of these go into sub-specialty training. The deans have learned to take an FTE faculty position in family medicine and break it into ten part-time faculty positions in orthopedics, gastroenterology, etc. We need family doctors.

Nurse practitioners quote 75% training in primary care but studies by the Jefferson County Health Department show only 23% actually do primary care[1]. A University of Kentucky study shows only 33% and a similar study from North Carolina shows only 30% of ARNPs actually practice primary care. We are all human beings and like other animals we all will take the easiest path. The sub-specialty pay is higher and after residency the work environment is usually gentler than family medicine.

Studies by Barbara Starfield showed that the US spends three times more than other Western Industrial Countries on Health Care but we are ranked 37th in quality of health care[2]. The other countries emphasize primary care and that is how they provide quality cost-effective care. She also presented studies that show that where there is a significant primary care presence, as opposed to specialties, that morbidity, mortality, and costs are all improved[3,4].

Despite their claims to the contrary, specialties are not primary care. The people who are there in the office keeping patients out of the hospital and doing preventative care are Family Physicians, general internists and general pediatricians – the true primary care docs. These are the most cost-effective physicians4. Increasing these physicians will decrease costs and improve health for our country.

My daughter is a general pediatrician. She had been offered an extra year as chief resident in pediatrics. Instead she made the decision to go into a primary care private practice and provides care to a county near Louisville that is grossly underserved in primary care. When they were announcing the residents' choices as she was graduating from her residency the medical school staff waxed poetic about those going into neurology, cardiology, endocrinology etc., but when they got to Casey they said, "She is going to open a private practice. Good luck with that." In a very sarcastic tone they reflected the University's general attitude toward primary care. This must change.

I suggest that we give medical students financial counseling before they begin medical school. They should be told based on income what subsidies and financial help that they would be eligible for. They should also be given counseling on personal finance toward the end of taking out the least amount of school loans possible so that the choice of primary care will not be limited by debt.

I suggest that medical schools should be incentivized to encourage Family Medicine. They will not unless we cut a path that will be easy to follow. If we are serious about increasing primary care then legislatures and Medicaid/Medicare must tie financial grants and payment directly to a medical school's ability to produce residents who are practicing primary care five years out. As per the Kentucky Institute of Medicine Task Force Report from August 2007, "The main sources of funding for graduate medical education are from Medicare, the Veterens Administration, and private funding of programs and positions.[5]" The financial incentives must be enacted at the federal level. Each specialty feels that they are the best choice – everyone should strive to be a neurosurgeon/dermatologist/cardiologist etc, just as I feel that only the best students should become Family Physicians. But, the studies show that if we want to make a change toward cost-effective quality care then we must produce more family docs, more general Internists, more general pediatricians as all as PAs and ARNPs who are going to practice as primary care providers.

I love and appreciate my specialty colleagues and I appreciate the great care they provide my patients.

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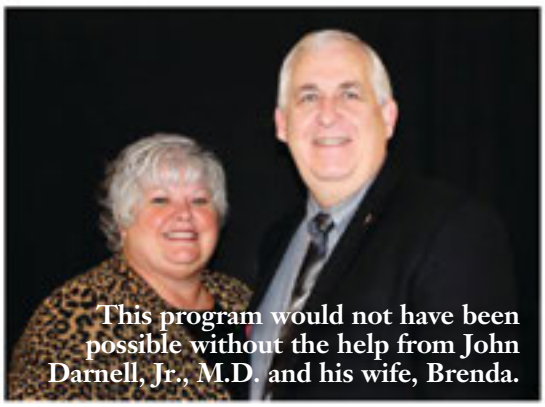
2010 Winner-East Kentucky FMRP
2011 Winner-St. Elizabeth FMRP
2012 Winner-St. Elizabeth FMRP



This program would not have been possible without the help from John Darnell, Jr., M.D. and his wife, Brenda.

SPECIAL THANKS TO OUR SUPPORTERS

Kentucky Academy of Family Physicians Foundation

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ST. CLAIRE FMRP WINNERS
Nina Lum, M.D. with KAFP Foundation President Nancy Swikert, M.D. and team mate, Amanda Ramey, D.O..

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However, the time is coming where we will need to open up more resident slots as we increase the number of medical school graduates. Those slots should be in Family Medicine because those graduates will not go into specialties but will practice primary care.

