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AAFP State Tar Wars® Poster Contest Winner Places Second at National Conference

Congratulations to Anna Lusk, Scottsboro, Alabama, who placed second in the national poster competition July 16, 2012, in Washington, D.C.

The views and opinions expressed in Scope do not necessarily reflect the policy of the Alabama Academy of Family Physicians.
Attention Providers!

GET READY

NEW IMMUNIZATION REQUIREMENT FOR 6TH GRADE ENTRY

Beginning with the 2010-2011 school year, a dose of Tdap vaccine will be required for Alabama students age 11 years or older, entering 6th grade. This requirement will increase by one successive grade each year for the following 6 years to include sixth through twelfth grades, beginning fall of 2016.
A New Health Care Paradigm

Following the National Conference of Family Medicine Residents and Medical Students, I caught a cab to the airport rather than the usual shuttle because of a tight schedule. The cab driver was not from this county, and when he found out that I was in town representing Alabama and that I was a physician, he wanted to talk. He let me know that he was studying to be a pharmacist. He then asked me if Alabama was rural, and I said parts of it were very rural. He said his country was rural as well, and he asked me if folks in Alabama had trouble getting to adequate health care. I admitted that some did and that was what I was working on as part of my job.

“That is good,” he said. “I come from a rural area. In my country, there is not adequate health care because of corruption. My sister, she was pregnant and went to the dispensary. They said they could not help her, and she would have to go into the city. We put her in the bed of [he pointed to a pickup truck] one of those, and we drive her on the bumpy road for two hours. When we get to the city, she was dead. This is not an unusual story in my country. I come to America to study but cannot go back because, my countrymen, they do not care. So I will be a pharmacist in America.”

I had to admit that, although we had care delivery problems, death during transportation via flatbed for a routine pregnancy complication was not common anymore, even in the Alabama Black Belt.

We have come a long way in Alabama, but we still have a ways to go. While in Kansas City, I met Roger Kauffman. He graduated from the University of South Alabama Family Medicine Residency Program in 1980 (the first class). He said, “Not long before I was there as a resident, something like 60 percent of deliveries in Mobile County were done by lay midwives. Are there still a lot of those in Alabama?” I was proud to say that we have done a good job of moving antenatal care out of the hands of untrained laypeople and into the hands of those more professionally trained, at least for those women with good transportation. Infant mortality has fallen from 44 out of 1,000 births in 1945 to eight out of 1,000 in Alabama today.1 In the 1980s, when Dr Kauffman was in training, there were 27 counties that offered no obstetrical care. In 2012, there are 35.2 There are very few family physicians doing deliveries in Alabama (some say fewer than 30). We have regionalized our delivery services and consequently regionalized our prenatal care and preconception care as well. The infant mortality in the state has remained remarkably stable during the past 30 years, despite these changes. The regional variation has become greater. There are seven counties where infant mortality is almost double the national average and one where it is almost triple. In four of those counties, there are no obstetrical providers. All of these counties, however, have family physicians doing primary care. Not enough of them, but the backbone of care, the family docs, are out there.

As someone who does pregnancy care in a controlled training setting, I am aware of the reasons that family physicians choose to not participate in this service. The hours are erratic, the practice infrastructure to do it correctly is expensive, and a bad outcome can be devastating. However, as long as people continue to participate in preconception activities, babies will be made. We as family physicians may or may not choose to deliver, but we can all choose to assist patients with preconception care.3 These include attention to chronic conditions and optimizing control prior to conception; detection and treatment of infections known to cause damage to fetuses or poor birth outcomes; eliminating teratogenic medications; and achieving lifestyle improvements, such as abstinence from tobacco and optimizing weight control. It is estimated that, with very little effort and no additional obstetrical infrastructure, we could drop our infant mortality by 50 percent.

Why bring this up now? Aside from my First-World guilt following my cab ride, for us to get from 6.8 deaths per 1,000 live births to three deaths, we have to change the way we think. I want to point out that we in family medicine are about to be offered the opportunity to affect infant mortality in a very real way. The Patient Protection and Affordable Care Act offers Alabama the opportunity to ensure access to health care for almost all legal citizens in 2014 either through insurance that will be required to pay for preventive services or through expanded Medicaid, which will pay for preconception services. As each of you considers the world in which you practice now, think of how much better it might be if that child with the congenital illness could have been born disease-free. To provide services such as preconception counseling, we will need to deliver care differently. Too often, we are up to our necks in alligators. The goal of my presidential year is to make sure the Academy provides you access to the resources to drain the swamp. We are starting a Patient-Centered Medical Home task force to help the Academy to determine what you need to achieve that end.

