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KAFP JOURNAL

WINTER 2024
EDITION 61

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EDITION 61

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BY JONATHAN BECKER, MD, CAQSM, FAAFP, *PRESIDENT*

Message From **Your New President**

By the time this is read, you all will be returning to the office after what I hope was a relaxing and enjoyable holiday season. Admittedly, that statement feels a bit off as I write those words just after Election Day in November. While watching the returns, even in passing, it struck me once again that election results will impact the care that we are able to provide to our patients. I don't believe it is a partisan statement at all to imply that our elected representatives will have an impact on health care in some fashion – good, bad, neutral – somehow, someway government and medicine are inevitably intertwined.

For many of us, some sense of autonomy was one of the reasons we went into medicine; to have some control over our profession and to help to direct our patients in the way we feel best. The reality is obviously a very different one, and we all learn this very early in our career. Everyone has their hands in medicine whether it be government, insurance companies, health care organizations, and on and on. Clearly, this is not groundbreaking news, as we all share in these frustrations, and it creates a certain sense of helplessness.

As an individual, it is hard to feel like you could have an impact. So much feels out of your control as an individual physician. That is why it is so important you have an organization like the KAFP working on your behalf. Our Advocacy Committee is incredibly engaged and fighting for the Family Physicians in Kentucky. We employ a lobbying firm to assist in our efforts as well, but they can only do so much. It is crucial that the membership make their voice heard in any way they can.

Well, I am one person, what can I really do?

As a lone physician one often feels less than empowered to make change, but it is so important to remember that people want to hear from their doctors and do want your feedback in so many forums. No one wants to read another email, but please keep up with updates from the KAFP and AAFP. No one has time to complete tedious surveys (yes, they are a pain), but that is often the only way our organizations can gather data. It's hard to imagine anything feeling more fruitless than calling or emailing a legislator, but if they don't hear from physicians, they will certainly be hearing from other constituencies. This is the only way leaders will know the state of being a practicing physician and the impact that their choices will have on the way care is delivered.

Over the past month or so it has been my pleasure to meet with a few recent graduates in the Louisville area to tell them more about the KAFP and ways to get involved. It was clear that the Academy's efforts in the areas of advocacy, reducing health inequities, and commitment to diversity and inclusion all mesh well with the interests and concerns of the younger primary care physicians. I applaud Dr. Naseeruddin for establishing the important KAFP JEDI (Justice, Equity, Diversity, and Inclusion) Committee to address these important areas. What concerned me, however, is the lack of knowledge they had about the work the KAFP has been doing toward these goals. As an Academy, we need to do a better job of letting our members know of the work being done on their behalf.

Be on the lookout for requests to participate in meaningful ways. Doctors' Day at the Capitol should be soon approaching. This is an excellent opportunity to show support for our group. Sooner than later, we should have dates finalized for the 2024 KAFP Annual Meeting – yes, that planning is already underway. It would be fantastic to have participation beyond the 'usual' attendees, and even better to get many residents and recent graduates involved.

The end of the year is always a great time for reflection. Unfortunately for most, the key moment at year's end is worrying whether or not you hit your RVU target. I'd ask each of you to take some time to think about all the people you have truly *helped* during this past year. Help for our patients can come in so many ways whether it's finding a cheaper prescription, writing a letter so someone can keep the electricity on, or making that lifesaving catch and getting people the definitive care they need. Countless times, I have had residents look at me at the end of a clinic session and say that they really didn't help anyone today having done some well visits, maybe giving some reassurance, or going over lab results. They are long sick of me repeating the famous Hollywood line, "there are no small roles, just small actors." Providing reassurance, decreasing patients' angst and anxiety, and yes, filling out a form is indeed a service to our patients and allows them the peace of mind to get along with the rest of their lives. We all should be humbled and thankful for the gift we have been given to enter people's lives in the way only a Family Physician can. Last year, my predecessor, Dr. Monica Sullivan asked you all to "pause, rewind, and review your path" with the onset of the new year. I can't think of any way to put it more eloquently.

Lastly, a year end thanks to our KAFP staff, all of our leaders, delegates, committee members and board for their tireless work. This organization would not function without you.

Keep at it, Kentucky! Here is to a fantastic 2024.