We need to pay more for primary care as it has been proven to be cost-effective[3]. We need to support primary care doctors who actually see patients in the office instead of overloading our ERs. We need to support doctors who practice preventative care. It costs a lot less to treat hypertension, to treat hyperlipidemia, and to encourage diet and exercise on a hundred patients than it does to treat one patient in the hospital for months as they await a transplant.

We must cut a "loggin' road" to training more family docs. We must make it easier to become a practicing family doc. Make it easy and make the universities choose to support more general internists and pediatricians to join our family doctors and our PA and ARNP colleagues as we care for our patients. We must make the politicians listen to those of us who are struggling to keep our offices open financially. We, as family docs, must take the time that we cannot find and send the money that we do not have to engage those politicians so that they will understand the importance of the change that must occur in healthcare. The US must emphasize primary care in order to improve our health system and to be able to afford the healthcare that our patients deserve.

Let us make it easy for students to wander the path to becoming "my doctor" for our patients.

1. Primary Care and Oral Health Workforce Study, REACH of Louisville Inc, Dec '11, pg 29.
2. Murray C, Frenk J. Ranking 37th — Measuring the Performance of the U.S. Health Care System. NEJM 2010; 362:98-99.
3. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005;83(3):457-502.
4. Starfield B. The future of primary care: refocusing the system. NEJM. 2008 Nov 13;359(20):2087, 2091.
5. Kentucky Institute of Medicine Task Force Report: Comprehensive Statewide Physician Workforce Study. August 2007. Pg 20.

Dr. Rick Miles, FAAFP is a solo Family Physician for over 32 years in Russell Springs KY. Dr. Miles is an associate clinical professor, serving as a rural preceptor for the University of Louisville, University of Kentucky and Pikeville Osteopathic School. He served as president of the KAFP in 1999 and was the KAFP citizen Doctor of the year in 2010. Dr. Miles has served on many committees and boards for the KMA such as the Technical Advisory Committee for Medicaid, Chairman of the Drug Formulary Committee 1992-1994 and is presently the Chairman of the Insurance Affordability and Availability Committee. Dr. Miles currently serves as an Alternate Delegate to the KAFP.

GARY CANNON, M.D. NAMED THE 2013 CITIZEN DOCTOR OF THE YEAR

GARY CANNON, M.D. of Richmond was the recipient of the Kentucky Academy of Family Physicians 2013 Citizen Doctor of the Year Award. This is the highest award of the KAFP and it recognize a member for their contribution to their patients and their community. Dr. Cannon was nominated by DeShana Collett, MSPAS, PA-C, President of the Kentucky Academy of Physician Assistants. Ms. Collett stated in her nomination letter "Dr. Cannon has demonstrated great leadership, compassion, work ethic and morals throughout his personal and professional career. Dr. Cannon has illustrated these characteristics in every aspect of his life, which distinguish him from his peers. In 28 years of practice, Dr. Gary Cannon has proven his commitment to high quality, family centered health care. He is a board certified physician in family medicine and urgent care medicine. In the clinical setting I have observed him spending time with patients and their families easing their concerns about illnesses. Patients who come to see Dr. Cannon do not leave without a detailed progress note overviewing their recent visit. He is dedicated to health literacy and education." The award was presented to Dr. Cannon on Saturday November 16th, at the KAFP Annual Meeting at the Campbell House, Lexington.

Ron Waldridge, II, M.D., Immediate Past-President presents the 2013 Citizen Doctor of the Year Award to Gary Cannon, M.D..

2013 KAFP DISTINGUISHED SERVICE AWARD

JAMES O'BRIEN, M.D. of Louisville was the recipient of the Kentucky Academy of Family Physicians 2013 Distinguished Service Award. This award recognized Dr. O'Brien for his service in leadership within the KAFP that contributed to the advancement of the specialty of family medicine. In addition Dr. O'Brien was recognized for his academic achievements while serving as Chair of Family and Geriatric Medicine at the University of Louisville's School of Medicine. The award was presented to Dr. O'Brien on Saturday, November 16th at the KAFP Annual Meeting at the Campbell House, Lexington.

Ron Waldridge, II, M.D., Immediate Past-President presents James O'Brien, M.D. with the 2013 Distinguished Service Award.

