The Official Publication of the Kentucky Academy of Family Physicians

KAFP JOURNAL

FALL 2021
EDITION 52

Your New President

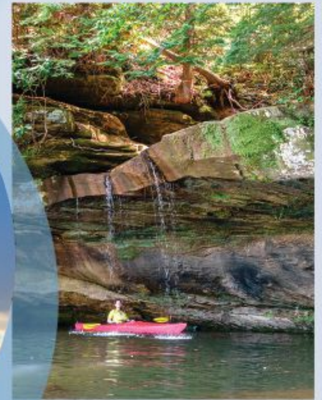
Syed A Naseeruddin, MD, FAAFP, CAQSM

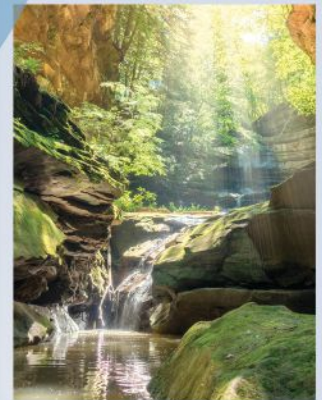
Outpatient Management of COVID Infections

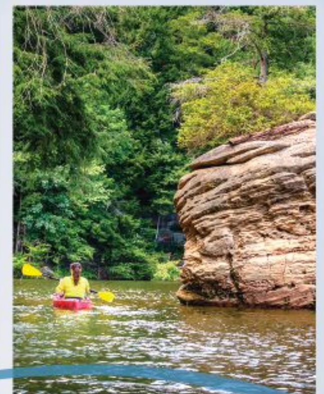
Primary Pediatric Hypertension: A Rising Public Health Problem

Physician Opportunities
Rural Primary Care

Owensboro Health







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New KAFP President Syed A Naseeruddin, MD, FAAFP, CAQSM

Your New PRESIDENT

Meet Me and My Goals for KAFP: Part 1

Special Guest, Reid Blackwelder, MD, FAAFP from the TNAFP and an AAFP Past President installs Syed A. Naseeruddin, MD, FAAFP as the KAFP New President.

Dear fellow colleagues and members of the Kentucky Academy of Family Physicians; I would like to express my gratitude to our Creator for bringing me to this point in my life where I am experienced, capable, and deemed worthy by the KAFP Board of Directors to take on the leadership of our chapter. It is a great honor and trust that you, our membership, and executive leadership, have bestowed upon me; and I intend to take on the opportunity with dedication and vigor.

I don't think I would be here were it not for the guidance, encouragement and love that has been provided by my predecessors, especially Dr. Lisa Corum, Dr. Patty Swinney and Dr. Melissa Zook; I also received much support from our Executive Vice President, retired Col. Gerry Stover, and our Executive Assistant, Janice Hechesky, all of whom ten years ago foresaw the leader that I would become today.

I wanted to introduce myself to those of you who I have not had a chance to meet personally. I was born in Memphis, TN and later raised in the suburbs of Atlanta, GA. I attended the Georgia Institute of Technology and obtained my bachelor's degree in chemistry. I then moved to the armpit of the south, Augusta, GA where I first pursued my master's degree in Molecular Biology followed by my medical degree at the Medical College of Georgia.

I had been selected for a health professions scholarship by the US Air Force and so immediately after graduation, I took my oath of office as a Captain and reported for duty to Keesler Air Force Base in Biloxi, MS. After completing my military service, I went through the match again to pursue general surgery at Montefiore Medical Center in Bronx, NY where I soon became disenchanted with the surgery culture of not spending time listening to the patient's needs. I felt that my heartfelt call was Family Medicine, and on the other end of the phone was the rural program through Dartmouth University, which was in Augusta, ME.

I had gone from one Augusta to another, and I trained in an unopposed rural program where I personally thrived. I enjoyed my patients and grew a dichotomous love for both OB and Sports Medicine. I chose to pursue a fellowship in sports medicine – which moved me to Pittsburgh, PA. It was during my fellowship year that I was introduced to the Pennsylvania Academy of Family Physicians; I was asked by the chapter to represent them at the National Conference of Constituency Leaders (NCCL) in 2008. Needless to say, I *was hooked* and had the time of my life meeting the National leaders of AAFP and making friends with other representatives from across the country.

After fellowship, I was offered a position to collaborate with the Army at Fort Campbell, KY to help set up a sports medicine clinic model as an outreach of their primary care clinics. After this accomplishment I opened a traditional

solo practice model for primary care sports medicine which I kept afloat for 5 years. But in the end, it was not sustainable due to a paucity of sports patients.

I had started moonlighting in small rural emergency rooms where I felt at ease as I was proficient at reading x-rays [thanks to fellowship training] and managing the primary care issues often seen in rural ERs. I soon started doing ER primarily due to my affinity for complete and immediate care I was able to offer the patients... and no call or late-night charting/phone call follow ups was a definite plus – yeah! I have continued sports coverage as the medical director for a number of bodybuilding shows in both KY and TN alongside high-school event coverage.

It is based upon my ER work that I have identified two interventions that Family Physicians can make that can positively impact our patients. I have condensed these into two of my four goals for this upcoming year: (i) the high rate of nicotine and vaping amongst young adults, and (ii) the lack of any end-of-life plans and "Medical Orders for Scope of Treatment" (MOST) or "Do Not Resuscitate" (DNR) documentation in patient records.

I can easily say that 80% of my ER patients in Franklin, KY and Pineville, KY were smokers...and 95% of my COVID patients used nicotine. It is very disheartening to see such high usage amongst our rural Kentucky patients, and I feel this may in part be due to lack of education during their elementary and middle school years. Had health professionals intervened, lives could have been saved in adulthood, especially during this respiratory pandemic. Here are some factoids courtesy of the AAFP:

- **23.6%** of adults and **8.9%** of high school students in Kentucky smoke
- **26.1%** of high schoolers in Kentucky use electronic cigarettes/vaping products
- **34%** of cancer deaths in Kentucky are attributable to smoking
- **8,900** adults in Kentucky die each year from their own smoking and 119,000 Kentucky kids under 18 will die prematurely due to smoking[1]

The leading cause of death and preventable disease in the U.S. is felt to be cigarette smoking and secondhand smoke exposure.[2] Cigarette smoking has been causally linked to increased risk of disease in almost all organs in the body, including heart disease, stroke, chronic obstructive pulmonary disease, and lung cancer.[2] The AAFP and the KAFP urge all state, federal and private sector institutions involved in tobacco prevention and cessation to increase new initiatives to reduce smoking rates to **less than 10 percent by 2024** and eliminate death and disease caused by tobacco use.