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BY CHRIS ZOWTIAK, MD

Lung Cancer Screening in Kentucky

November was Lung Cancer Awareness Month. In honor of far too many Kentuckians who have lost their lives to lung cancer, let us borrow a few additional moments this winter to truly give lung cancer our heightened awareness. Lung cancer is the deadliest cancer in the United States, more so than the next three cancer killers combined (breast, colorectal, and prostate).[1] Sadly, Kentucky has long been the state with the highest incidence and highest lung cancer mortality rate in the nation.[2] Here in the Commonwealth, we statistically diagnose lung cancers at later stages and experience lower survival rates for multiple subtypes of lung cancers compared to overall lung cancer patients in the Surveillance, Epidemiology, and End Results (SEER) database.[3] Later diagnosis equals later stage cancer, which equals lower chance of 5-year survival, despite amazing advancements in therapies.[2] In Kentucky, we catch just under one quarter of all lung cancer cases at an early, localized stage, when the 5 year survival rate is approximately 63%. Unfortunately, we catch far more of our cases when they are metastatic, late stage, and associated with just an 8% 5-year survival rate.[3]

Kentucky's abysmal lung cancer incidence is attributable to multiple factors including persistently high rates of tobacco use (approximately 19.6%, higher than the national average, and 48th in the nation),[2] radon exposure, heavy metal exposure, and exposure to environmental contaminants related to coal mining.[3,4] There is also evolving research into potential genetic susceptibility specifically associated with rural Kentucky communities.[3] Unfortunately, many of the factors associated with increased risk of lung cancer also contribute to the stigma and shame associated with the diagnosis.

Fortunately, there is much more we can do to improve the state of lung cancer incidence and survival in Kentucky. Obviously, prevention remains our most important priority. Partnering with our patients to support their efforts at smoking cessation is crucial, and the deep relationships we form with our patients over years of caring for them are among our best tools to help see them through to quitting for the last time. Additionally, screening for and diagnosing lung cancer at earlier stages is of critical importance. Low dose computed tomography (LDCT) lung cancer screening is a vastly underutilized tool to this end. The analysis of the National Lung Screening Trial (NLST) and subsequent Medicare coverage for LDCT lung cancer screening demonstrated a significant positive impact on diagnosis of lung cancer at early stages.[5] The United States Preventative Services Task Force (USPSTF) now recommends "**annual screening for lung cancer with low dose CT for all adults aged 50-80 years old who have a 20 pack year smoking history and currently smoke or have quit within the past 15 years.**" Screening can be discontinued once the individual has abstained from smoking for ≥15 years or has received a life-limiting diagnosis or diagnosis that would preclude lung surgery.[6] Of note, this is a 2021 change from the prior recommendation to screen only adults 55-80 with at least a 30 pack year history of smoking within the prior 15 years. This expanded recommendation will help us capture more at-risk Kentuckians at earlier stages of disease.

Currently in Kentucky we are screening just 10.6% of the eligible, high-risk population for lung cancer. However, the surprising news about this awful statistic is that we are actually leading the nation in LDCT lung cancer screening. The national screening rate is only 4.5%, and we Kentuckians are second only to Massachusetts (come on, folks!) in national lung cancer screening rate. Still, we can do so much better (certainly better than Massachusetts!), especially considering our far larger population of at-risk patients. Kentucky is one of 24 states with full Medicaid coverage of LDCT lung cancer screening that follows the most updated guidelines without requirements for prior authorization or copays.[2] That is certainly something to be proud of and a great place to start building our efforts to save more Kentucky lives.

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Chris Zowtiak, MD is a board certified Family Physician who cares for patients in Northern KY and serves as Assistant Director of the St. Elizabeth Residency in Family Medicine. She obtained her undergraduate degree in psychology from Dartmouth College and her medical degree from Georgetown University. She completed her residency training at OHSU Cascades East Family Medicine Residency in Klamath Falls, OR, where she practiced for 3 years. She returned to NKY in 2014 with her husband to practice, teach, and raise their five little boys near family.

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KCP Kentucky Cancer Program

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

Kentucky Public Health

By Bob Babbage, MA, and Rebecca Hartsough, PhD

Letter From the Lobbyist

Governor Beshear Staying in Governor's Mansion

Incumbents are difficult to beat and incumbent governor **Andy Beshear** proved no exception, besting Attorney General **Daniel Cameron** 52.5% – 47.5%.

