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SPRING 2021
EDITION 50

KAFP Spring Conference

On Zoom
May 15

Physician Health and Well-Being

Lead Screening in Children

Lessons in Learning

UNIVERSITY OF PIKEVILLE
KENTUCKY COLLEGE OF OSTEOPATHIC MEDICINE

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The University of Pikeville, Kentucky College of Osteopathic Medicine (KYCOM) is currently seeking qualified candidates for the position of Assistant/Associate Professor of Osteopathic Principles and Practices and Family Medicine. This full-time position is under the supervision of the Chair of the Department of Osteopathic Principles and Practices and the Chair of the Department of Family Medicine. This position is shared and has a faculty appointment in both the Departments of Osteopathic Principles and Practices and Family Medicine with direct responsibility for teaching, osteopathic clinical research and service in the Kentucky College of Osteopathic Medicine (KYCOM).

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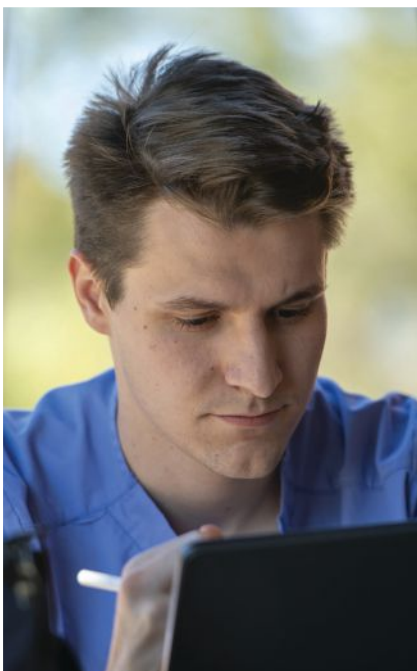

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EDITION 50

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BY ASHA SHARMA MD, FAAFP, *PRESIDENT*

message from Your PRESIDENT

Is Everyone OK Out There?

Nearly a year into a global pandemic we have gained a new perspective on the concept of "change." As usual, Family Medicine is at the forefront, and we have set the example of adaptation. In this article I would like to highlight some of those areas and lead into our Spring CME/KAFP meeting. In an effort to reach our members and to meet them "where they are," our spring meeting will be entirely offered in virtual format.

Diversifying how we practice Primary Care

We now offer "types" of appointments – in person, on a phone, on a video, in a respiratory center, and yes – even in the parking lot. As the world of Telehealth has evolved we have evolved along with it. We are literally meeting patients where they are – both physically and mentally. The concept of "team care" has lived up to its expectation. We have worked with our schedulers and our clinical staff to maximize triage skills in order to determine what appointment type will be most appropriate. They have risen to the occasion, working at the top of their skills set in order to take the best care of our patients. As primary care physicians we have gone back to basics; talking to our patients. As sometimes a hands on clinical exam is not possible in this new age, we've honed our communication skills. Some of the lost art of primary care is returning as we rely solely on history taking in order to develop our differential diagnoses. Our patients are depending on us to help them through struggles in mental health, disease burden, and their social determinants of health.

Moving forward and accepting rapid change can be quite difficult. The weight of the past year is starting to show in ourselves, our colleagues, and our patients. How do we navigate through such a difficult time with grace and hope? We ask for help. Behavioral Health is a topic pushed to the forefront over this past year, and we have to get creative in how we incorporate it into our daily practice. For some, there are behavioral health experts providing care in the primary care office setting already, and for others, learning efficient ways to incorporate it into an office visit is going to be key. Some may be comfortable providing mental health care beyond prescription management, and others need a place to start. The KAFP spring meeting is addressing this topic specifically. The goal for our Behavioral Health Specialists is to present innovative ways to provide care for your patients in this area. They will provide examples and be present for panel discussion to meet your needs.

Over the past year as the care model and telehealth have evolved, our patients now have essentially unlimited access to their physicians. This in turn has increased our administrative burden, managing in-person visits, video visits, e-messages, and telephone calls.

Easing administrative burden in Primary Care

Over the past year as the care model and telehealth have evolved, our patients now have essentially unlimited access to their physicians. This in turn has increased our

administrative burden, managing in-person visits, video visits, e-messages, and telephone calls. Our already chaotic days have become more difficult to manage. Our boundaries of work and home are now more blended than ever. Taking some time to determine what scheduling template works the best for your model of care can be very helpful. Trying different time slot templates to accommodate for e-visit/messages/phone calls may help your day go a bit more smoothly. In the long term, anything that can be done to personalize and protect your time in practice will keep you at your best. In addition to all of these changes, there has been a major update in E/M coding. Finding personalized balance is very important and gaining a comfort level with the new coding model will help decrease the charting burden. Using our time to the maximum advantage helps us end our day in the practice setting and keeps our home time protected. Our KAFP spring meeting will highlight the new E/M coding model and help you incorporate it into your daily practice. Making our work lives easier is always a plus.

Help KAFP Help You

In my last article I discussed recruiting fresh faces to the KAFP and increasing involvement with the KAFP committees. I continue to meet virtually with Kentucky Family Medicine Interest Groups to engage medical students as often as possible. I am hoping as the year progresses and we adjust to all of our day to day clinical practice, more KAFP members will reach out to get involved. I can understand how busy our lives have become and want members to know that any involvement is welcome – no matter how large or small. Member engagement is what keeps the KAFP forging to the forefront, and we need our members to keep us going. We have ample opportunities on each of our committees – advocacy, education/practice enhancement, membership/communication, and academy operations.

I look forward to hearing from you and I hope to see you all at our virtual KAFP Spring Meeting May 15th, 2021.

Please contact me at asha.sharma@thechristhospital.com to discuss any issues or ideas.

I also encourage our members to visit our website at www.kafp.org to stay up to date on news and upcoming events.

Respectfully,
Asha Sharma, MD, FAAFP

By A. Stevens Wrightson, MD

Letter From the Editor

Oral Health, COVID, and Health Disparities

This month in the Lexington Herald Leader paper, Dr. Stephanie Poynter, the Dental Director at Family Health Centers, Inc. in Louisville, KY, talked about the perennial issue of poor oral health in our state. As she points out, Kentuckians have always been plagued with high rates of oral disease, including childhood caries, periodontitis, and tooth loss. A child with tooth decay suffers not only pain, but poor nutrition, lower school performance, and ultimately fewer career options, particularly when compared to children who maintain optimal oral health. Dr. Poynter gives a shout out to the Kentucky Oral Health Coalition (KOHC), a diverse, multidisciplinary collaborative whose mission is "to improve the oral health of all people of Kentucky." The KOHC stresses education of parents, families, the public and policymakers, which forms the basis of their advocacy initiatives.