50 YEAR AWARDS

The Kentucky Academy of Family Physicians honored members who graduated medical school 50 years ago at the 62nd Annual Scientific Assembly awards ceremony. Ron Waldridge, II, M.D., Immediate Past-President presented awards to the 1962 Medical Student Graduates.

Kenneth Crabtree, M.D. from Gamaliel, KY

Max Crocker, M.D. from Lexington, KY

Jerry Martin, M.D. from Bowling Green, KY

The following honored physicians were not able to attend the event:

John Gilbert, Jr., M.D., *Hazard, KY*
Mary Hall, M.D., *McDowell, KY*
Virginia De Guzman, M.D., *Martin, KY*
Harold Haller, SR., M.D., *Louisville, KY*
Charles Noss, M.D., *Stanton, KY*
Joseph Sadtley, M.D., *Louisville, KY*

SIXTH ANNUAL RESIDENT SCHOLARLY EXHIBIT CONTEST

FIRST PLACE

Title: Transitioning a Family Medicine Residency Quality Improvement Program Designed for a Paper Chart Documentation System to an Electronic Medical Record (EMR) System

First Author: Abigail Debusk, D.O.

University of Kentucky Family and Community Medicine Residency Program

SECOND PLACE

Title: Using Diabetic Report Cards to Improve Quality of Care

First Author: Amanda Ramey, D.O.

St. Claire Family Medicine Residency Program

THIRD PLACE

Title: Transitioning a Family Medicine Residency Quality Improvement Program Designed for a Paper Chart Documentation System to an Electronic Medical Record (EMR) System

First Author: Saranne Perman, M.D.

University of Kentucky Family and Community Medicine Residency Program

FOURTH PLACE

Title: Comparison of VTE Prophylactic Enoxaparin Dosing in the Hospitalized Obese Population Using Standard vs. Weight Based Dosing: An Analysis of Antifactor – Xa Levels

First Author: Veronica Caudill-Engle, D.O., Melissa Haddix, D.O.

East Kentucky Family Medicine Program

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2013 EXEMPLARY TEACHING AWARDS

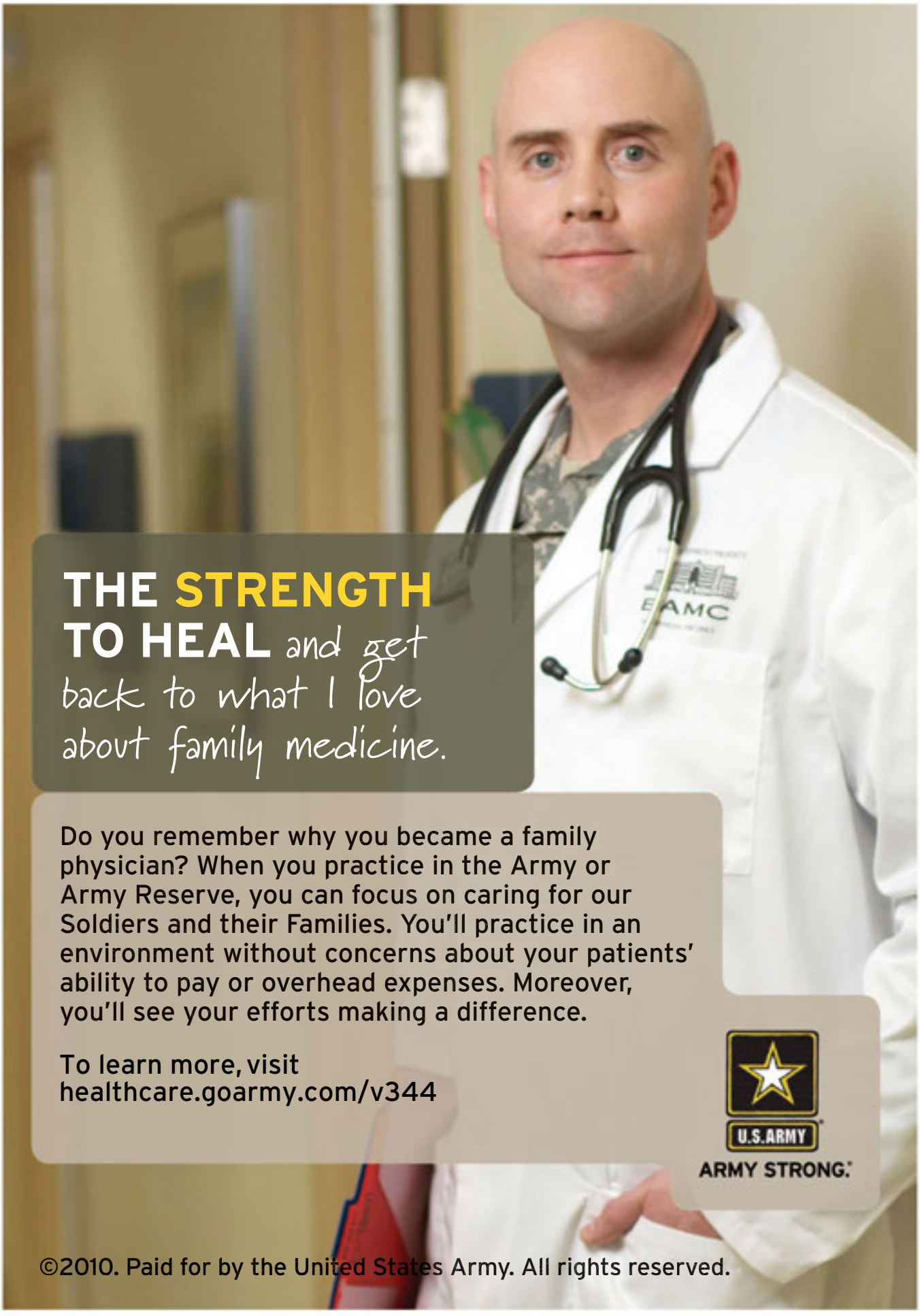
DONALD JOSEPH SWIKERT, M.D., FAAFP of Edgewood was the recipient of the Kentucky Academy of Family Physicians 2013 Exemplary Full-Time Faculty Award. This award recognizes a full time faculty member for excellence in graduate medical education teaching. Dr. Mark Boyd, Past President of the KAFP, and who submitted Dr. Swikert's nomination package for this prestigious award stated, "Don is not only recognized at the state level for his excellence in graduate medical education by his name but also is well received among his national colleagues in the Society of Teachers of Family Medicine." The award was presented to Dr. Swikert on Saturday, November 16th at the KAFP Annual Meeting at the Campbell House, Lexington.