In an election that saw just 38% turnout, down from 2019's 44%, the electorate majority stuck with Beshear, a Democrat, while electing 5 Republicans to other statewide offices – proof that split ticket voting is alive and well in Kentucky.

Notable in increasing Beshear's reelection margin was the bump from 23 counties voting in his favor in 2019 to 28 in 2023. Ranging from Daviess in the west to Perry and Letcher in the east, the governor was able to dig into razor-thin margins in red counties and build up additional support in metro areas that got him elected the first time around.

While questions remain as to the impact of social issues and the endorsement of former president Trump on the race, it's clear that Beshear succeeded in some part due to his sticking to the fundamentals and focusing on the office rather than competing against his opponent. He now is looking to move Kentucky forward past an inaugural term beset by the pandemic and a series of tragic natural disasters across the state.

Cameron, gracious in defeat, called on his supporters to pray for the Governor and to help in their own way to make Kentucky better for the generations to come. Odds are this will not be the last time voters see his name on a ballot.

2024 Legislative Session – Health Policy to Anticipate

The 2024 Legislative Session begins on Tuesday, January 2. All 138 House and Senate members will convene in Frankfort for a 60-day session that must conclude by April 15. An even calendar year means that the two-year budget will be determined, and House and Senate leadership are well underway in discussions about how to spend the annual $14 billion in General Funds.

Healthcare and health policy are always top areas of spending and concern. Our team spent time with Health Committee Chairs Rep. Kimberly Moser (R-Taylor Mill) and Sen. Steve Meredith (R-Leitchfield) at the Kentucky Chamber Legislative Preview. Moser and Meredith outlined issues they plan to focus on in the upcoming session.

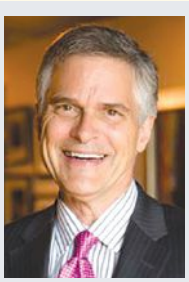
Healthcare worker shortages continue to be a top priority, with both chairs looking at legislation to attract more workers to Kentucky. Bills to increase GME slots, provide loan forgiveness, reduce workplace violence, and provide psychiatric fellowships are all on deck for January.

Burnout is a chief concern. Making sure we support our doctors, especially those working in underserved areas is critical for these leaders.

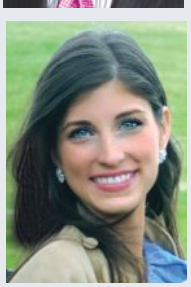
Medicaid reimbursement rates are a recurring theme. Many rates have not been increased since the late 80s and early 90s. The need to increase dental rates and behavioral health rates have been discussed in committee at length.

Meredith plans to tackle pharmacy benefit manager reform. Moser is working on a "momnibus" bill to address gestational diabetes and mental health issues for new parents through postpartum. Rep. Moser is also working on prior authorization policy; she hopes to pass a "gold card" bill.

As always, we will work with KAFP to delineate your priorities for this session and determine issues where you can lend support. Your perspective, your experiences, and expertise are valued and trusted in the legislature.



Bob Babbage, MA 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. Mr. 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, PhD brings an extensive research background to Babbage Cofounder. Dr. Hartsough 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.

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BY EMMA C. DOYLE, BLAKE S. EDMONSON, AND WILLIAM J. CRUMP, MD

Novel Practice Arrangements for the Next Generation of Primary Care Physicians

Prologue

Kids these days… As I prepared my talk to the primary care interest groups at the ULSOM on the future of primary care, I couldn't help but decry some of the negative changes that I've seen over my forty-plus years of practice. Over 100 mostly M-1s and M-2s attended and stayed awake, so I guess they could understand how reminiscing might be pertinent. I told them as I began practice, I admitted my own patients to the hospital and made daily rounds on them. With low overhead and my receptionist doing all the billing, my nurse and I could easily get through the 15-18 scheduled patients as well as 2-3 call-ins each day and still get to our kids' events every evening. As I walked down the hall from room to room, I could dictate a very brief note into my portable "Dictaphone," and first thing the next morning I could sign the printed dictation in just a few minutes. The notes were for doctors to facilitate good care.