Asha Sharma, MD, FAAFP pinning the KAFP President's pin on to Syed A. Naseeruddin, MD, FAAFP

Immediate Past President , Asha Sharma, MD, FAAFP presenting the President's Award to Syed A. Naseeruddin, MD, FAAFP.

Physicians are the leading trusted source of medical knowledge and excellent messengers to encourage smoking cessation.[3] Roughly 70 percent of tobacco consumers see a primary care physician annually.[4] Nearly 70 percent of smokers want to quit; family physician's offering advice, referrals to tobacco cessation programs, and overall support can drastically improve success rates.[5]

I have unfortunately been in the position of running codes on patients both in the ER as well as hospitalized inpatients. I see a number of nursing home patients also

continued on page 6

continued from page 5

President's Medallion presented

being sent to the ER when they have chosen comfort care or Do Not Hospitalize, but the nursing home staff or the family is unaware of their wishes. I am put in the precarious position of running unnecessary or undesired codes on patients; or I am having to acquire DNR decisions from patients or loved ones during or after intubation becomes necessary.

One study found that only 37% of older adults had completed an advance directive; this compares with 5% to 15% of all adults.[8] African-American patients were even **less** likely than white patients to have any advance directive. Reasons include lower levels of awareness about advance directives among African-American adults compared with white adults; different attitudes toward advance directives among providers serving different populations; and beliefs and values among African-American people that may contribute to these differences, including greater preferences for life-sustaining therapies, less comfort discussing death, and greater distrust of the health care system.[9]

I opine that these discussions would be best held at the primary physician's office rather than in an emergent situation. Many patients do not understand the purpose and use of the MOST form versus a DNR. It may be an unintended lack of either resources or awareness by family physicians which is causing a failure in implementing these care decisions for high-risk [Asthma, COPD, Diabetes, Cardiac, and Renal] patients or geriatric patients. I intend to prepare a resource document for family physicians in KY to reference to assist in getting these discussions started with their patients at an office visit set aside **solely** for this discussion and planning.

In a similar vein, organ donation levels are concerning in the state. While 97% of Kentuckians have a positive view of organ donation, and 85% of them stated they would like to donate, only 59% of them joined the Kentucky Donor Registry.[6] The need for organs is high and the wait lists are long, and Family Physicians providing patient education and information may help sway the other 25-40% towards joining the state Registry.

- More than 1,000 people in Kentucky are waiting for a lifesaving transplant.
- Every 10 minutes someone is added to the national waiting list.
- 22 People die every day waiting for a lifesaving transplant.
- One organ donor can save up to eight lives
- One tissue donor can heal more than 50 lives
- Every year over 1,000 Kentuckians have eyesight restored through a cornea transplant
- Living donors can provide many types of organs, including the kidney and segments of the liver, lung, and pancreas without reduced function to their own bodies.[6]
- All donor families receive grief support through the KODA Aftercare Program[6]

A valuable resource is the Kentucky Organ Donor Affiliates (KODA) which is dedicated to saving lives through organ and tissue donation and transplantation.[6] KODA was formed to establish a statewide educational and procurement network.[6]

I think providing information/pamphlets and having this discussion with patients during the "end of life" visit proposed above would be of huge benefit to our citizenry and provide improved quality of life to many. There are five nearby hospitals [Vanderbilt, UK, Jewish, University of Cincinnati and Norton Children's] that offer transplant services and would gladly welcome any living donors for their pre-transplant patients. Most of these have websites for interested donors who would like to direct an organ to a loved one or friend, or they may also donate to the general waiting list.

I began involvement in the KAFP around 2010 after I was referred by Dr. Reid Blackwelder, who was AAFP President the year I received my FAAFP designation. I met with Dr. Swinney and Dr. Zook and was quickly made to feel welcomed into the organization and started representing our state at national meetings.

I have been to NCCL four or five times, to Annual Chapter Leader Forum (ACLF) once and have served on the membership and education committees. I have presented CME lectures at our academy meetings on two occasions and have been invited to attend the WV chapter annual conference and present there as well. After three years, I was asked to become secretary by the state Executive, and the rest is history.

I wanted to elaborate on my pathway to leadership to illustrate to our student and resident members that there are several pathways to involvement and leadership in the state chapter. I will further outline my plans for fostering leadership in Part 2 of my goals in our next Journal. I encourage any interested chapter constituents to approach anyone on the board about finding out how your goals can be met by your state organization. There is a place for everyone at our table, and please feel welcome to contact me directly if I can help.

MY GOALS FOR 2022 [Part 1]:

1. AIM HIGH – INCREASE MEMBERSHIP AND ATTENDANCE AT OUR CONFERENCES

2. IMPROVE COMMUNITY HEALTH AND END OF LIFE CARE
   a. REVIVE "TAR WARS" WITH A FOCUS ON YOUTH INHALANT AND VAPING IN PRE-TEENS AND ORGANIZE A SPORTING TOURNAMENT TO INCREASE COMMUNITY AWARENESS AND INVOLVEMENT.
   b. COMPASSION IN CARE – ENCOURAGE FAMILY PHYSICIANS TO DISCUSS ORGAN DONATION, END OF LIFE AND DNR OPTIONS WITH PATIENTS AND ENCOURAGE ADVANCED DIRECTIVES AS PART OF ROUTINE ADULT AND GERIATRIC CARE

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Presentation of the Clark Bailey Cane

KAFP's New President, Dr. Syed; New Chair, Dr. Sharma and New President-Elect Dr. Sullivan

By A. Stevens Wrightson, MD

Letter From the Editor

Freedom

I have heard that word bandied around quite a bit in the last year and a half. It is an incredibly important concept for humans and citizens of the United States. So, what does it mean?

"The power or right to act, speak, or think as one wants without hindrance or restraint." Okay.

"Absence of subjection to foreign domination or despotic government." Certainly.

"The state of not being imprisoned or enslaved." Interesting. I think I will save this for later.

Another question I might ask. Is freedom an all or none experience? Do we all have the same potential to be free?

Clearly, we should be free to wear a mask or not, to gather in crowds or not, to get immunized or not...or should we? What about going to the grocery safely or being able to worship with a reasonable belief that you will not have a fever two days later and be on a ventilator in a week. Shouldn't I be able to go anywhere I want, even if I know I have a potentially contagious and deadly condition, because I am free to do so?

No. I cannot drink alcohol and drive, or at least, if I do and cause a wreck or get pulled over, I will pay the consequence. So, I may be **free** to drink and drive, but I **choose** not to, because it is the right thing to do for me and my community.

Freedom and choice are intertwined. Ultimately, freedom allows us to make choices and the choices we make have a huge impact on our lives, on the lives of others, and our freedoms.