What disparities exist in oral health care delivery? The Center for Disease Control points out that social determinants of health, where people are born, live, learn, work and play, result in poorer outcomes for those in certain racial, ethnic and socioeconomic groups. These include higher rates of cavities in Mexican American and Black children compared to Whites age 2-5 years (33%, 28%, and 18% respectively) and a 3 times higher percentage of untreated cavities in children from low income households compared to children in higher income homes.[3] These disparities persist throughout the lifespan with higher rates of oral disease in those with low education, low income and in those from Black and Hispanic families. Periodontal disease, the leading cause of tooth loss, is rampant in those over 65, especially those that are poor or a minority racial or ethnic group.[3]

Why is this important now? During the last twelve months of the COVID-19 pandemic, racial and ethnic disparities are apparent in Black and Hispanic communities. Hospitalization rates were up to three times higher and death rates were 2 times higher when comparing Blacks and Hispanic patients to White patients.[,] Many preventive care services were put on hold during the pandemic, particularly dental care.[4,5] As is unfortunately expected, those that have the most difficulty with access to a dentist or oral health care provider have been the ones most impacted by this loss, particularly the young, the old, and those in rural locations.[6] Examples include the school-based clinics and mobile clinics that are perhaps just now beginning to reopen. Prior to COVID-19, these clinics provided much needed screening and preventive services to many children who would otherwise not get to the dentist. Improvements that have occurred over the past years may have been lost. We will likely see the ramifications, such as increased number of cavities or at-risk teeth, over the next few years. Other dental office closures have reduced access to minorities and the elderly, especially those in nursing homes devastated by the pandemic and the lockdowns. Oral health disparities exist and in times of crisis, they worsen.

Dr. Poynter outlines an approach to address these disparities, both during the time of COVID-19 and beyond.

- Promote oral health literacy campaigns that teach the basics to your patients, both children and adults.

- Integrate oral health care into Family Medicine and primary care. Family physicians see children before they are born and 6-10 times before their first birthday, when they should start to see the dentist. Who better to provide detailed oral health care guidance to expectant and new families?

- School based programs help with providing oral health access and should be supported.

- Promote telehealth services in medical and dental care. For those rurally situated, teledentistry holds great promise. Care of the elderly may likewise be enhanced with teledentistry visits and oral health assistants in rural clinics and nursing care facilities.

- Advocate for funding for dental services through Medicaid and Children's Health Insurance Programs (KCHIP) so that there can be closure of the gaps in child health coverage.[1]

As a critical social determinant of health, access to preventive and restorative dental care has far reaching implications. Getting children on the right path towards optimal oral health will have tremendous benefits in the future. Addressing the oral health needs of the poor and those with limited access, including minority patients and the elderly, results in improvement in other health care objectives, such as Diabetes control and stroke prevention.[7,8] For those that would like more information on oral health disparities and how you can address those in primary care, think about having your practice join the KOHC and going to one of their meetings. It is particularly important for health professionals who are not dentists to have a seat at the table and provide insight into the oral health needs of their patients.

Our family medicine practices need to integrate oral health into the comprehensive care we provide patients. This includes discussing oral health with our prenatal patients. Reducing oral disease in a pregnant patient before they deliver will decrease or at least delay the onset of oral disease to their baby. What an important message to share with your young family that wants to do the best they can for their child. All primary care practices that are seeing children should be applying fluoride varnish. It is easy, inexpensive, and recommended by the USPSTF. If you are not providing this service, please start. Those of us who care for patients in nursing homes should ensure that these patient's oral health needs are met, including daily hygiene routines and periodic dental checkups. Finally, diabetic patients will have improved glycemic control with good oral care. We should ensure dental care and referral is a routine part of our diabetes care plans. All these interventions, and the data that supports them, can be found in *Smiles for Life*, an oral health curriculum designed for anyone who delivers health care to patients.[9]

February was National Children's Dental Health month. This is the time to improve oral health care delivery for our patients, especially those who are most vulnerable. As I close, remember and share these healthy teeth tips for you and your patients:

- Parents should brush their children's teeth for two minutes, twice per day using fluoride toothpaste after waking up and before going to bed.

- Parents should floss children's teeth once per day, usually before bed, once the teeth start to touch. This habit should be maintained throughout life.

- Replace toothbrushes every three to four months. Always replace a toothbrush if the bristles have worn out or the owner has been sick.

- Eat healthy foods and avoid sugary drinks. Choose fluoridated tap water to help prevent cavities.[2]

And I might add, help your patients see their dentist regularly, and if that is not possible, talk to your patients about what they can do to keep their mouths healthy. Happy smiles!

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By Bob Babbage and Rebecca Hartsough

Letter From the Lobbyist

Limiting Executive Power

Public policy has taken a decidedly political turn all throughout the pandemic. At the crux of concerns in Kentucky, two issues stand out: conflicting health recommendations and diverging application of law.

With the CDC urging the return to school, the largest public system with 100,000 students — Louisville — has yet to go back to the classroom. Over 110 of 120 counties are at least partially back in classrooms.

Likewise, the inevitable inconsistency of outcomes from decisions has angered many. The most often cited example was places of worship. Churches had limited attendance while big box stores were open to the public.

Myriad other questions arose, such as who in the workforce is "essential" and critical in times like 2020. Simply put, it took time to make these determinations. Telehealth emerged as an answer, but in crucial moments, the regulations were lacking to move professions into tele-treatment.

Now the political urges have governors of two states embroiled in recall efforts, New York and California. The drive on the west coast to put California Governor Gavin Newsome back on the ballot for a new vote is gaining steam.

Like a number of states, Kentucky took a measured but decisive approach, placing limits on executive power. At the same time the legislature as well as the attorney general would have new duties in periods of crisis such as a pandemic.

Here's a look at the General Assembly's action, with some bills already subjected to vetoes by the governor, then veto overrides by the legislature. The next stop: starting the path through the courtrooms of the Capitol in Frankfort, heading to the state Supreme Court.

House Bill 1 allows any business, school, or church to remain open provided they have policies that meet the CDC guidelines or rules set by the governor, whichever are least restrictive. Bill sponsor Rep. Bart Rowland (R-Tompkinsville) collaborated with Senator Ralph Alvarado (R-Winchester) and newcomer Senator Adrienne Southworth (R-Lawrenceburg) on the measure. The legislation also reverses the executive order concerning parental visitation of biological parents and Kentucky foster children and permits visitations at long-term care facilities. In response to Governor Beshear's lawsuit, Franklin Circuit Judge Phillip Shepherd issued a 30-day restraining order for House Bill 1.