It wasn't actually the EMR that changed everything. It was Medicare's escalating demands for what had to be included in the note in order to pay me less every year for the visit. Other insurers followed suit. Billing became a sub-specialty and staff overhead rose, so that most primary care docs were up to 26-28 patients a day to make ends meet. The result was 8 minutes spent with each patient, which was no way to practice medicine. Then the EMR added "transcriptionist" to my job description which was the death knell for the true generalist. There was not enough time to make hospital rounds, so strangers were managing my admitted patients. Then not enough time for call-ins for acute problems, ergo the rise of urgent cares, again by strangers. And I was still finishing EMR notes instead of attending my Grandkids' evening events.

Ask any patient. Our "system" is broken. Barbara Starfield's landmark work 20 years ago compared a primary care visit begun at the same place with a visit with the same person over time. Not only were outpatient costs 2-3 times higher without continuity of doc, but also more ED visits and hospitalizations. Patient satisfaction was remarkably better with continuity of doc. This isn't rocket science. Who do you want to take care of you when an acute illness sidelines you or results in hospitalization? In my humble opinion, health insurance is the problem.

Having also worked with medical students for almost 40 years, I am not surprised when every year I see many who are family docs at heart choose a sub-specialty because they just don't want to work on a treadmill fueled by 8-minute visits. Rather than continue to curse the darkness, I had two of my M-4 students doing an independent study elective with me investigate rural innovative practice arrangements that allow for little dependence on a brick-and-mortar clinic and a very lean staff facilitated by more telemedicine visits. Direct primary care (DPC) is the ultimate model, breaking free entirely from the health insurance shackles. The full-time DPC practice may have only 500-600 active patients, and the average time with each patient is almost 35 minutes. It is also "continuity urgent care" like the old days. Critics will say this is elitism, as the FM in traditional practice has 1800 active patients, and if everyone does DPC, who will care for the other 1200? My considered response is that DPC may allow for many more of those "FMs at heart" to stay with FM to take care of the population. And maybe instead of sliding into hospitalist or ED positions, more of those choosing FM will practice the way I did in the past. Most developed countries have 80% primary care and 20% subspecialists. The U.S. has the reverse. The DPC option may be a way to balance things.

When I finished my talk to the students, there was a long line to ask me questions about DPC and telemedicine. I invite you to enjoy the M-4 students' report on what the future might look like. I plan to be practicing part time when I see it, so I can get finished on time to attend my Great Grandkids' evening events.

Bill Crump, MD

Imagine you are a rural family physician. On today's schedule are 25 patients, each with 15-minute appointments. An important procedure was not approved by a patient's insurance. You call the insurance company to get the procedure approved. You wait on hold for 45 minutes, thinking of all your patients queuing in the waiting room while you listen to a selection of "calming" elevator music. Or, you have just finished a preventative appointment, only for the patient to confide in you that she is seriously considering ending her life. This patient deserves all your attention, but you cannot help remembering all the patients in line after this one. These are real situations I experienced on my family medicine clerkship that made me seriously consider not applying to a family medicine residency. Luckily, I found out that primary care can exist outside the mainstream insurance-based delivery model. Here, we discuss alternative models that students and residents could consider when favoring quality over quantity of care.

Direct Primary Care

Direct primary care (DPC) is a model that allows physicians to forego dealings with insurance companies by being paid directly by their patients. The basics of a DPC practice are:

1) Patients pay physicians directly as a recurring membership fee that covers most or all services.
2) Patients are not charged per-visit out-of-pocket amounts greater than the equivalent of their recurring fee for usual primary care services.
3) Government and private insurance are not billed for primary care services provided.

The benefits of DPC are related to the severance of the relationship between physician and third-party payer. First, the physician can format their delivery of care however they see fit. The physician may choose to provide only in-person or virtual service, or a combination of both. Some physicians even choose to provide house calls for severely disabled patients. Second, because aspects of the clinical note are only required in a complex structure by third-party payers, a DPC physician may document their services however they wish. An EMR may or may not be needed, and there is no need to document irrelevant negative findings. Third, with no need to generate a required Relative Unit Value (RVU) goal, a DPC physician is free to see fewer patients per day while spending more time with each patient. Most DPC physicians spend an average of 35 minutes with each patient, compared with an average of 8 minutes for all PCPs (2). Finally, DPC physicians are more available to patients. DPC patients with urgent needs are typically managed, often virtually, the same day, rather than going to urgent care or waiting for days or weeks to be seen in the traditional model.