But are freedoms doled out equally amongst us all? We in the United States have a wealth of freedoms that other countries, say, Saudi Arabia, do not.

But even here, at home, we are not all blessed with the same freedoms. We know that certain social determinants impact our health and our ability to stay healthy. I live in a safe neighborhood. I can jog at any time, day or night and really have no fear of any bad outcome, except that I might trip on a crack in the sidewalk (has happened more than once) or get hit by a passing car or bike because neither of us looked (has not happened, thankfully).

A physician friend of mine in Lexington told me recently of a worker in their office who was awakened at night to the sound of a bullet coming through her front window and exiting out the back of the house and into the neighbor's home. This event was not unusual for this neighborhood. How free are those in that community to walk, run, bike, and enjoy fellowship, especially once the sun has set? And if she wanted to move, is she free to do so, given the cost of housing and the time and effort involved, especially if it took her away from her less-than-average paying job.

About 3 years ago, my daughter was returning from a semester at school. She had a late start and did not get into Lexington until 2 am. She was traveling down Winchester Rd and noticed a police car behind her. The car followed her for a couple blocks until it was joined by another cruiser, at which point, she was pulled over. She was terrified, knowing that she was not speeding, so why in the world would she be pulled over. One officer came to her door, took a look at her in her T-shirt and bright pink shorts with her designer dog (a whippet) sitting next to her, and everything seemed suddenly to relax. The officer did want to look at the bag of dog food she had in the back seat, then gave her a ticket for having a taillight that was out. My daughter asked if she could call her parents who had been waiting up for her and he graciously said yes. Just thinking about that encounter terrifies me.

What if I was black? What if this was my black son, not my daughter? What if Freddy, the whippet, was Scruffy, the dog from the Humane Society. What if my daughter reached for her phone before she asked for permission to use it?

That's not the story, however. I am an educated white male with a white family who has so many freedoms and so

many choices I can make. Not so with those who are people of color, who are poor, or who live in poor neighborhoods with inadequate education, housing, and safety.

With my freedoms and choices, come responsibilities. Pardon me for sounding trite, but you see, I really do believe I should "pay it forward." That is a primary reason I became a family physician. I had the freedom to choose almost any profession, but I chose to be a family doc because I thought it suited me and allowed me to serve. I know a bunch of you, my colleagues, who feel exactly the same way.

I also chose to be vaccinated against COVID, very early. I really thought it would allow us to get back to normal much sooner. But we didn't, not nearly to the degree I hoped. There may have been a few weeks that I was a bit lax with wearing my mask, outdoors, around others. That has passed. I have always worn a mask in stores. My wife and I were the only people at our church with a mask on for months. I went to a funeral in Louisville, my sister-in-law's mother. I was the only person with a mask out of 200 people.

You might say, "Your mask did nothing to protect you in that situation." I would have to agree. However, if a handful of people saw the mask and had a thought or two about ways to protect themselves and their loved ones, I feel I provided a service. If nothing else, maybe someone thought, "Bless his heart. He cares enough about others to keep a mask on."

Some people might say my mask is a crutch. I cannot go anywhere without it. But you see, I am free to choose to wear the mask, and that choice sets me free. I don't need to worry about getting COVID, because I have done all I can to prevent it and the rest is truly up to God.

So, what about the third definition of freedom, about "not being imprisoned?" We all are free to make choices that imprison us. Alcohol, food, gambling. Being free to choose not to mask and not to vaccinate leads to another type of imprisonment. For some, it is illness, for others it is the illness of loved ones. For almost all the rest, it is imprisonment to the notion that we are the center of the universe and no one else matters. That seems like a lonely place to me.

I really worry about those who are not free to make choices, like the poor, or children, or those suffering chronic illnesses, especially in areas where vaccination rates are so low like rural Kentucky. I know this pandemic has cost the country a ton of money but couldn't we all at least agree that wearing masks and getting vaccines is a good thing? Do we have to argue over something that is so obvious? Freedom to choose to cooperate. That would be amazing. Choices that set us free.

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By Bob Babbage, MA and Rebecca Hartsough, PhD

Letter From the Lobbyist

Kentucky General Assembly Special Session 2021

The Kentucky General Assembly convened September 7 through September 9, 2021 to pass measures related to Covid-19 emergency provisions and regulations. The GOP-led House and Senate met in Frankfort following an "extraordinary session" call from Governor Beshear, which was prompted by the recent state Supreme Court decision ruling in favor of the General Assembly's recent curtails on emergency executive powers.

Below is a summary of the most relevant highlights of the 2021 Special Session.

Mask Mandates Fall to Local Officials

The GOP-led supermajorities stripped the governor's power of issuing a statewide mask mandate. Local school boards now have the power to determine district's mask policies. County Judge Executives also hold power to institute mask mandates and guidelines, which some have already put into place.

Future statewide mandates are prohibited until June 2023.

As of September 16, there were 138 of the 171 school systems requiring masks. More could join the list. Three relatively small systems opted not to require masks, these being Gallatin County in Northern Kentucky, Science Hill Independent near Somerset, and Burgin Independent in Mercer County.

Anti-vaccine Mandates Lost Steam

A group anti-mandate advocates within the GOP attempted to attach a series of floor amendments to bills that were either ruled out of order or failed because they lacked enough votes to suspend the rules.

Matt Castlen's (R-Owensboro) amendment would have banned any local school district from implementing its own mask mandate. Rep. Savannah Maddox's (R-Dry Ridge) and Josh Calloway's (R-Irvington) proposal would have banned schools from mandating vaccines or using "intimidation tactics or negative incentives to encourage vaccination."

A proposal to ban vaccine mandates at health care facilities failed after Sen. Adrienne Southworth's (R-Lawrenceburg) motion to suspend the rules did not receive a second from any other senator. Sen. Stephen West (R- Paris) drafted an amendment that would have banned any private employer from mandating vaccines, which also failed in the chamber.

Hospitals, Nursing Homes Still Face Staffing Shortages

As you know well, hospitals and nursing homes across the state have highlighted the soaring costs and major staff shortages brought on by the pandemic.

Although the General Assembly made some efforts to address health concerns, the related bills did not include additional funds for pay increases to nurses and health care aides.

However, the legislature did ensure continued funding for COVID-19 testing supplies. To combat staffing shortages, hospitals and nursing homes will now be able to use paramedics under supervision of medical personnel.

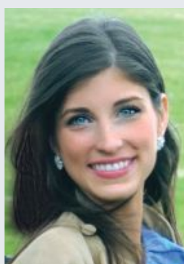
The House and Senate also lifted certain restrictions for nursing home visitations.

Lastly, legislation spearheaded by Dr. Ralph Alvarado (R-Winchester) encouraged vaccine campaigns and more access to monoclonal antibody treatments for people with COVID-19.