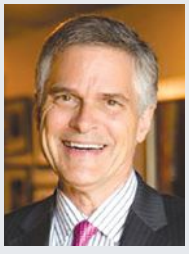
Senate Bill 1, championed by Senator Matt Castlen (R-Owensboro), limits executive orders issued by the governor to a 30-day duration unless the General Assembly extends the time. The language also prohibits the governor from issuing another executive order concerning the same matter unless the General Assembly approves. This bill becomes law in early March.

House Bill 2, sponsored by Rep. Joseph Fischer (R-Ft. Thomas), would transfer some powers dealing with abortion laws from the governor to the Kentucky Attorney General. House Bill 2 would give the attorney general the authority to regulate clinics and cite violations that might arise.

Senate Bill 2, sponsored by Sen. Steve West (R-Paris), would limit certain administrative regulations from lasting longer than 30 days. The legislation also gives the legislature more involvement in reviewing regulations, even changing them, or finding them "deficient". This bill becomes law in early March.

House Bill 5, which deals with reorganization of boards and commissions by the executive branch, passed the Senate on Saturday. Over a number of years, various governors have significantly changed major state boards to match their agendas. If House Bill 5 becomes law, this option would be limited. Rep. Michael Meredith (R-Oakland) stated the bill would better ensure the separation of powers among the branches of government by removing language in statute dealing with temporary reorganization powers and giving the legislature more oversight with these actions.

Standing out in all of this are the family physicians, health department administrators, hospital workforce and others dealing with the crisis day and night. As elected leaders examine the COVID crisis in the aftermath, doctors can lead the review of action taken and action needed.



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.

By Amanda Jeffries, DO

Lead Screening in Children

Oftentimes parents will go to great lengths to protect their children from the dangers that they can see. However, the risks that are unseen can be the most harmful. Exposure to lead can lead to lasting neurocognitive deficits and health effects and, without routine screening, can go undetected in high-risk populations until these irreversible deficits have shown themselves. According to the CDC, lead poisoning is the leading preventable environmental disease.[1] The primary source of exposure is ingestion, which is most common from 6-24 months during normal hand-to-mouth behaviors.[2] The highest rate of absorption occurs through the GI tract in infants and children, so lead in dust or water sources contributes sizably to increased blood lead levels.[3] Other sources of lead ingestion include food, soil, inhalation, and lead paint in homes or on toys.[1,2] Even at low levels, lead can affect children's IQ and academic achievement, causing behavioral and learning problems, hyperactivity, hearing problems, and impaired growth.[4]

Screening Guidelines

The Lead Verbal Risk Assessment is a tool to help identify at-risk patients that can be easily utilized during well child visits when appropriate. According to the American Academy of Pediatrics (AAP), this verbal risk assessment should be performed at 6, 9, 12, 18, and 24 months as well as 3, 4, 5, and 6 years of age.[5]

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Questions on the Lead Verbal Risk Assessment (as listed by the Kentucky Cabinet for Health and Family Services) are as follows:

- Do you live in or visit a building built before 1978, with peeling/chipping paint or with ongoing renovation (dust)?
- Do you have someone close to you (at work/home/church/school) that has or has had lead poisoning or an elevated blood lead level?
- Do you or someone who visits or lives with you work in an occupation or participate in a hobby that may contain lead?
- Does the patient use folk remedies, cosmetics or use old painted pottery to store food?
- Does the patient live near a busy road/ highway?

For more detailed information regarding occupations or folk remedies that have increased risk of lead exposure please see the full copy of the Lead Verbal Risk Assessment as published by the Kentucky Cabinet for Health and Family Services.[6] Identification of at-risk patients should occur through screening with the Lead Verbal Risk Assessment at the recommended routine child health maintenance visits.

Additionally, according to the Kentucky Cabinet for Health and Family Services, at-risk populations include children under the age of six, Medicaid eligible children, and those living in targeted zip codes.[7] Targeted zip codes take into consideration areas with pre-1950 housing and areas with increased percentage of the population living at or below the poverty line. A list of targeted zip codes separated by county can be found through the Kentucky Cabinet for Health and Family Services at https://chfs.ky.gov/agencies/dph/dmch/cfhib/CLPPP/TargetedZipCodes32014.pdf.[7]

If the risk assessment is positive, then a blood lead level test would be warranted. If an initial capillary sample is elevated, a confirmatory venous sample should be obtained.[4] This targeted lead screening strategy is a change from the previous, older recommendation of universal blood lead level screening, but one which still allows us to provide excellent, individualized care. Although universal screening is no longer recommended by bodies such as the AAP or CDC, Kentucky Medicaid still requires blood lead level testing to be performed routinely at 12 and 24 months.[5,8]

Management of Elevated Blood Lead Levels

As of 2012, blood lead level greater than 5 micrograms per deciliter is considered elevated enough to elicit action. Prior to 2012, blood lead level was not considered actionable until 10 micrograms per deciliter. This lower value gives us the opportunity to work with parents or caregivers to identify mechanisms of exposure and take action.[1,4] All blood lead levels greater than or equal to 2.3 micrograms per deciliter should be reported to the Kentucky Cabinet for Health and Family Services through the CLPPP lab data reporting system within 7 days.[8] According to the American Academy of Family Physicians (AAFP), education and counseling should be offered if, through the screening process, a child is found to have lead level up to 20 micrograms per deciliter.[4] There should also be a home visit and visual investigation, and, per Kentucky Cabinet for Health and Family Services, if the blood lead level is greater than 15, there should also be a referral for comprehensive lead risk inspection.[8] The current recommendation for blood lead level greater than or equal to 45 micrograms per deciliter, or if symptomatic, is chelation therapy with dimercaprol or penicillamine (though this is less commonly used).[4] Early symptoms of lead poisoning include headache, weakness, irritability, malaise, stomach cramps, sleeplessness, loss of appetite, vomiting, and weight loss.[8]

Counseling and Education for Parents

Counseling should be aimed at explaining the risks of lead poisoning and providing education with actionable steps that the

parent can easily understand and follow. If a family lives in a home that was built prior to 1978 (though the greatest risk is prior to 1950), there are measures they can take to reduce lead exposure. A relatively easy change to make is to housecleaning techniques. Damp dusting, wet mopping, and vacuuming daily with a HEPA filtered vacuum can reduce lead dust; additionally, leaving shoes outside of the home can reduce lead dust from being tracked in.[9] Placing tape, plastic, or cardboard over chipping paint can reduce the chance that the lead paint makes its way into a child's mouth.[8] Frequent hand washing with soap and water, particularly prior to eating and sleeping can reduce lead dust exposure as well.[9] Reminding parents of other common sources of lead exposure can also be helpful as they attempt to eliminate risk. These include, according to the CDC, imported toys, imported candy and wrappers, pottery and ceramics, lead leaching into the water supply from lead pipes or solder, as well as azarcon or greta which are used in the Hispanic community as traditional home health remedies for indigestion.[1] Additionally, there are dietary changes that can prevent absorption of lead, namely increasing vitamin C, iron, and calcium in the diet.[8] A low-fat diet leads to faster elimination of lead, and less lead is absorbed on a full stomach than an empty one,[8] so offering children smaller, low-fat meals more frequently throughout the day can decrease total absorption.