Preconception care is just one example of how improved access will allow us to make a huge impact in people’s lives, if we choose to do so. Join me in taking advantage of the opportunity. Let’s make Alabama a better place.

References

The Scope of Family Medicine
Life Stages ’12 Meeting

This year’s meeting will be on the same format as the 2011 meeting. Day 1 (Saturday) will feature seven CME sessions, as listed below. Day 2 (Sunday) will offer a four-hour Self-Assessment Module (SAM) on depression. By the end of this session, you will have completed the 60-question Knowledge Assessment portion of this module. Twelve CME credits are awarded for successfully completing each Part II Module. Once you have completed the clinical simulation, the ABFM reports your credit to the AAFP’s Continuing Medical Education Records Department.

In an effort to “go green,” the AAFP will be uploading our syllabus to a protected website for our registered attendees. Each attendee will have the option of downloading to his or her computer/tablet or printing the syllabus and bringing a hard copy to the meeting.

**SATURDAY, DECEMBER 8**
7-8 a.m. .....................................................Continental Breakfast
8-9 a.m. .....................................................Office Management of the Infertile Couple – Michael P. Steinkamfp, MD
9-10 a.m. ...................... Health Care Law Update – Rich Sanders, JD
9 a.m.-12:30 p.m. .......................Starting Your Practice
10 a.m. .....................................................Eczema & Beyond: Common Problems in Primary Care – Elizabeth Jacobson, MD
11:30 a.m.-12:30 p.m. .............................................Managing Pain in the Elderly – Speaker TBA
12:30-1:30 p.m. .............................................Strolling Lunch
1:30-2:30 p.m. .......................Overuse Injuries – Speaker TBA
2:30-3:30 p.m. ...............Urinary Frequency: Urge or More – Tom Kincer, MD
3:30 p.m. .....................................................Break to View Exhibits
4-5 p.m. .....................................................Current Obesity Rx Options – English Gonzalez, MD
5 p.m. ............................................................................. Adjourn

**SUNDAY, DECEMBER 9**
7-8 a.m. .....................................................Continental Breakfast
8-10 a.m. .....................................................SAM session
10-10:30 a.m. ............................................. Break
10:30 a.m.-2:30 p.m. .......................SAM Session
12:30 p.m.(estimated) ..................SAM session concludes

Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

When calling the Embassy Suites for your hotel reservation (800-EMBASSY), mention that you want a room in the Alabama Academy of Family Physicians room block.

Deadline for making hotel reservations in our room block is November 1.

**Registration Fees**
Total conference registration (Days 1 and 2): $275
Day 1 only: $125
Day 2 only: $150

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**NO REFUNDS AFTER November 15, 2012**
State of Alabama Honored by CMS for Efforts to Improve Child Health

The state of Alabama is one of four states recently honored for its leadership efforts to improve children’s health care, including oral health care, by the Centers for Medicare and Medicaid Services. Alabama was recognized at the Second Annual CMS Medicaid-CHIP Quality Conference in Baltimore, where Medicaid Assistant Medical Director Melinda Rowe, MD, MBA, MPH; and Chris Sellers, ALL Kids director of data and evaluation, accepted the award on behalf of the state.

Along with Vermont, Washington and West Virginia, Alabama was cited for the collective efforts of Medicaid and ALL Kids to encourage children to access needed health care services and to track and report on quality measures related to children’s dental care. Criteria for the award included above-average performance in terms of EPS-DT-eligible children receiving preventive dental services, reporting on dental quality measures, and the accuracy and quality of a database used to link children to needed dental services. The initiative is part of the CMS Oral Health Initiative, which has as its goal to increase the proportion of children in Medicaid and CHIP who receive a preventive dental service by 10 percentage points by 2015.

“We greatly appreciate your dedication to serving and building capacity for measuring and reporting information toward improving health care for children in Medicaid and CHIP,” CMS Chief Quality Officer Marsha Lillie-Blanton said. “You are a valued partner in our three-part aim to improve care, improve health and, through improvement, lower health care costs.”