In the End

Over the history of special sessions, none in memory has addressed major health issues until now. The House and Senate convene January 4, 2022, for the "long session" of the General Assembly. Several actions mentioned here are set to expire or get a review on or before January 15. Additionally, the governor and legislature will complete a 2-year state budget, allocating major federal funds, including many federal allocations due to be spent by September 2022.

Bob Babbage is a graduate of Eastern Kentucky University and holds master's degrees from the University of Kentucky Patterson School of Diplomacy and Lexington Theological Seminary. He completed the Harvard University Senior Executive Program. Joining top state and regional leaders and Kentucky's prominent congressional delegation, Bob is recognized as the "architect" of the award-winning DC Fly-In, managed by Commerce Lexington. He received a "Washington Influential" honor in 2012. Bob is a frequent platform and boardroom speaker and workshop facilitator. He is a sought-after political analyst and commentator providing twice-weekly insights on WVLK Radio (ABC) and election coverage analysis for WLEX-TV (NBC). Bob Babbage heads Babbage Cofounder, the lobby and advocacy firm proudly representing family physicians in Kentucky. For more information on how to contact your legislator, visit: https://apps.legislature.ky.gov/findyourlegislator/findyourlegislator.html.



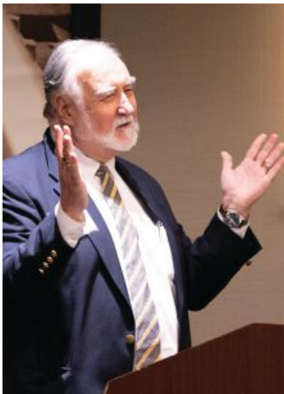
Rebecca Hartsough, Ph.D., Policy Director brings an extensive research background to Babbage Cofounder. Rebecca worked previously in higher education, legal, and healthcare sectors, most recently serving as the data science liaison for Embold Health. She earned a doctorate in Political Science & Quantitative Methods from Emory University.

50 YEAR AWARDS

This is the 41st year we honored physician members of the Kentucky Academy of Family Physicians who graduated from medical school 50 years ago, the Class of 1971.

The following doctors were unable to attend:
Rodney Bates, MD, FAAFP
James Dean, MD
David Frost, MD, FAAFP
Robert Hendren, MD
Charles Nichols, MD, FAAFP
Nilkhanth Purohit, MD, FAAFP
Jerry Smith, MD
Warren Stumbo, MD, FAAFP

Robert William Prassad Steiner, MD awarded 2021 Exemplary Teaching Award for Full-Time Faculty



The Kentucky Academy of Family Physicians (KAFP) Board of Directors selected Robert William Prassad Steiner, MD professor in the Department of Health Management and Systems Sciences at the School of Public Health and Information Sciences and Associate Professor in the Department of Family and Geriatric Medicine at the University of Louisville School of Medicine, as the recipient of its 2021 Exemplary Teaching Award for Full-Time Faculty.

The award recognizes a KAFP member who has demonstrated exemplary teaching skills as well as implemented outstanding educational programs and/or developed innovative teaching models.

Dr. Rick Miles, who nominated Dr. Steiner stated “He was ahead of his time. He knew his patient care, but he also was talking about system care during my residency in 1977 to 1980, what we know now as chronic care management.”

Dr. Steiner earned his degree in medicine from the University of Louisville and completed a residency in family practice at U of L Hospital. He joined the U of L School of Medicine Department of Family Practice faculty as an assistant professor in 1977. He took a sabbatical to earn his Master of Public Health (1988) and PhD in Epidemiology (1998) from the University of North Carolina. He served as formal liaison for the UofL School of Medicine to the Jefferson County Health Department (JCHD) for two years and was acting deputy director of the JCHD from 1994 to 1996. Dr. Steiner transferred from the U of L School of Medicine to the newly formed School of Public Health and Information Sciences (SPHIS) in 2005. In addition to his teaching responsibilities, Dr. Steiner has served as SPHIS representative to local organizations including the UAW/Ford Kentuckiana Health Collaborative and the Health Enterprise Network.

Asha Sharma, MD, FAAFP presents this years Full Time Faculty Teaching Award to Robert William Prasaad Steiner, MD, PhD, FAAFP

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A. Stevens Wrightson, MD awarded 2021 Distinguished Service Award

The leadership of the Kentucky Academy of Family Physicians (KAFP) has recognized the accomplishment of A. Stevens Wrightson, MD by awarding him the Distinguished Service Award. This award is given to a family physician who has served in leadership roles with the KAFP and advanced the specialty of family medicine through their deeds and actions.

Dr. Wrightson began as Associate Editor of the KAFP Journal (KAFPJ) in 2005 and in 2017, upon the retirement of Dr. Bill Crump, assumed the role of Editor. As the editor he has continued the KAFPJ legacy of providing family medicine focused articles of the highest quality. He has extended KAFPJ presence through his outreach efforts to all the family medicine residency programs in the Commonwealth of Kentucky as well as our schools of medicine. The KAFPJ reputation among other family medicine chapters has resulted in requests for re-prints of articles our members have contributed. He has ensured the KAFPJ is a news resource for our members as well as a resource for students and residents to publish scholarly work.

Asha Sharma, MD, FAAFP presents this years Distinguished Service Award to Alan Stevens Wrightson, MD

Dr. Wrightson hails from Louisville and received his undergraduate degree in Chemistry from Vanderbilt University. He attended the University of Kentucky College of Medicine where he also completed his Family Medicine Residency. Since August 2010, he has practiced at Bluegrass Community Health Center in Lexington, first as Medical Director, and now as Chief Executive Officer. In 2013, he helped BCHC become the first Kentucky-based health center to achieve Patient Centered Medical Home (PCMH) recognition. Dr. Wrightson has been a founding steering committee member of Smiles for Life, the award-winning national curriculum designed to assist primary care providers in integrating oral health care in their day-to-day practices. Dr. Wrightson is part of a 2-doctor family. His wife, Michelle, is an internist in Lexington. They have 4 children.

Founded in 1948, the Kentucky Academy of Family Physicians represents more than 1,500 physicians and medical students statewide. It is the largest medical specialty society devoted solely to primary care. The Kentucky Academy of Family Physicians is a chapter of the American Academy of Family Physicians.

Cynthia Villacis, MD honored with Citizen Doctor of the Year Award for 2021

Bowling Green, KY – Cynthia Villacis, MD, from Florence, KY was the recipient of the Kentucky Academy of Family Physicians highest award – Citizen Doctor of the Year for 2021. Dr. Villacis received the award at the Kentucky Academy of Family Physicians (KAFP) Annual Scientific Assembly in Bowling Green, KY.