Conclusion

As primary care providers, we have a unique opportunity to provide education to our patients regarding minimization of lead exposure, particularly for those living in higher risk zip codes designated by the Kentucky Cabinet for Health and Family Services. While primary prevention through counseling is best, secondary prevention through screening high risk populations is extremely important. Staying up to date on lead screening guidelines and incorporating them into practice is invaluable for the long-term health and development of our smallest patrons.

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Amanda Jeffries, DO, Amanda Jeffries, DO, grew up in Bardstown, KY. She graduated from Transylvania University with an undergraduate degree in psychology, then completed her medical school education at University of Pikeville KY College of Osteopathic Medicine. She is currently a first year family medicine resident at St. Elizabeth Healthcare. Dr. Jeffries enjoys spending time with her son, Rhett, her husband, Derek, and their dog, Penelope.

BY JOHN A. PATTERSON MD, MSPH, FAAFP

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Mindful Practice® - University of Rochester School of Medicine and Dentistry

The *Mindful Practice*® program at the University of Rochester School of Medicine and Dentistry is the premier international training program for mindfulness-based approaches to physician well-being and clinical practice.

Mindful medical practice is described as 1) the capacity for lowering one's own reactivity (paying attention to experiences without reacting to them), 2) the ability to notice and observe sensations, thoughts and feelings even though they may be unpleasant, 3) acting with awareness and intention (not being on auto-pilot, knee jerk reactivity) and 4) focusing on experience, not the labels or judgments we apply to them (feeling an emotion rather than wondering if it is OK to feel that emotion).

The Mindful Practice® program develops qualities of exemplary clinicians in medical students, residents and practicing physicians. These qualities include- ***Attentive observation*** - Observing without making judgments that distort or diminish one's understanding. This involves monitoring one's own biases, thoughts and emotions. ***Critical curiosity*** - By opening up to possibilities in each moment and with each patient, rather than premature closure and discarding disconfirming data, we avoid jumping to conclusions and making snap judgments. ***Informed flexibility ("Beginner's mind")*** - Addressing the mind's tendency to take only one perspective on a problem. By allowing a continually fresh perspective and taking more than one perspective simultaneously, more diagnostic and therapeutic options open up. ***Presence*** - Involves "being there" physically, mentally and emotionally for patients, and accurately communicating an understanding of the patient's concerns and feelings back to them (empathy and mindful communication). Narratives are shared about success at intentionally, mindfully "being there" in a noisy, fast paced, stressful clinical

environment. Those speaking and listening in such narratives can experience increased confidence, self-efficacy, control and choice as internal antidotes to the stress of medical education and medical practice.

These skills can *enhance the quality of life and decrease perceived stress* in medical students, residents and practicing physicians. They can increase diagnostic accuracy and reduce medical errors while increasing the quality of care and the quality of caring. *Mindful medical practice* helps physicians increase self-awareness, resilience and well-being, while improving relationships with patients and colleagues.

University of Rochester Mindful Practice® programs include interactive presentations, workshops, and seminars for physicians, physicians-in-training and medical educators. They are built on a strong bio-psychosocial foundation and utilize narrative medicine, appreciative inquiry and mindfulness meditation to develop a capacity for personal and professional *mindfulness.*

Mindfulness is a naturally occurring human capacity, not just restricted to meditation or other "mindfulness-based" interventions such as mindfulness-based stress reduction (MBSR) or mindfulness-based cognitive therapy (MBCT). *Mindfulness can be cultivated through various means including meditative exercises, physical activity, narrative, dialogue, poetry, and music*. Learners are encouraged to find their own methods for cultivating mindfulness in their daily lives.

Ron Epstein MD is co-director of Mindful Practice®. His 1999 JAMA article, titled "Mindful Practice," is a seminal publication in the field of mindfulness and self-awareness in medicine. He is also the author of *Attending (Medicine, Mindfulness and Humanity)* (2017), a book written for doctors, patients and their families. It highlights the importance of mindfulness in the caring and healing provided by exemplary physicians. Co-director Mick Krasner MD demonstrated enhanced empathy and diminished burnout in primary care physicians participating in a Mindfulness Based Stress Reduction (MBSR) intervention. Epstein and Krasner co-created a series of programs in Mindful Practice® at the University of Rochester School of Medicine and Dentistry to address the educational needs of medical students, residents, medical center faculty, and community-based physicians. They then began to offer similar programs nationally and internationally. Intensive residential workshops are offered twice yearly. These retreat-like immersions promote compassion and healing for oneself and for others. The personal and professional impact is potentially life-changing and lifesaving for physicians, as well as those they love and those they serve.

Mindfulness can be cultivated through various means including meditative exercises, physical activity, narrative, dialogue, poetry, and music. Learners are encouraged to find their own methods for cultivating mindfulness in their daily lives.

References:

1. Mindful Practice®, University of Rochester School of Medicine and Dentistry https://www.urmc.rochester.edu/family-medicine/mindful-practice.aspx.
2. Epstein, RM. *Mindful Practice*. JAMA. 1999;282(9):833-839
3. *Attending (Medicine, Mindfulness and Humanity)*, Simon and Schuster (2017.)
4. Krasner, MS, et al. *Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians*. JAMA. 2009;302(12):1284-1293.

John A. Patterson MD, MSPH, FAAFP, chairs the Lexington Medical Society's Physician Wellness Commission, is past president of the Kentucky Academy of Family Physicians, is board certified in family medicine and integrative holistic medicine and is a certified Physician Coach. He teaches mindfulness for the UK Health and Wellness Program, Saybrook College of Integrative Medicine and Health Sciences (Pasadena) and the Center for Mind Body Medicine (Washington, DC). He owns Mind Body Studio in Lexington, where he offers integrative mind-body medicine consultations and classes, specializing in stress-related chronic conditions and burnout prevention for health professionals.