Alabama Medicaid Patient Care Network Marks First Anniversary

Alabama Medicaid’s first Patient Care Network celebrated its inaugural year August 1, commemorating a year in which Medicaid patients — especially those with high-cost or chronic conditions — benefitted from the coordinated care offered through the program.

Kim Eason, executive director of the Care Network of East Alabama in Opelika, attributes the program’s first-year successes to strong relationships built between primary care providers and case managers.

“Building relationships with our physicians and their staff have been the key to our success,” she said. “Having case managers embedded in and assigned to physician practices has been very beneficial.”

Eason explained that program officials originally were unsure how or if they would receive referrals from physicians and how physicians would want to communicate with the network. Their teamwork has paid off, however.

“The physicians in our network area have been very engaged and supportive of the network. We also have a great staff of RN case managers, social-worker case managers and community health workers. Our employees have chosen to work with the network, and I have such great respect for the work that they do,” she said.

Care Network of East Alabama now plans to expand its effort during its second year by strengthening its relationship between primary health providers and local mental health agencies and substance-abuse-cessation providers. A full-time pharmacist also has been hired to assist physicians and community pharmacists with medication issues for patients.

The east Alabama program is one of three pilot sites started during the past year that have experienced immediate success in reducing costs to the state while improving the quality of care. Together, the three network areas serve approximately 80,000 Medicaid recipients through the Patient 1st program. The other pilot programs, one in west Alabama and one in north Alabama, were recognized along with the Alabama Medicaid Agency in May for the use of innovative methods to help Alabama government agencies reach new levels of effectiveness and responsiveness.

A fourth pilot program, the Gulf Coast Patient Care Network, covering Mobile and Washington counties, was launched July 1, 2012.

For more information about Medicaid’s Care Networks, go to http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.1_Care_Networks.aspx.
AAFP Members in the News

William H. “Bill” Coleman, MD, PhD, of Scottsboro, Alabama, was named to the Alabama Healthcare Hall of Fame. After dedicating almost 40 years to improving health care in rural Alabama, Coleman was inducted during a ceremony on July 28, 2012. Coleman graduated from the University of Montevallo with a bachelor’s degree in biology with intentions to teach, but the more time he spent in school, the more he felt his true calling was in practicing medicine. After earning his master’s degree in anatomy from the University of Alabama Medical College, Coleman pursued a medical degree at the UAB School of Medicine and completed his family medicine residency at the University of Alabama at Huntsville School of Primary Care in 1977. In 1984, he served as president of the Alabama Academy of Family Physicians, and 10 years later, he was elected president of the American Academy of Family Physicians. He is also on the Alabama Rural Health Association Board of Directors and serves as the president of the Alabama Academy of Family Physicians Foundation. He currently serves as the director of the Office for Family Health, Education and Research at the UAB School of Medicine, Huntsville Regional Medical Campus.

Benjamin “Tate” Hinkle, a past president of the Alabama Academy of Family Physicians Student Chapter, was elected Student Section alternate delegate to the 2012 American Academy of Family Physicians Congress of Delegates to be held in Philadelphia, Pennsylvania, October 15-17. Tate was elected by his peers during the American Academy of Family Physicians National Conference of Residents and Students July 26-28 in Kansas City, Missouri.

$1,000 Stan Brasfield, MD, Scholarship for Alabama AFP Residents Is Available

All resident-members of the Alabama Academy of Family Physicians are eligible to apply for the annual Stan Brasfield Memorial Scholarship. The family of the late Dr. Brasfield created the scholarship fund to honor his memory; it is to be given annually to a first- or second-year resident who meets certain criteria.

Dr. Brasfield, a Montgomery native, earned his medical degree in Alabama. He died at the untimely age of 33 while practicing in Florida. The scholarship is in the amount of $1,000. The criteria are as follows:

• The award will go to a first- or second-year Alabama family medicine resident who has demonstrated financial needs, as expressed in a short (one page or less) essay submitted by the applicant.
• The recipient will preferably be married and have an Alabama connection of some kind. Please tell us of any such connection.
• The deadline for receipt of essays will be Monday, December 31, 2012; send your essay to the attention of Chapter EVP Mr. Jeffrey Arrington at: alafamdoc@charter.net.
The U.S. Preventive Services Task Force’s (USPSTF) recent recommendation against PSA-based screening for prostate cancer has sparked renewed controversy over the value of screening. Understandably, this has put many primary care physicians in a difficult position to know what to do in advising their patients.