The Citizen Doctor of the Year Award honors an outstanding, community-minded family physician who provides compassionate, comprehensive care. Dr. Villacis is a Direct Primary Care Physician (DPC) in Florence, KY. A DPC physician has a smaller patient population so that they can provide direct communication and same or next-day visits. DPC practices do this through an alternative payment model based on a monthly membership fee. Nominations for this award come from not another physician but from the community. Here is an excerpt from the community nomination letter – "I know if I need to see her, I will have no trouble getting an appointment. In addition, I know she will take the time to REALLY listen to my concerns and answer my questions. I never feel rushed when I am in her office. Dr. Villacis is truly concerned with the well-being of her patients. She is knowledgeable, professional, and caring. You cannot go wrong by selecting her for this award."

The KAFP 2021 Citizen Doctor of the Year is Cynthia Villacis, MD

Dr. Villacis is a board-certified family physician. She completed medical school at Wright State in Dayton, OH in 1999. She did her Family Medicine Residency at St. Elizabeth in Edgewood, KY graduating in 2002. She is a certified Life Coach and in addition to membership in KAFP, she is a member of the American Society of Addiction Medicine, Northern Kentucky Medical Society, and Northern Kentucky Chamber of Commerce. She started and owns Health Connections Direct Primary Care, PLLC.

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Eric Kiltinen, MD awarded 2021 Fleet Award

The Kentucky Academy of Family Physicians Foundation (KAFPF) is honored to recognize Eric Kiltinen, MD as the 2021 Fleet Award recipient.

Established in 2020 the award recognizes a young Kentucky Family Physician who exhibits those qualities of being a personal family physician. A physician that:

- looks after people as people, not problems
- has warm personal regard and concerns for patients
- integrates clinical information and the use of technology with patient values
- establishes relationships with patients grounded on trust
- is accountable to patients
- is there for patients in time of health crisis
- takes continuous responsibility for every patient

Eric Kiltinen, MD

Dr. Don Swikert in his nomination of Dr. Kiltinen described him as "In my mind, Eric stands out as an effective personal physician by observing the recent hours he has spent with his panel of patients preparing for an effective and thorough handoff to other physicians as he leaves the program and our practice."

In April 2020, the Fleet Memorial Fund of the San Diego Foundation awarded the KAFP Foundation a grant of $25,000, the request of Ms. Sally Fleet Johnson. Kevin A. Pearce, MD, Professor at the University of Kentucky's Department of Family and Community Medicine is the personal physician for Ms. Johnson. Ms. Johnson expressed her wish to formally recognize and support Dr. Pearce, through a grant from her family's charitable foundation, in his mission to improve the health of communities via high quality primary care. This led to her encouraging the KAFPF to apply for a grant that would provide recognition awards for family physicians practicing in Kentucky. Ultimately it was decided that the purpose of the award should be to inspire young physicians to be personal physicians.

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*Source: USDA FoodData Central. FDA's Daily Value (DV) for potassium of 4700 mg is based on a 2005 DRI recommendation. In 2019, NASEM updated the DRI to 3400 mg. Based on the 2019 DRI, a serving of milk provides 10% of the DRI. FDA rule-making is needed to update this value for the purpose of food labeling.

The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

Source: USDA FoodData Central online at https://fdc.nal.usda.gov/. Mean values calculated from database entries across all fat levels of plain vitamin D-fortified fluid milk in Legacy, Foundation, and Survey (FNDDS) data sources.

BY MARY ANN BARNES, MD

Outpatient Management of COVID Infections

It has been a challenging time for family physicians. The pandemic has brought a whirlwind of changing information and recommendations in the midst of fear and tragedy. As confusing as it has been for those of us who know that science is built on probability, it has upended many of our patients' confidence in expert recommendations. This review is intended to help us, as patient advocates, provide clarity on recent evidence for the outpatient treatment of COVID.

Reducing Transmission

First and foremost is the prevention of the spread of the disease. Vaccinations help, but many of our patients and neighbors have been reluctant to take this vital step. We can and must provide strong counsel to those around us to stem the epidemic and reduce the risk of more virulent variants. Secondly, wearing masks has been shown to protect not only the person wearing them, but also those around them. Handwashing is also an essential component of prevention of disease.

Once an infection is diagnosed, the current CDC guidelines recommend at least a 10 day quarantine, AND at least 24 hours of no fever (without the use of antipyretics) before ending isolation. Close contacts of the index patient have recommendations that vary based on whether they themselves were vaccinated.

Unvaccinated close contacts should quarantine for at least 10 days. This may be shortened to 7 days if they have a negative COVID test. This recommendation was recently updated from the previous CDC recommendation of a 14 day isolation period.

Vaccinated close contacts should self-monitor for symptoms and isolate if they develop fever or other symptoms of COVID. In the absence of symptoms, no isolation is required.

If the COVID patient has any dyspnea, it is recommended that they obtain a pulse oximeter and check their oxygenation twice a day. Should their peripheral oxygen saturation drop below 94%, they should seek medical care. Pulse oximeters are available over the counter at many pharmacies and supermarkets. Other symptoms that should drive further evaluation include neurological changes, chest pain, severe dyspnea, syncope, or hemoptysis.

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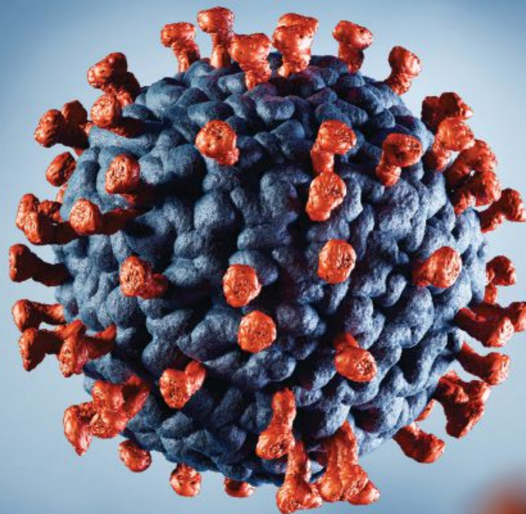
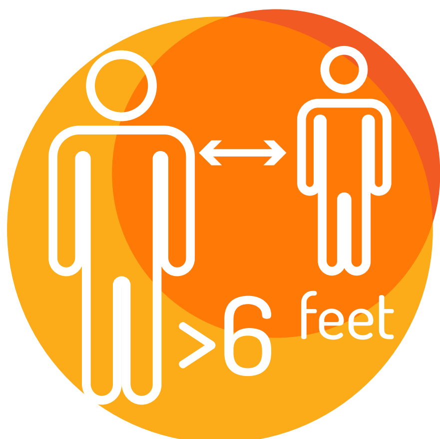


Getting 'Back to Normal' Is Going to Take **All of Our Tools**

If we use all the tools we have, we stand the best chance of getting our families, communities, schools, and workplaces "back to normal" sooner:

Get vaccinated.