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8AM-9AM
EVIDENCE FOR THE USE OF MEDICALLY ASSISTED TREATMENT: A LOOK AT PRESCRIBING BUPRENOPHINE/NALOXONE
Presented by Rick Miles, MD, FAAFP

9AM-10AM
A SHOT IN THE ARM: UPDATE ON VACCINES AND VACCINE HESITANCY
Presented by Patty Swiney, MD, FAAFP

10:15AM-11:15AM
BEHAVIORAL MEDICINE TOPICS COMMON IN PRIMARY CARE
Presented by RaeAnn Calhoun, MSW & Dani Ortega, MSW
SUBSTANCE USE SERVICES: A SNAPSHOT OF TELEHEALTH TREATMENT
Presented by Lisa Hernandez, LCSW, TCADC

11:15AM-12:15PM
CODING AND BILLING CHANGES IN 2021
Presented by Monica Sullivan, MD, FAAFP

12:30PM-2:00PM
KAFP BOARD OF DIRECTORS & COMMITTEE CHAIR ZOOM MEETING

BY MELISSA L. ZOOK, MD, FAAFP, FASAM, HIV-S

My Tattoo and My Patients

The only tattoos I saw growing up were on the weathered biceps of my Uncles and other old men. Faded and green with bleeding edges and blurry artwork, the tattoos were badges of honor, relics from their services days in World War II or Korea.

It didn't occur to me to want a tattoo myself until I was in my thirties and had worked diligently with a therapist for several years to come to terms with my past and define a deliberate way forward for myself. Once the idea took hold, I stewed and pondered every aspect of the tattoo for years before committing to it. I fretted over the lettering style, the size of the art and the tattoo's exact wording. I agonized over the fallout from such an uncharacteristic and irreversible move. Would I regret it in twenty years? Was it unprofessional? What would my employer do? What would my father say?

I feared Hepatitis C, a common sequelae of the non-professional tattoos I see daily in my practice. But what was the risk of HCV from a professional artist? Negligible, I thought, but I scoured Pubmed and scanned the literature until both my OCD and paranoia were satisfied that it was safe to see a professional, licensed artist.

Next, I considered the tattoo's location on my body. I wanted to be able to both see and read it, for it would be a reminder, an admonition really, to stay true to myself. I'd also seen enough tattoos on geriatric skin in my practice to know that skin elasticity is fleeting and tattoo droop is forever. I started an informal observational study of my elderly aunts at family events. I surreptitiously checked out their forearms and wrists while chatting with them at parties. I discovered that while forearm skin wrinkled and drooped with age and correlated with both leatheriness and plumpness, none of my aunts had saggy wrists.

Thus, I finally felt confident deciding on my right wrist as the tattoo's location. I further logically concluded that since I am left-handed, I could cover it with a watch or bracelet without interfering with my handwriting or typing but would easily be able to see and read it when needed. And, while the validity of my own observational research was questionable, I felt reasonably sure that both my genetics and diligent sunscreen use would not fail me and my own wrist skin would not droop or sag long after menopause.

My last step was a trial run, a temporary henna tattoo I obtained at a mall in Ohio. The decision nearly derailed the permanent tattoo for several reasons. First, the smell of the henna nauseated me, setting up a noxious stimulus response in my hippocampus at the sight of it. Second, henna is meant for graphic art, elaborate swirling and dotted patterns, not lettering, and it didn't achieve the smooth and compact look of the design that I was hoping for. Since henna is squeezed like icing from a parchment paper cone, the lettering was wiggly, far too large, and worst, crooked. I looked like I had drunkenly scrawled a SOS message in brown Sharpie on my right arm. The whole thing was a disaster and took weeks to fade away completely.

Tired of my endless debate, and the research that my wife saw for the delay tactics they were, she kidnapped me one afternoon and took me to the shop I'd painstakingly vetted. She knew I would never follow through on actually getting the tattoo if she didn't take me to the threshold of the studio herself. She was right, of course, though I've never admitted it to her. I entered the studio wishing I'd had a couple of tumblers of Woodford Reserve with lunch. When the artist placed the tattoo template on my wrist in the orientation I requested, he asked me if I realized the words would be upside down. People would have trouble reading it, he said. I looked at him, confused. It hadn't occurred to me that others would need to be able to read it. I was certain of my intent. "Yep. That's how I want it. It's a reminder to myself, I'm the only one who needs to be able to read it." He didn't argue with me.

In case you didn't know or couldn't imagine, the experience of rapidly oscillating needles stabbing thousands of tiny ink droplets into the volar dermis of the wrist is, in fact, exquisitely painful. Laying still on the table, and afraid the slightest jerk would lead to a permanent misspelling, I quickly found the slow, mindful breathing and pinpoint focus that failed to come to me during the labor and delivery of my son. The artist was humane, stopping frequently and distracting me by engaging conversation. I left the shop without having passed out, chickened out or flinched. I had a properly oriented and, more importantly, correctly spelled, tattoo. I was delighted by my bravery, thrilled with the result and realized halfway home that the artist gave me back my credit card without a receipt.

The ink, it turned out, was a gift from him to me.

I've had the tattoo seven years now and I've not regretted it. None of my fears were realized. I hide it when I want to, but rarely do I do so. I know I'm still negative for Hepatitis C and HIV because my OCD has checked my antibody levels to both repeatedly over the years. My employer didn't fire me or force me to cover it with a band aid or sleeve. My father has never mentioned it. Ever. He simply pretends it does not exist. It has not tanked my professional career, I am still invited to teach, lecture and write.

But what surprises me the most are the ongoing patient reactions. The tattoo has been a touchstone connecting my patients and me. They ask me what it says, and I tell them, 'Speak Your Truth.' I hold my wrist up so they can see it and

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Family Medicine

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read it properly. Then as often as not, I talk about speaking *their* truth to an abusive partner, a dying mother, or a father in prison. We talk about standing up for who they are so they can be heard, be counted and be free. We talk about speaking their truth to a bullying ex, or setting a firm boundary with an abuser or saying for the first time in their life what it is that they want and what they need. We talk about using "I" statements like, "I need," "I want," and "I feel." And then we role play, and we practice until they, in own their own words and in their own voice, believe that what they are saying, is, in fact, their truth. It is a powerful experience to be in a room with a person hearing their own voice for the first time.

It is no less affirming when they return and tell you that they put those words into action. My patients have gushed about how it was both freeing and empowering to stand up and that it got them what they wanted or needed and so they did it again, and again, and again. And now, the person sitting in front of me is glowing and transformed because they understand the difference between before and after and they never ever want to go back to before again.