As a member of a large urology group that extensively uses PSA testing in our everyday practice, I believe it is ill-advised to adopt a “one-size-fits-all” policy that recommends against screening for all patients. Here’s why:

Prostate cancer is the most common cancer in American men after skin cancer. It is the second-leading cause of cancer death among American men behind lung cancer. This year, it is expected that 241,740 new cases of prostate cancer will be diagnosed in the United States, and about 28,000 men will die from this disease.

In Alabama, prostate cancer is particularly lethal. The death rate from prostate cancer in Alabama is the third-highest in the nation, and for African-American men in this state, the death rate due to prostate cancer is the highest in the nation. We believe that the reason for these disturbing statistics is that many men in Alabama don’t have the opportunity for early detection and treatment.

Consider this:

Since the advent of widespread screening, the death rate from prostate cancer has declined more than 40 percent. In addition, the reduction in advanced disease has been truly remarkable: in 1991, before PSA testing was widely available, 20 percent of men were diagnosed with prostate cancer that had metastasized; today, that number is less than 4 percent.

A recent study published in Cancer (July 30, 2012) concluded that, if pre-PSA-era rates were present in the modern U.S. population, the total number of men presenting with metastatic prostate cancer would be approximately three times greater than the number actually observed.

So why the controversy?

In May 2012, the USPSTF recommended against PSA-based screening for prostate cancer. The Task Force said that the reduction in prostate cancer mortality is at most very small and that there is a moderate certainty that the benefits of PSA-based screening do not outweigh the harms.

The USPSTF’s recommendation was based on two studies that appeared in The New England Journal of Medicine in 2009: the U.S. PLCO (Prostate, Lung, Colorectal and Ovarian) Cancer Screening Trial and the ERSPC (European Randomized Study of Screening for Prostate Cancer).

The PLCO study showed no survival benefit from prostate cancer screening after seven years of follow-up, but for prostate cancer, that time period is too short to see any meaningful difference between treated and untreated groups. Also, 40 percent of the “unscreened” patients were screened prior to entering the study, and at 10 years, the data were only 67 percent complete.

The ERSPC study showed a 20 percent higher death rate in unscreened patients, and the median follow-up was nine years. The study concluded that prostate cancer screening decreased the death rate but resulted in significant overdiagnosis. Removing the data contamination in the ERSPC study showed that there was a 31 percent reduction in prostate cancer deaths.

More recent studies demonstrate a clear advantage to prostate cancer screening. For example, the Göteborg study showed that prostate cancer mortality was reduced almost by half as a result of PSA testing; this study involved 20,000 men during a 14-year period and was partially funded by the NIH. A 2012 update of the ERSPC study showed a 38 percent survival advantage in screened patients during years 10 and 11 of follow-up.

Other research points to a conclusion that, while many prostate cancers are cured, not all need to be cured. A recent article in The New England Journal of Medicine showed that for some patients with low-risk prostate cancer, the survival without treatments was equal to the survival with radical prostatectomy.

At present, being able to distinguish the aggressive cancers from the “insignificant” cancers is somewhat problematic. We clearly need better methods to determine the differ-
ence in the cancers that need to be treated and those that don’t.

We can certainly hasten that day by advocating more forcefully for increased funding for prostate cancer research. Recent data shows that breast cancer research is funded at a rate of more than twice that for prostate cancer.

Until a better screening test is developed, more can be done to make PSA screening more selective. For example, if a man’s PSA is less than 1 at age 40 — the American Urological Association’s recommended starting age for prostate cancer screening — then he probably doesn’t need to be screened on a yearly basis until he reaches age 50.

As with all things in medicine, our knowledge of prostate cancer and its detection is evolving. But should we abandon PSA-based screening just because it has some shortcomings?

I, along with other urologists I practice with, think not. We strongly believe that the PSA test, when properly interpreted, continues to be a useful test in the early detection of prostate cancer and that patients should have the right to decide whether to be screened after consultation with their physician.

Should you recommend prostate cancer screening for your patients? Look at the objective data, and you be the judge.