Wear a mask.



Stay 6 feet from others, and avoid crowds.

Wash hands often.

www.cdc.gov/coronavirus/vaccines

12/09/20

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Pharmaceutical Interventions for Outpatient COVID Treatment

One of the most challenging parts of this epidemic has been keeping up with the evidence for potential therapies that may help our patients overcome the devastation of this disease. Indeed, even as this section is scribed, the author wonders what new information will surface between the composition and publication! None the less, this is a synopsis of the evidence to date.

Over-the-counter Options

Vitamin D deficiency increases the risk of severe disease in COVID infections. Small studies have shown supplementation with 25-OH vitamin D significantly reduced ICU admissions. There is no evidence that patients with adequate levels of vitamin D benefit from supplementation. Patients at risk for deficiency and adverse outcomes should be supplemented with 2000 – 4000 IU a day.

Zinc supplementation appears to be helpful in patients who are deficient, have comorbidities or are older, though none of the studies on this therapy have been well designed. Ongoing studies are evaluating it use in prospective, randomized controlled trials. Over the counter zinc supplements are readily available and have very few side effects, making them an easy and safe recommendation for use in patients with restricted diets, malabsorption syndromes (remember to include all your patients with obesity surgery in addition to the celiac and inflammatory bowel disease patients we always consider), or those who may be at risk for deficiency.

Melatonin has anti-inflammatory and antioxidation effects that might be helpful in the treatment of COVID. A large observational study showed that persons taking melatonin supplements may have a reduction in the risk of infection from COVID. Its use is generally considered to be safe with minimal side effects. Typical doses range from 3 to 10 mg at night.

Drugs Under Investigation and Consideration

Ongoing research is investigating possible benefits of the SSRI fluvoxamine and aspirin. Though corticosteroids are used in hypoxemic patients in the inpatient setting, there is currently no recommendation for their initiation in the outpatient setting. Hospitalized patients may be continued on corticosteroids upon discharge, however. A recent randomized, but not placebo controlled, trial in older high-risk adults showed that inhaled corticosteroids (budesonide) may reduce the symptomatic period by almost 3 days, but did not reach statistical significance for fewer hospitalizations or deaths.

COVID is well known to cause vasculitis and hypercoagulability. Prophylactic therapy could be considered in outpatients with high risk of clotting, pending the outcome of several trials. It is certainly prudent to maintain a high index of suspicion for the development of DVT/PE in symptomatic non-hospitalized COVID patients and to treat with therapeutic anticoagulation when these are diagnosed in the outpatient setting.

Monoclonal Antibodies

If the infected patient is at risk for poor outcomes, monoclonal antibodies have an emergency use authorization approval from the FDA. These antibodies bind to the spike protein of the virus, reducing its entry into cells. This treatment reduces the risk of hospitalization and emergency room visit by about two thirds, with a number needed to treat of 16 to 20.[4] Currently, three regimes are approved, two of which use two different antibody types to prevent resistance. These treatments are not indicated for hypoxemic or hospitalized patients and must be given within the first 10 days of symptoms.

The NIH recently updated its protocols and recommendations for treatment of monoclonal antibodies to include the following populations based on strong evidence:

- BMI > 30
- Chronic lung disease
- DM
- Age 65 years and older
- Cardiovascular disease

Other groups that are considered high risk but do not have as strong as evidence include:

- Immunosuppression
- Overweight (BMI 25-30)
- Chronic Kidney Disease
- Pregnancy
- Sickle cell disease
- Neurodevelopmental or congenital disorders that are medically complex
- Dependence on medical technology that is not related to COVID (e.g. tracheostomy, gastrostomy)

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What is NOT Recommended

Hydroxychloroquine, chloroquine, and azithromycin were trialed early in the pandemic on hospitalized patients with mild to moderate COVID based on in-vitro antiviral activity. A recent meta-analysis showed that there was no benefit in outcomes and their use is ineffective. In addition, the risk of QT prolongation with hydroxychloroquine mandates extreme caution. Azithromycin was studied in a randomized, controlled trial and did not reduce hospitalizations or speed recovery. Therefore, its use is not indicated.

Studies on the use of colchicine have had mixed results. The anti-inflammatory and cardioprotective effects of this medication spurred this research. A retrospective study of mostly inpatients showed reduced mortality from COVID. One outpatient study showed insignificant reductions in the incidence of pneumonia and increases in the risk of diarrhea and pulmonary embolism. The study was somewhat messy because it included patients with proven COVID infection and patients with symptoms consistent with disease but no testing. A subgroup analysis showed there was a slight, though statistically significant, reduction in hospitalizations in patients with PCR-confirmed disease. Further studies are needed.

Ivermectin was trialed based on in-vitro antiviral activity for mild, moderate and severe COVID. Some of the doubt of its efficacy stems from evidence that the concentrations needed for the in-vitro effects are not obtainable in the lung or plasma. However, there is a raft of mixed-quality literature with vertigo-inducing results. A good review of the technical and design flaws in the original ivermectin studies is available on-line. A recent randomized, placebo-controlled outpatient study of almost 400 patients failed to demonstrate a benefit on the resolution of symptoms. However, a recent systematic review and meta-analysis suggested there may be some benefit in mild to moderate disease, although the authors did state many of the studies included were of low quality. This meta-analysis is further complicated by the fact that a significant part of the review included a study that was later retracted. At present, the FDA and WHO only recommend its use in the context of clinical trials. Unfortunately, there has been a recent spate of calls to the Kentucky Poison Control Center for ivermectin overdose. This risk highlights the necessity to keep informed and not get ahead of good quality evidence.

L-arginine is being investigated currently, but there are no recommendations for supplementation to date.

Contagion control and symptom monitoring continue to be the mainstays of outpatient COVID treatment. High risk patients should be referred for monoclonal antibody infusion within the first 10 days of symptoms.

Finally, at the time of writing this article, Merck and Ridgeback Biotherapeutics have announced a "positive interim analysis" of their antiviral drug, Molnupiravir, in their Phase 3 MOVe-OUT Trial at day 29 of the study. Merck has announced plans to seek Emergency Use Authorization for the outpatient use of this antiviral drug in non-hospitalized adult patients with mild to moderate COVID-19 infection from the FDA. Their study is not yet completed nor peer-reviewed, but data will likely be available by the time of this publication.