Ron Waldridge, II, M.D., Immediate Past President and Mark Boyd, M.D. presented Donald Swikert with 2013 Exemplary Full-Time Faculty Award.

KELVIN PERRY, M.D. of Corbin was the recipient of the Kentucky Academy of Family Physicians 2013 Volunteer Teaching Award. This award recognizes a volunteer community faculty member for their excellence in clinical graduate medical education. Dona Roberts, M.D. Professor of Family and Geriatric Medicine at the University of Louisville's School of Medicine submitted the nomination package for Dr. Perry. In his packet was this quote from MS4 Amelia Nordmann, "Dr. Perry is one of the best teachers I have encountered. I spent a month with Dr. Perry in his ambulatory office in Corbin, Kentucky as a third year medical student. Within the first hour in his office I could tell that Dr. Perry had an excellent relationship with his patients." The award was presented to Dr. Perry on Saturday, November 16th at the KAFP Annual Meeting at the Campbell House, Lexington.

Ron Waldridge, II, M.D., Immediate Past-President presents Kelvin Perry, M.D. the 2013 Volunteer Faculty Award.

"TRUE TEACHERS ARE THOSE WHO USE THEMSELVES AS BRIDGES OVER WHICH THEY INVITE THEIR STUDENTS TO CROSS; THEN, HAVING FACILITATED THEIR CROSSING, JOYFULLY COLLAPSE, ENCOURAGING THEM TO CREATE THEIR OWN." - NIKOS KAZANTZAKIS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DOCUMENTATION PITFALLS *with EMRs*

All of us are grappling with implementation or expanded use of electronic medical records (EMRs). Some are using them effectively and efficiently and are striving toward higher levels of meaningful use; some might still be wrestling with how or whether to implement more basic functions. Among the many changes to physician practice that come with EMRs, it is becoming increasingly clear that our habits for documenting the patient encounter are going to need significant review and change as well.

For years, we have looked forward to the day when EMRs would help improve our documentation, and hopefully lead to capturing higher billing levels and increased revenue. EMR-based documentation should be faster, more complete, more legible, and more organized, and should allow us to document patient information more efficiently so we can get paid appropriately for the work that we do. In many cases, this is exactly what has happened, and patient care as well as medical practice is likely better for it.