References
3. Id.
4. Id.
Dr. Allen Perkins received his undergraduate degree with honors from Louisiana State University, Baton Rouge, Louisiana, in biochemistry. He attended Tulane University, New Orleans, Louisiana, where he earned a master’s degree in public health and completed his medical school training. After joining the Navy, he completed his first year of residency at Portsmouth Naval Hospital and served as a diving medical officer in Kaneohe, Hawaii. He returned to the Gulf Coast to complete his family medicine residency at the University of South Alabama, where he has served on the faculty since 1993. Dr. Perkins became board-certified in family medicine in 1994. He also serves as the president of the Alabama Rural Health Association.

The Scope of Family Medicine had an opportunity to sit down with Dr. Perkins and get to know our new president a little better.

What was one of the reasons you chose family medicine as a specialty?
I was looking for a field that combined my interest in the delivery of preventive services with my desire to be a “real doctor.”

As a former residency director, what were some of the challenges you have faced training the youth of family medicine, and how is that different from your days as a resident?
I think that residents today have [more of an] investment in their own education ... understand that they are education consumers and demand that their activities be relevant. Also, there is much less of an effect of “because I was taught that way” and much more “that’s what the evidence shows.” Lastly, the trade-off of service for education has broken down somewhat, in that residents are less likely to put in hours of “scut” in exchange for a pearl — though, if the care needs to be done, most residents will still step up.

Where do you see family medicine in 10 years?
I see us delivering care as a part of a team, where we do what we do best (assist patients in handling their complex illness, treat acute illnesses effectively) and others do what they do best (including the patient) to make everyone healthier and happier.

What’s your favorite part of family medicine?
Both taking care of folks that I have taken care of for 20 years (although they have aged and I haven’t) and seeing folks that I taught doing well in their practice.

Is there a particular patient encounter from your early days that you still think about today?
In April of 1987, when I was an intern at Portsmouth Naval Hospital, I saw a 54-year-old male patient for fatigue and discovered a previous diagnosis of iron-deficiency anemia. He was again anemic. He was subsequently found to have Stage 4 colorectal cancer, for which he received treatment. About six months later I admitted him from the emergency department (where I was working after finishing internship while waiting for a school) with jaundice. The ward team provided aggressive care, but he died anyway.

This patient had been seen by one of my intern colleagues in July of 1986 (the first month of our internship), who found an iron-deficiency anemia. He was placed on iron, felt better, came back for follow-up and was discharged from care.

The lessons I took away from this patient were as follows:
1) Quality care should not be dependent on specialty or level of training. My colleague could have consulted with the attending physician who was sitting in an office on the unit (and may have). My colleague could have read about the workup of anemia. Instead, being young and inexperienced, he treated the symptom but did not look for the disease process. There were no processes in place to ensure that the patients received appropriate care at this clinic. I have worked to make sure that a patient seen in practices that I am associated with receive care that is predictable and of high quality regardless of who he or she sees.

2) Colon cancer is not a pleasant way to die. The diagnosis of this patient was made with a rigid sigmoidoscope (remember those?). The literature on colon cancer screening was just emerging. I have followed with interest the literature on early detection and cure of colon cancer through use of colonoscopy and home stool testing. I would like to believe that this patient, who was of an age that screening is now indicated, would have potentially been spared this death as the result of a caring family physician facilitating this screening. We are doing research now on the ability of primary care physicians to get such preventive services accomplished in their practices. We are not as good as we could be, and that includes our practice in Mobile.

3) We are all going to die. Having a terminal illness makes this much more likely. There comes a time to move to comfort measures. As family physicians need to be advocates for our patients in disease prevention and treatment. We also need to be advocates for moving from cure to comfort when it is appropriate. In my patient’s case, he relied on the naval hospital to be his “provider,” and we did not make that transition easy for him. As somebody’s family doctor, I always try to do better.

Dr. Perkins lives in Mobile, Alabama, with his wife, Danielle, and their two children, Henry and Lucy. Please join us in welcoming your 2012-2013 president, Allen Perkins, MD.
Past presidents of the Alabama AFP

American Academy of Family Physicians Chairman of the Board Roland Goertz, MD; Tonya Bradley; and Speaker of the American Academy of Family Physicians John Meigs Jr., MD

2012 Annual Meeting
Photo Recap
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Our College is dedicated to improving health care in this state by working with family physicians in the context of their community.

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