Summary

Contagion control and symptom monitoring continue to be the mainstays of outpatient COVID treatment. High risk patients should be referred for monoclonal antibody infusion within the first 10 days of symptoms. Supplementation with 25-OH vitamin D, zinc, and melatonin should be recommended in deficient patients. The results of on-going research will help clarify what treatments are most efficacious for this devastating disease. Until then, we need to constantly remind our patients and communities that prevention is the best medicine.

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Mary Ann Barnes, MD is on the faculty of St. Elizabeth Healthcare Family Medicine Program. She has been practicing acupuncture for almost twenty years and was board certified in Integrative Medicine in 2015.

BY MARYE MARGARET BOGGS, MD, MPH

Primary Pediatric Hypertension: A RISING PUBLIC HEALTH PROBLEM

Primary pediatric hypertension (PPH) is increasing in prevalence, is underdiagnosed, and as a result is undertreated in the United States. The prevalence of primary pediatric hypertension is estimated to be 3-4% in the United States.[10] Although the impact of untreated PPH on the health outcomes of the population is not well established, PPH is an increasing public health concern as pediatric patients with hypertension are more likely to be treated for hypertension in adulthood.[6,16] Essential hypertension (eHTN) has been recognized as a major risk factor for cardiovascular disease and events in adults.[13] In addition, eHTN is recognized as a major contributor to morbidity and mortality rates in adults, as cardiovascular disease remains the leading cause of death in the United States and globally.[1, 3] There are few reasons to think that the impact of hypertension in children is harmless given the relationship of long-term elevated blood pressure to cardiovascular disease and adult mortality. The purpose of this article is to review the most recent guidelines and evidence pertaining to PPH, including etiologies, pathophysiology, screening, treatment, and monitoring recommendations.

Pediatric hypertension is defined based on age, sex, and height.[18, 20] In 2017, the American Academy of Pediatrics (AAP) Clinical Practice Guideline (CPG) Subcommittee for Screening and Management of High Blood Pressure in Children and Adolescents released updated guidelines to assist in the diagnosis of pediatric hypertension.[7, 20] Three separate blood pressure readings are required to make the diagnosis. Based on the new CPG for children between one and thirteen years of age, normal blood pressure (BP) is any BP < 90th percentile for age, height, and sex. Elevated BP is defined as a BP between 120/80 mmHg and the 95th percentile, or a BP ≥ 90th percentile to less than 95th percentile, whichever is lowest. Stage 1 hypertension is defined as a BP ≥ 95th percentile up to the 95th percentile plus 12 mm Hg, or between 130/80 to 139/89 mmHg, whichever is lowest. Stage 2 hypertension is defined as a BP ≥95th percentile plus 12 mmHg, or greater than or equal to 140/90 mm Hg, whichever is lowest. For children thirteen years of age and older, an elevated BP is defined using the

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same guidelines the American College of Cardiology recommends for adults.[4] Therefore, a systolic blood pressure of 120 to 129 mm Hg and a diastolic BP less than 80 mm Hg defines elevated blood pressure for children thirteen years of age and older. In this age group, stage 1 hypertension is defined as a BP between 130/80 to 139/89 mm Hg and stage 2 is defined as a BP ≥ 140/90 mm Hg.

Table 1:

Criteria for Hypertension in Children Aged 1 - < 13 Years

Classification	Criteria for Age/Height/Sex %ile*	Numeric Criteria*
Normal	< 90th percentile	
Elevated BP	≥ 90th percentile to < 95th percentile	120/80 mm Hg up to < 95th percentile
Stage 1	≥ 95th percentile to < 95th percentile + 12 mm Hg	≥130/80-139/89 mm Hg
Stage 2	≥ 95th percentile + 12mm Hg	≥ 140/90 mm Hg

* Apply whichever criterion is *lower* to diagnose hypertension

Etiology

The etiology of PPH is multifactorial.[3, 12, 14] A child's genetic makeup, environmental exposures before and after birth including cultural and familial behaviors and socioeconomic status all contribute to the development of PPH.[14] Evidence suggests factors in utero, such as whether a mother smokes cigarettes or consumes a high sodium diet, contribute to changes in renal structure and function. These changes result in a reduction in total nephrons and an increase in sodium reabsorption. Thus, prevention of PPH will require a multidisciplinary team, and efforts should begin before birth in high-risk pregnancies.

Pathophysiology

The pathophysiology of PPH is driven by the same complex neuro-immuno-metabolic abnormalities seen in adults.[11,12] Children with PPH have been found to have advanced vascular aging as shown by increased carotid intima-media thickness, increased stiffness of large arteries, lower area of microcirculation, and decreased endothelial function.[11, 16]

Screening Currently the United States Preventative Service Task Force (USPSTF) does not recommend screening all children aged three to eighteen years of age at average risk for hypertension.[15] The data required to support this recommendation were determined to be insufficient because the benefits and harms cannot be calculated from the current body of evidence.[8, 15] Although there is data that hypertension in childhood is associated with eHTN into adulthood, which we know is directly linked to cardiovascular disease, there is an insufficient amount of evidence suggesting that early detection and treatment of pediatric hypertension improves adult outcomes.[15, 18]

On the other hand, the AAP CPG recommends screening all children three to eighteen years of age annually.[7, 20] Additional measurements in healthy children do not need to be taken more than once yearly. Thus, weighing the risks and benefits of screening each child is important.[2, 15] Screening children with risk factors for hypertension like obesity should be done at every healthcare encounter.

The best screening tool available is a manual oscillatory BP machine. Measurements taken using an appropriately sized blood pressure cuff on the right upper arm are the most accurate.[20] If the blood pressure reading is over 90th percentile, repeat BP measurement by auscultatory method is recommended. Two measurements should be taken and averaged. Blood pressure measurements of the wrist and forearm are not recommended.

Diagnostic Tests Recent studies suggest PPH is now the leading cause of pediatric hypertension.[11] The shift in the leading cause of pediatric hypertension from secondary to primary resulted in a change in guidelines for the evaluation of pediatric hypertension. The CPG once focused on evaluating for the most common causes of secondary hypertension. Children younger than six years of age are most likely to suffer from renal parenchymal, renovascular, endocrine, and cardiac anomalies resulting in hypertension. For children less than six years of age, the diagnostic evaluation should always include a renal ultrasound.[20] A renal ultrasound is only recommended in children six years and older if the patient has abnormal renal function or proteinuria on urinalysis. *All* children diagnosed with hypertension should be evaluated with a urinalysis, basic metabolic panel, and lipid panel. For patients with a Body Mass Index (BMI) > 95th percentile, HgbA1c and hepatic function tests should also be obtained. Obtaining an EKG is no longer recommended. An echocardiogram should be obtained to evaluate left ventricular structure and function if pharmacological therapy is initiated.