Mary was in her sixties with uncontrolled diabetes and a slew of children, grandchildren and friends to whom she could not say no. She was so busy with her commitments to others that she neglected her own health. The idea of saying no was as distressing to her as any of the deadly sins. We practiced declining a variety of requests. Not, "I can't" or "Could it be tomorrow" or even "No, but...." We practiced no as a complete sentence without explanation or justification. At first, you'd have thought I'd asked her to moon a crowded church, she was so distraught at the idea of saying no, much less without an explanation, but we persisted and she practiced and got more comfortable with the concept. Then, she went home and she tried it. The first time she said no was to a woman from church who wanted her to bake a cake for her son's wedding. "I near fell out, I was so full of nerves," she said when I saw her in follow up. "But I just said, 'I'm sorry, I just can't.' I near gave in, I was so jangly, but she just said, 'I understand,' and that was that. I had to stop myself from calling her back and changing my mind I felt so dang much guilt." Mary wasn't always successful at saying no, particularly to her children's and grandchildren's manipulations, but she was able to speak her truth without malice or contempt and slowly did improve her own diabetes quite a bit. I don't know that she was any less busy, but I do think that the reduction in stress from over-commitment contributed greatly to her lower A1c.

The ink on my arm gives me permission to ask about the tattoos on my patients, to ask about their own story and journey. I've learned about patient's regrets, their losses and their own spirituality and their suffering. I've learned how tattoos cover up scars and how they can heal. I've seen beautiful work cover up bad art or a regrettable decision to permanently etch a temporary boyfriend's name into their skin. Tattoos are proof that our idols and ideals change with time and while we mature and grow, tattoos are often a permanent reminder of temporary insanity. My patient probably still won't want Justin Bieber's face on their bicep when they are seventy-five or a revolver and the word, "Die" between their shoulders when they're in a nursing home.

But a tiny sparrow over her clavicle reminds my patient of the hope she felt after recovering from a suicide attempt. Little wings represent the infant another lost to SIDS. A bloom covers a surgical scar left after a knife attack by an abusive ex-husband on a third. I know a father who reproduced, on his leg, a drawing done by his child who was killed by a drunk driver. A crucifix and Latin inscription on the chest wall reflects another's unwavering faith. These too are mementos of war, healed wounds of personal battles hard fought and won, reflections of who they are and what scars they carry with them, visible to all, forever.

Answering questions honestly about my tattoo is how I've learned how prison tats are made and what they signify. I've learned the myriad ways that tattooing is accomplished when the proper tools aren't available. I've also been surprised to learn just how many of my patients tattoo themselves. Given how painful it is and how unusual and difficult some of the places are on the body to reach without years of yoga practice, it's a pretty big number.

My tattoo gives me credibility with my patients and legitimizes my concerns that their non-professional tattooing can lead to Hepatitis B and C and that when I suggest they use licensed services, I'm not dissing the art, or judging them personally, but rather want them to do it as safely as possible.

The tattoo also personalizes, normalizes, and humanizes me to my patients. I'm not an 'other,' I'm someone who both appreciates tattooing and has something I want to say. The ink shortens the distance between my education and position and that of my patients without being intrusive. It's another tool in my box to connect with them.

Dr. Melissa Zook is a family physician at London Women's Care in London, Kentucky. She graduated from Penn State College of Medicine and completed family medicine residency through UNC at the Moses Cone Hospital in Greensboro, NC. She is a buprenorphine-waived physician for 275 patients. Her clinical interests include addiction, HIV, hepatitis, mental health and healthcare issues unique to rural populations.

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Helps maintain a healthy immune system, helps support normal growth and development and helps maintain healthy skin.

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Helps maintain a healthy immune system, helps regulate metabolism and helps protect healthy cells from damage.

Iodine
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Necessary for proper bone and brain development during pregnancy and infancy; linked to cognitive function in childhood.

Potassium*
10% Daily Value

Helps maintain a healthy blood pressure and supports heart health. Helps regulate body fluid balance and helps maintain normal muscle function.

*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 DON SWIKERT MD, FAAFP, FORMER KAFP PRESIDENT

Good News for Family Physicians

On January 1, 2021 the Centers for Medicare & Medicaid Services (CMS) implemented changes to evaluation and management (E/M) codes for office or other outpatient visits. These changes apply only to American Medical Association's (AMA's) Current Procedural Terminology (CPT) codes 99202 – 99205 and 99211 – 99215. The rationale for these changes is the result of CMS "Patient over Paperwork" initiative with a key goal of administrative simplification. CMS, the AMA, the American Academy of Family Physicians (AAFP) and other Specialty Societies worked on the development of these changes to reduce the everyday documentation burden placed on physicians.

Selection of the appropriate service level will be only based on:

- The level of medical decision making (MDM) as defined for each service; or
- The total physician time for each service on the day of the encounter.

For each, history and physical examination is still to be documented, but is no longer required for code selection, and the appropriateness is determined by the physician.

Clarity on definitions of criteria involved in determining level of service is very important.

- **Time:** is not just face-to-face time. Time includes preparation time and documentation time.
- **Problem Addressed or Managed:** when it is evaluated or treated at the encounter. Notation that another professional is managing the problem without documenting additional assessment or care coordination does not qualify.
- **Self-limited or minor problem:** is one that runs a definite and prescribed transient course not likely to permanently alter health status
- **Stable, chronic illness:** is a problem with an expected duration of at least one year and is defined by the specific treatment goal for an individual patient. If not at treatment goal, the problem is not considered stable.
- **Acute, uncomplicated illness or injury:** is a recent or new short-term problem with low risk of morbidity. Example might be cystitis, allergic rhinitis, and simple sprain.
- **Unique Tests:** are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single unique test. Credit cannot be claimed if a test is performed and billed in-house on date of service (eg, A1C, rapid strep test).
- **External Physician Note:** is a prior note by a physician or other qualified healthcare professional who is not in the same group practice or is classified as a different specialty or subspecialty.
- **Independent Historian:** is a family member, witness, or other individual who provides patient history when the patient can't provide a complete history or the provider thinks a confirmatory history is needed (such as teacher reports).
- **Social Determinants of Health:** are economic or social conditions that influence health. These codes should not be coded as primary diagnosis. Example codes are:
    - Z55.0 – Illiteracy and low-level literacy
    - Z59.0 – Homelessness
    - Z59.1 – Inadequate housing
    - Z59.4 – Lack of adequate food and safe drinking water
    - Z59.5 – Extreme poverty
    - Z60.2 – Problems related to living alone
    - Z62.21 – Child in welfare custody
    - Z63.31 – Absence of family member due to military deployment
    - Z63.72 – Alcoholism and drug addiction in family

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Kentucky Women's Cancer Screening Program

Helping Women Stay Healthy

*Do you have **uninsured** patients in need of **FREE** breast and/or cervical screening?*

Please refer program eligible patients to a participating local health department or a contracted provider to receive FREE Mammograms and Pap Tests.