But we are now starting to see another side—the "Dark Side"[1] of EMR documentation. It is becoming increasingly clear that while physicians can and should use the efficiencies of EMRs to improve documentation of the patient encounter, it is also possible to abuse those same documentation tools to document work that was not done, which is essentially billing fraud.

In September 2012, Attorney General Eric Holder Jr. and the Health and Human Services secretary, Kathleen Sebelius, sent a letter to five major hospital trade associations describing "troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it's illegal."[2] These concerns often relate to "up-coding," which is basically a fraudulent extension or abuse of the benefits that EMRs are supposed to provide.

Some data has been published on this issue but it is only starting to emerge; one report described the financial consequences of possible up-coding in the Emergency Room, and indicates that increased use of higher-level codes is not due just to seeing sicker patients, but due in part to "gaming the system" by using E/M codes to financial advantage.[3]

There are other documentation issues that are not concerning for fraud, but are just as concerning for inaccurate patient care. This article will outline some of the EMR documentation pitfalls that all of us need to watch for in order to preserve good patient care, achieve the benefits of EMRs without risking fraudulent documentation, and get paid for the work that we do, but not the work that we don't do.

COPY/PASTE

Copying one note and pasting the text into the next note is one of the longest-recognized problems with EMRs.[4] While it can be an efficient way of copying static information, it runs the risk of copying information that is inaccurate, no longer true, or simply not obtained by the physician at that point in the patient's care. Copy/paste functions should be used sparingly, only when needed to enter a large amount of static information into the chart in a way that benefits patient care, and should always be reviewed carefully before pasting.

TEMPLATES

Templated text can be a great option when documenting a procedure or a well-child exam, but like the other potential pitfalls the text needs to be reviewed for accuracy before finalizing the note. Incautious or incorrect use of templates may lead to information in the chart that does not seem to pertain to the actual patient's situation, which may "give the impression that the physician may not have performed the examination or procedure documented in the record."[5]

CARRY-OVER TEXT

A great deal of information in the chart is entered into the final, compiled EMR note, often without physician awareness or review. Clearly having a patient's past medical history, medication list, active problem list, or family and social history included as part of the note, can be a very beneficial use of EMR capabilities, particularly when sending a consultation request. But potential problems include carry-over of inactive or resolved problems, old medications, or old family or social history information that is no longer

true but hasn't been updated. Before information like this is carried over automatically, it should be reviewed for accuracy by the physician—particularly if "reviewed past medical history" is claimed as a medical decision-making bullet for E/M coding purposes. Information should not be carried over automatically without having to be reviewed.

"EXPLODING" DOCUMENTATION

Our traditional rule of thumb for documentation is that "if it isn't documented, then it wasn't done." But EMRs are changing that paradigm. Time-saving EMR features such as auto-documented past medical histories, problem lists, family histories, and review of system lists are intended to make documentation easier. But if these fields are populated into the note automatically, or with a single mouse click, and have not been reviewed and updated, or if there is no indication that the physician actually reviewed the information that day, then an auditor may question the validity of the information documented, particularly if it does not change from visit to visit. Make sure to actually review and update "static" information, and have some means of indicating in the chart that you have done so.[6]

NON-ENGLISH COMPILED TEXT

The final version of the EMR note looks very different from what is entered into the template. It is possible that few physicians go back and look at the "compiled" note—which represents the actual chart documentation and would be sent to a colleague. Make sure that your actual note is in English, does not contain nonsensical phrases or partial sentences, and is suitable for sharing with colleagues to describe patient care.

AUTO-FILLED TEXT

One potentially serious EMR documentation pitfall is the use of auto-filled text. When a physician clicks "normal" for a physical exam or review of system item, the EMR typically fills in the appropriate English description of negative findings. However, this obligates the physician to have actually performed those exam steps or asked those ROS questions, and to be very familiar with the default text that is filled in for "normal" findings.

One author calls this a "pseudohistory"[7] since the auto-filled text, even when used properly, may force a description of symptoms due to EMR word choice that is different than what the patient described. In the worst case, particularly with a nurse or medical assistant entering the history, important diagnostic details of the patient's history could be lost by forcing the history to match terms and structures used in the EMR.