Treatment The treatment of PPH is modeled after the treatment of eHTN in adults. Lifestyle modifications are discussed at the time of diagnosis before pharmacological therapy.[20] Education regarding the importance of daily physical exercise and low sodium diets should begin immediately. Referral to a comprehensive program for age-appropriate child nutrition and healthy behaviors should be considered, if available, especially for children with comorbidities.

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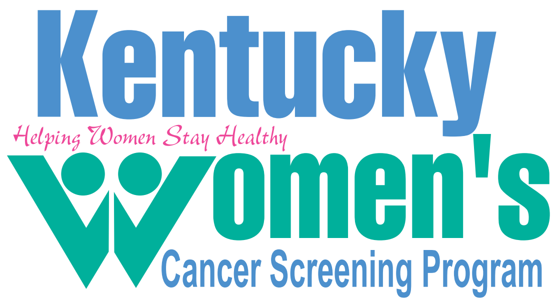

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- Has no health insurance (no Medicare, no Medicaid, or no private health insurance)

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The Kentucky Women's Cancer Screening Program (KWCSP) offers FREE breast and cervical cancer screenings. The program provides Mammograms and Pap tests and follow-up services, education and outreach to low income, eligible women. Once in the program, if a woman has an abnormal screening, the KWCSP covers the cost of most diagnostic tests. If a pre-cancer or cancer is found, the program connects her to treatment through Medicaid's Breast and Cervical Cancer Treatment Program (BCCTP). The KWCSP provides services through Kentucky's local health departments, community health clinics and other healthcare providers. A woman does not have to reside in the same county in which she receives services. Healthcare providers, please refer eligible women to a participating KWCSP clinic/provider. For a participating clinic/provider listing call KWCSP, 1-844-249-0708.

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If the patient is diagnosed with elevated BP, the child should return in six months for repeat BP measurement. If the patient's BP remains elevated after six months of lifestyle modifications, lifestyle modifications should be reinforced and continued for another 6 months. If at one year BP remains elevated, 24-hour ambulatory blood pressure monitoring (ABPM) should be completed.

For patients with BP readings in the stage 1 hypertension range, lifestyle changes should be addressed, and the patient should return in two weeks for a repeat BP measurement. If the BP is abnormal, upper and lower extremity measurements should be obtained. At this point, if the reading continues to be abnormal, weight management and nutrition referrals should be considered, if applicable, and the child should be asked to follow up in three months. If the BP remains elevated, ABPM should be completed. Pharmacological treatment is initiated if ABPM confirms the diagnosis.

For stage 2 hypertension measurements, upper and lower extremity readings should be obtained initially and a follow up visit in 1 week should be arranged. If the BP remains elevated, ABPM should be initiated to confirm diagnosis. If the diagnosis is confirmed, pharmacological therapy should be initiated. Patients with symptomatic stage 2 hypertension or BP more than 30 mmHg higher than the 95th percentile should be treated urgently. Angiotensin Converting Enzyme-Inhibitors (ACE-Is) and Angiotensin Receptor Blockers (ARBs) are first line therapy in children who are not of childbearing age. Dihydropyridine Calcium Channel Blockers (CCB), such as amlodipine, and thiazide diuretics, such as hydrochlorothiazide, are also appropriate alternatives or second agents that can be added to lower BP to achieve a measurement at goal.

Monitoring

Patient's with PPH should be seen multiple times per year. The frequency of office visits and lab work depends on whether the patient takes medication and has controlled disease.

Patients with controlled PPH should follow up every 3-6 months and get lab work every 6 months if taking an ACE-I or ARB. If the patient has uncontrolled PPH, the patient should be seen every 2-weeks until a stable medication regimen is established. Repeat echocardiography should be performed at 6–12-month intervals in children with refractory hypertension despite treatment, impaired cardiac function, or left ventricular hypertrophy.[18,20]

ConclusionPPH is a public health concern because of its relationship to morbidity and mortality. PPH is likely underdiagnosed due to the complex definition and the fact that secondary hypertension was historically the leading cause of pediatric hypertension, as discussed earlier. As pediatric obesity and diabetes mellitus continue to increase with increasing age, PPH will continue to increase.[9] The underdiagnosis of PPH is likely to increase the development of potential complications, including cerebrovascular and cardiovascular disease, in a younger population.[6, 12, 13] For this reason, it is imperative that we increase its recognition and contribute to improving the diagnosis, treatment, and monitoring of PPH through awareness and implementation of guidelines.[19]

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BY WILLIAM J. CRUMP, MD

HUMANITIES

Emergency Use: A Revolutionary Concept

General Washington saw it as a sign of weakness
And bore the scars

It was still experimental and strange it seemed
A simple scratch to protect an army?

Worth a try if hidden from enemy prying eyes
But at Valley Forge a last resort in full view

Masks not even a thought
And quarantine a reverse miasma

Psalm 91 says not to fear
Angels won't allow you to strike your foot upon a stone

But was it an angel of fear who guided Jenner?
The father of our country would say surely not.

During the critical part of the revolutionary war, Washington discovered that many of the British soldiers had been exposed to smallpox as children and therefore were immune. He realized that his forces were being decimated by this infection, as many of the colonists had not had previous exposure. Washington himself had contracted the disease in Barbados 25 years earlier, leaving him with a small scar on his nose. Quarantine was known to be effective, but was very unpopular and simply could not be enforced in tightly packed encampments. The irritation of quarantine was confounded by the prevailing concept at the time that plagues were spread by a cloud of evil termed a miasma. Variolation was established almost 20 years before Edward Jenner's landmark paper showing that inoculation with cowpox could prevent smallpox. The procedure during the time of Valley Forge required taking a small amount of exudate from a smallpox lesion and placing it in a scratch on the soldier's arm. The result was a very mild illness but sometimes quarantine was still suggested. Reports from the time show that Washington believed that if the enemy knew this process was going on with his army, they would know to attack while the Continentals were weakened. So he sent waves of his army away for this to occur, unknown to the enemy. In the truly desperate days of Valley Forge, he changed this policy to include variolation within the encampment.

The risk of this procedure for "emergency use" was that it would cause an outbreak within the encampment. In one of Washington's letters, he said he feared the disease more than the sword of the enemy. He accepted the risk, and the rest of the story, as they say, is truly history.

William J. Crump, MD, graduated from the University of Georgia and completed his MD degree at Vanderbilt in 1979. He then completed a Family Medicine residency at UAB and a faculty development fellowship at UNC Chapel Hill. He has served as the Associate Dean at the University of Louisville Trover Campus in Madisonville since 1998. Having recently stopped delivering babies, he now has begun work on a series of books about medical lessons that could be learned from history.

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