Eligibility Requirements:

- Age 21 or older
- Has a household income at or below 250% of the federal poverty level
- Has no health insurance (no Medicare, no Medicaid, or no private health insurance)

All I Need to Know is Where I Need to Go! Call 1-844-249-0708!

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.

KCP Kentucky Cancer Program

CHFS KENTUCKY Cabinet *for* Health *and* Family Services

Kentucky Public Health

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The following table (Table 1) conveys the 2021 changes for Medical Decision-Making and time for the 2021 office visit guidelines.

Appropriate level of E/M services is based on: 1) Level of medical decision-making as defined for each service; **or** 2) Total time for E/M services performed. To quality for a particular level of medical decision-making, two of the three elements for that level of medical decision-making must be met or exceeded.

			Elements of Medical Decision Making (MDM)			wRVU
CODE	**TIME (MIN)**	**LEVEL OF MDM** Based on 2 of 3 elements of MDM	**NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED**	**AMOUNT AND / OR COMPLEXITY OF DATA TO BE REVIEWED OR ANALYZED**	**RISK OF COMPLICATIONS AND / OR MORBIDITY OR MORTALITY** Are based upon the usual thought process of the physician and do not require quantification	
99211	**NA**	**NA**	**NA**	**NA**	**NA**	**0.18**
99202 **99212**	**15-29** **10-19**	**Straight-forward**	**Minimal** ♦1 self-limited or minor problem	**Minimal or none**	**Minimal risk from additional diagnostic testing or treatment**	**0.93** **0.70**
99203 **99213**	**30-44** **20-29**	**Low**	**Low** ♦ 2 or more self-limited problems ♦ 1 stable chronic illness ♦ 1 acute, uncomplicated illness or injury	**Limited** *(must meet the requirements of at least 1 of 2 categories)* **Category 1: Tests & documents** ♦ **Any combination of 2 from following** ● Review prior external note(s) ● Review result(s) of each unique test ● Ordering of each unique test **or** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment**	**1.60** **1.30**
99204 **99214**	**45-59** **30-39**	**Moderate**	**Moderate** ♦ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment ♦ 2 or more stable chronic illnesses ♦ 1 undiagnosed new problem with uncertain prognosis ♦ 1 acute illness with systemic symptoms ♦ 1 acute complicated injury	**Moderate** *(must meet the requirements of at least 1 of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ♦ **Any combination of 3 from following** ● Review prior external note(s) ● Review result(s) of each unique test ● Ordering of each unique test ● Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** ● Independent interpretation of a test performed by another physician/other QHCP – not separately reported **Category 3: Discussion of management or test interpretation** ● Discussion of management or test interpretation with external physician / other QHCP – not separately reported	**Moderate risk morbidity from additional diagnostic testing or treatment** *Examples only:* ● Prescription drug management ● Decision regarding minor surgery with identified patient or procedure risk factors ● Decision regarding elective major surgery without identified patient or procedure risk factors ● Diagnosis or treatment significantly limited by social determinants of health	**2.60** **1.92**
99205 **99215**	**60-74** **40-54**	**High**	**High** ♦ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or ♦ 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(must meet the requirements of at least 2 of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ♦ Any combination of 3 from following ● Review prior external note(s) ● Review result(s) of each unique test ● Ordering of each unique test ● Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** ● Independent interpretation of a test performed by another physician/other QHCP – not separately reported **Category 3: Discussion of management or test interpretation** ● Discussion of management or test interpretation with external physician / other QHCP – not separately reported	**High risk morbidity from additional diagnostic testing or treatment** *Examples only:* ● Drug therapy requiring intensive monitoring for toxicity Monitoring may be by lab test, physiologic test, or imaging. Monitoring by history or exam does not apply. Ex. Electrolyte or renal monitoring when diuresis but not when chronically on a diuretic. Does not Apply: Monitoring glucose levels during insulin therapy. ● Decision regarding elective major surgery with identified patient or procedure risk factors ● Decision regarding emergency major surgery ● Decision regarding hospitalization ● Decision not to resuscitate or to de-escalate care because of poor prognosis	**3.50** **2.80**

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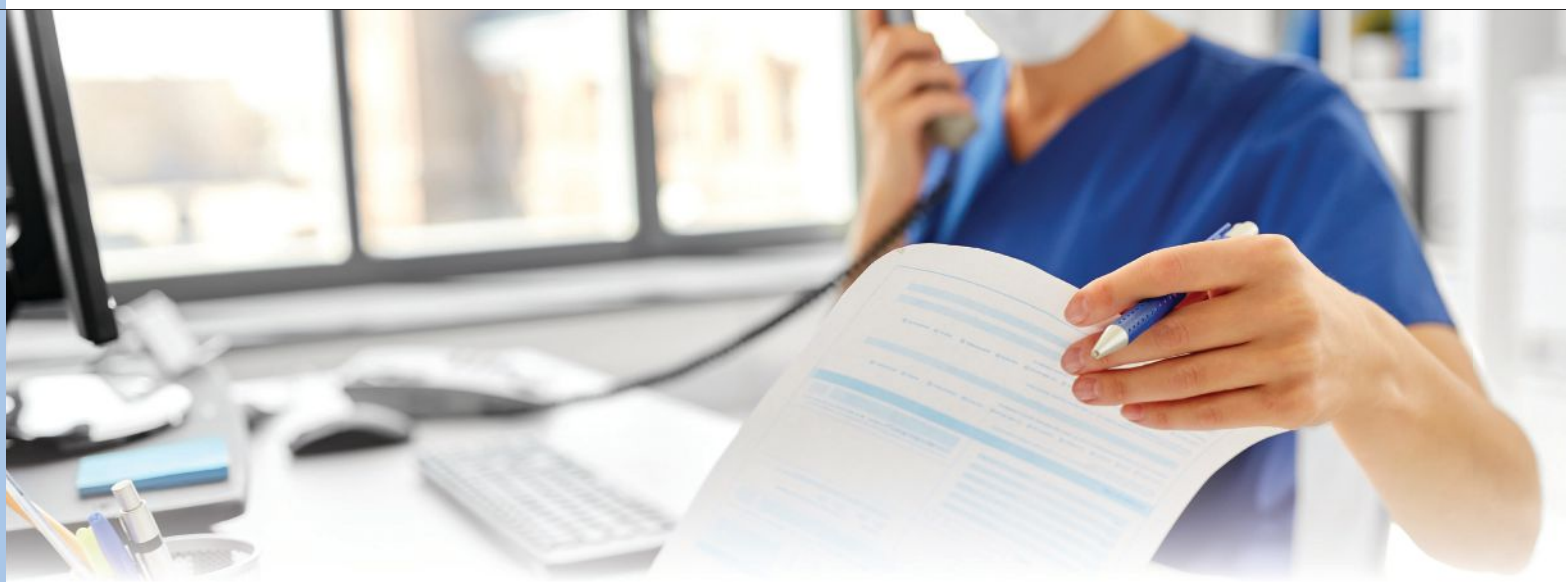

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The table below (Table 2) shows 2020 Medicare total payment and the 2021 Medicare total payment based on total RVU (not wRVU).