PROBLEM LIST BASED ON ICD CODES

A related issue is having a patient problem list forced into ICD codes, without further details or clarification available. Not only can important clinical details be lost by converting a written problem list into a list of ICD codes, but once a code is entered, the text description is often a generic description of the diagnosis corresponding to that code, which may lose additional clinical information.

SUMMARY

Ideally, EMRs are excellent tools that can improve patient care and improve documentation by making it easier to document recurring information and save a great deal of text entry. But "medical necessity" dictates what should be documented as part of the encounter,6 and it is too easy to let EMR shortcuts become dysfunctional and lead to inaccurate documentation which might also be a concern in chart audits. Use EMR shortcuts to make care more efficient, but make sure that what goes into the note accurately reflects the work that you have done, without falsely over-documenting work you have not done.

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Dr. Kodner completed residency training at St. John's Mercy Medical Center in St. Louis, Missouri, before moving to Kentucky.

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CASE REPORT:

Obtaining a Do Not Resuscitate (DNR) order in a patient who is a guardian of the Commonwealth of KY

In Kentucky, guardianship is a legal relationship between a court-appointed adult who assumes the responsibility of being a guardian for a ward. A ward is a person who has been declared "legally disabled" by the court and is no longer able to care for his or her personal and/or financial needs. If there is no one willing to care for the disabled person, the court will appoint the Cabinet for Health and Family Services as the state guardian.

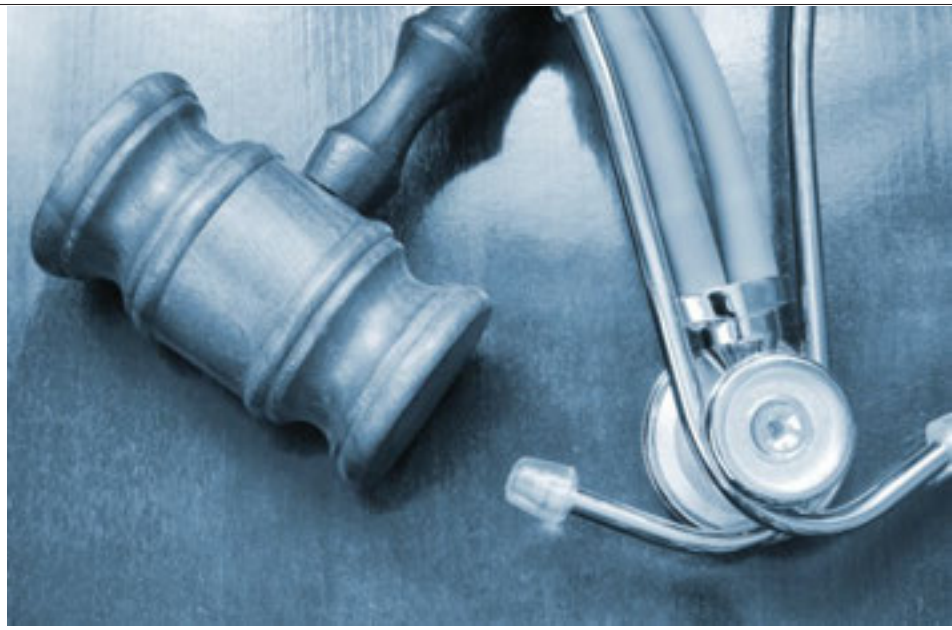
CASE:

In our case, a 68 year old male with a history of end-stage COPD, schizophrenia, and seizure disorder presented to the emergency room with decreasing oxygen saturations and fever. He lived at a facility and he was a guardian of the state due to his long-standing schizophrenia. About two weeks prior, he had been admitted for a COPD exacerbation. On exam, he was wheezing, but was comfortable. Labs were significant only for an elevated white blood cell count. Despite appropriate therapy for hospital acquired pneumonia,

continued >>

he decompensated and was intubated and placed in the Intensive Care Unit (ICU).

Approximately one week later, our patient was able to be weaned to nasal cannula and transferred to the floor. A feeding tube was placed in the ICU, and he required four-point restraints and two sitters to keep this in place. Though he was clinically improving, palliative care was consulted, as it was recognized that he was nearing the end of his life. A DNR status was obtained at this time. Two days later he abruptly decompensated. Antibiotics were restarted as well as comfort care measures. He was not re-intubated and he died two days later.