CPT Code	Descriptor	2021 total payment	2020 total payment	Difference $	% Difference
99202	Office/outpatient visit, new patient, Level 2	$69.04	$77.23	$(8.19)	-11%
99203	Office/outpatient visit, new patient, Level 3	$106.14	$109.35	$(3.21)	-3%
99204	Office/outpatient visit, new patient, Level 4	$159.36	$167.09	$(7.73)	-5%
99205	Office/outpatient visit, new patient, Level 5	$210.66	$211.12	$(0.46)	0%
99212	Office/outpatient visit, established patient, Level 2	$54.20	$46.19	$8.01	17%
99213	Office/outpatient visit, established patient, Level 3	$86.78	$76.15	$10.63	14%
99214	Office/outpatient visit, established patient, Level 4	$122.91	$110.43	$12.48	11%
99215	Office/outpatient visit, established patient, Level 5	$172.27	$148.33	$23.94	16%

2021 Conversion factor = 32.26 **2020 Conversion Factor = 36.09

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Don Swikert, MD, served as President of the Kentucky Academy of Family Physicians (1990-1991) and is currently a faculty member of St. Elizabeth Healthcare Family Residency Program after having served as its Program Director for 17 years. He has been involved in legislative advocacy and policy as Kentucky Medical Association Chair of the Legislative Quick Action Committee over the past 10 years and as Delegate of the American Medical Association for 24 years. He is married to Nancy Swikert, MD, also a former President of the Kentucky Academy of Family Physicians.

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BY ASHLEY ILES MD

Lessons in Learning

Before I decided to become a medical educator, I was painfully aware of my medical knowledge gaps. It was terrifying to consider being in charge of educating future medical professionals when there was so much that I did not know. But I took the plunge and accepted a position with the University of Louisville faculty on the vote of confidence of the Department of Family & Geriatric Medicine. Over the ensuing two years, to my surprise, the greatest hindrance to teaching was not actually my medical knowledge gaps. We are all life-long learners for a reason, after all. Rather, the greatest hindrance was my lack of knowledge about learning itself.

Learning is hard. That may seem like an obvious statement to some, but it was not a concept I had dwelt on in my years as a student. Even if it involved long hours of study, learning material for tests never felt terribly difficult for me. Which led me to the question that has haunted me since I started as an educator: was I actually "learning" in medical school or just passing tests? And the answer to that question holds very significant implications for how we should approach teaching our trainees.

Unfortunately, I have concluded that much of my time in medical school was spent on the latter: just passing tests. The vast amount of material I have forgotten since that time is evidence of such. We also know from research in psychology and education studies that learning requires mental work, and many of the study methods that medical students use to "learn" do not engage them in such effort.[1] For example, re-reading material has very little benefit for longer term retention, whereas active recall, such as flashcards and quizzes, are much more beneficial.[1] I wish I had known that as a medical student and focused more on learning for my career rather than the next grade. Now that I'm an educator, I want to teach my trainees what I did not know about how to learn.

There are many great books on these topics that I would highly recommend to any of you who, for your own learning or your trainees', want to know more. A few that I have found thoroughly informative include Small Teaching[1], How Learning Works[2], and How We Learn.[3]

In addition to not knowing how to learn, I had also never considered that there are hierarchical levels to knowledge mastery beyond memorization. I never paid attention to the difference between memorizing a piece of information versus applying a piece of knowledge to a particular patient care scenario. One model for thinking about this is a taxonomy created by Benjamin Bloom (aka, Bloom's Taxonomy) in the 1950s.[4] It has been modified some since his original work,[5]

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but the central concept is that learning does not end with the ability to recite information. Instead, there are additional levels of learning arranged hierarchically. Remembering and understanding are at the lowest levels, but as you "learn" material better you are able to use it for application, evaluation, analysis, etc. In medicine, we need our learners to move past simply remembering and encourage them in application. With this in mind, we can intentionally focus our lessons, bedside questions, and mentoring to prepare trainees for the actual practice of medicine where knowledge is useless unless appropriately applied.

The journey toward the higher levels of knowledge mastery is long and arduous. To this end, there is another pop psychology concept I wish I had learned about earlier in my journey: grit. Grit is a concept developed by Angel Duckworth who has a worth-the-read book of the same title.[6] She defines this quality of grit as "passion plus perseverance". Her research demonstrates that grit can be highly predictive of success in many ways, such as grittier students being more likely to graduate high school.[6] In many ways, our profession self-selects for students with both passion and perseverance. But as we move from trainee to professional, the work becomes more difficult, the tasks never-ending and the demands ever-increasing. We could all probably benefit from having some additional grit.

Now, knowing about grit is one thing, but how do we become grittier - or help our learners become grittier? Duckworth proposes that we should look to yet another psychology concept for one possible answer: growth mindset. This is a concept from psychologist Carol Dweck that has innumerable applications to our personal approach to medical practice, our professional approach to education, as well as the influence we can have on trainees who need perseverance.[7] Dweck describes two different states of mind in her work: a fixed mindset and a growth mindset. A fixed mindset represents a learner who believes that they are innately "good" or "bad" at something, such as math. This attitude is very limiting as a student who believes their potential in a subject is fixed, will likely not spend much more time trying to improve (or persevere). In the opposite way, a student with a growth mindset believes that being good at something is not an innate characteristic, but more a matter of time and effort.[7] Rather than being simply "not good" at math, a growth minded individual is "not good at math *yet*."

If you are unfamiliar with the concept of a growth mindset, I strongly encourage at least a short dive into Dweck's work. In the training of residents and medical students, it has become a cornerstone to my approach. They need encouragement to stop seeing every criticism or mistake as a "failure", which they relate to the bad grades they always had to avoid in years past. Instead, they need to understand that they are in an intense season of learning. They are not ready to be independent doctors, *yet*. And every mistake, attending's suggestion, or piece of knowledge relearned are necessary steps in the journey. Perseverance is not as difficult a task if the friction created by a fixed mindset can be relieved with strategically applied grease. We need to give ourselves permission to continue being learners, even as we strive for excellence.

Whether you are a medical educator, occasional preceptor, or spend all of your professional time in direct patient care, there is something here for all of us as life-long learners to learn about learning.

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