"IF THERE IS NO ONE WILLING TO CARE FOR THE DISABLED PERSON, THE COURT WILL APPOINT THE CABINET FOR HEALTH AND FAMILY SERVICES AS THE STATE GUARDIAN."

DISCUSSION:

After our patient was transferred from the ICU team back to the floor team, it became apparent that this was a patient at the end of his life. After reviewing hospital records and spending time with him, it was clear that he had a terminal illness and that he thought he had a poor quality of life. Furthermore, when reviewing medical records, a copy of a DNR form was found that he had signed before he became a ward of the state. This was not thought to be legal as the courts had no way of knowing if our patient had been mentally disabled at that time. After analyzing this information, a DNR status was pursued and obtained from the state. In our patient's case, it took just two days to obtain the DNR. The steps to obtaining a do Not Resuscitate order in a patient with a state guardian in Kentucky are listed below:

1. Two attending physicians must agree that the patient in question has a terminal condition and could reasonably be expected to die in a relatively short period of time.
2. Request a State Guardian DNR form from a social worker or the patient's state guardian.
3. The DNR form needs to be filled out first by the primary (admitting) physician and then a consulting physician. The attending must document in the progress notes on the date the form was signed regarding the patient's prognosis and reason for DNR order. After the attending physician writes a progress note, then the consulting physician must write a progress note documenting the prognosis and reason for the DNR order.
4. The form must be completed correctly and in its entirety and all diagnoses must be listed.
5. The form is submitted and a committee meets weekly to discuss these patients. Once the committee meets, it will make a decision about the DNR status. Physicians may be asked for further documentation.

In this case, the physicians were not asked for further documentation. Also, in this case, it only took two days for the process to be completed because the committee happened to meet the day after the paperwork was submitted. This is a surprisingly simple process that took little time once the medical team realized it was a possibility. In the teaching hospital where this occurred, it was not common knowledge that a DNR can be obtained for a patient who is a ward of the state.

Every patient deserves dignity at the end-of-life. Physicians often play a vital role in this transition. It is the responsibility of physicians to navigate this path with patients and to recognize when the end-of-life has come. The patient in this case was undoubtedly at the end of a long disease process. At the teaching hospital where he was treated, seven different hospital teams cared for him. Either the teams did not recognize he was dying or did not act on it. There is a lack of training on end-of-life issues in medical school and

residency. This is shown by the discomfort of physicians in discussing these issues and realizing when it is time to discuss them. Obtaining a DNR status in a terminal patient who is a ward of the state is feasible and relatively simple. The medical community needs to be more aware of this process. This is especially important in the academic setting.

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April Halleron M.D. joined Jewish Physician Group after graduating from the University of Louisville's Family Medicine Residency program in 2013. She completed her undergraduate and medical school training at the University of Louisville and continues to be committed to serving the Kentucky area.

Christian Davis Furman, M.D., MSPH, AGSF, is Professor of Geriatric Medicine in the Department of Family and Geriatric Medicine at the University of Louisville's School of Medicine. She joined the faculty in 2000, was named vice-chair for geriatric medicine in 2005. She is board certified in geriatric medicine and hospice and palliative medicine. Her research focuses on palliative medicine in the nursing home setting, and she serves as medical director for the university's geriatric medicine outpatient office, and at Masonic Home of Louisville. She was awarded a Geriatric Academic Career Award to teach palliative medicine to interdisciplinary teams in 2004. In 2012, Dr. Furman was the only Kentuckian among 73 individuals from 27 states and the District of Columbia selected to participate in the Center for Medicare and Medicaid Services' Innovation Advisors Program. In January 2013, Dr. Furman was selected as a Practice Change Leader for Health and Aging funded by the Hartford Foundation and Atlantic Philanthropies.

GETINVOLVED

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 emailing janice.hechesky@gmail.org.

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 2 hours.

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

Bylaws Committee: Chaired by Jerry Martin, 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 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, Website and e-mail.

Education Committee: Chaired by Melissa Zook, M.D.; this committee is responsible for developing CME that is targeted to the needs of membership.

Finance Committee: Chaired by John Darnell, Jr., M.D., Treasurer; 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 support undergraduate and graduate education in KY, and KAN's research initiatives that support private practice of family medicine.

Delegates to the KAFP Congress: Chaired by the Speaker Sam Matheny, 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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