DPC also demonstrates substantial financial benefits for the patient and physician. DPC patients pay an average monthly fee of $74 for services. These patients then spend less overall for healthcare, spending up to 85% less out-of-pocket than their traditional care counterparts[2]. The reason for lower total costs to patients is that, with increased access to primary care, DPC members experience 40% fewer ER visits and 25.54% fewer hospital admissions[1], where co-pays drive the cost of healthcare up for non-DPC members. DPC physicians have higher incomes as well, earning an average salary of $487,000, compared with an average salary at the time of $223,000 for other PCPs[3]. DPC physicians also see several non-monetary benefits: 98% reported increased quality of care, 97% reported improved relationships with patients, 88% reported less time spent on paperwork, and 99% reported an increase in their overall work satisfaction[1]. The data suggests that DPC can be a clear benefit for all.

One criticism of DPC is that it could reduce access to care. A lighter schedule and a much smaller practice panel reduces the number of patients a DPC physician serves, and a membership fee excludes patients that are unable to afford the fee. However, if the freedom provided by DPC attracts more students to primary care, thus improving the primary care workforce, they may make up for the difference. In urban areas, DPC is supported by well-insured, affluent patients. In rural areas, membership fees might be paid by small employers to recruit and retain their underinsured employees. If the DPC physician can respond quickly to relatively minor but urgent needs, this may also keep the

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patient at work. For blue-collar workers who do not receive paid sick leave, this is a win-win.

To find out how DPC fares in rural settings, we sent a survey to several rural DPC Coalition member physicians. We received answers from Dr. Robert Rosborough[4] (Silverton, Oregon, population 10,558), Dr. Shane Patterson[5] (San Andreas, California, population 3,729), Dr. Lara Briseno Kenney[6] (Leeton, Missouri, population 530), Dr. Joel Schumacher[7] (Plymouth, Indiana, population 10,384), and Dr. Noemi Adame[8] (Culver, Indiana, population 1,129). We also incorporate advice from Dr. Susan Wasson, who gave a presentation at the Association of American Physicians and Surgeons Thrive, Not Just Survive Workshop in 2014 about how to build a rural DPC practice.[9] Summaries of the answers we received will follow.

1. What made you decide to switch from traditional practice to DPC?

   Seeing 20-25 patients every workday is not quality care, despite the number of "quality measures" that are fulfilled. The amount of paperwork that a traditional physician must complete does not improve care and leaves less time to address complex health issues and preventative care. Corporate demands for productivity seem never to be fulfilled anyway, leaving physicians burned out due to stress and moral injury. DPC is more patient centered because, as Dr. Rosborough puts it, "time is the most valuable commodity in patient care."

2. What barriers did you need to overcome as you were building your DPC practice?

   The main barriers to building a DPC practice are financial. A physician building a 100% DPC practice should be ready to wait for months before they generate a regular salary. Start-up costs include procuring an office if desired, computer systems, and medical equipment, which can cost around $20,000. Start-up costs for a purely telemedicine practice could be as low as $5,000. Ongoing overhead costs can be closer to 25% rather than the 50-60% that has become routine in traditional practice. Dr. Schumacher suggests starting without the bells and whistles that patients don't always need, and perhaps working another part-time job as the DPC practice is built. Some reported few financial barriers at all, however, due to the large number of patients in their area desiring a better alternative to traditional primary care.

3. What format do you use for DPC?

   Most physicians we surveyed own their own building, commonly 50+-year-old houses, sometimes adjacent to their own homes. Some have other clinicians and staff working with them, including MAs and RNs. Others have no staff at all. All the responding physicians involve telemedicine, which provides their patients increased access to physicians, sometimes 24/7. Telemedicine is most often employed when a hands-on physical exam is unnecessary or impractical, and occasionally when deciding whether a patient requires immediate emergency services. Some physicians make house calls when their patients are unable to travel or temporarily out-of-town. The delivery format of DPC varies from practice to practice, tailored to best fit the needs of each physician and patient population.

4. How financially viable is rural DPC? What changes have you made to make your DPC practice viable?

   All responding family physicians reported that their rural practices have been solidly viable, many even reporting that they earn a higher salary with DPC. To keep DPC financially viable, the family physicians suggested keeping overhead low however possible. They also suggested that the best places to set up a DPC practice are those with little pre-existing primary care availability, where many patients have high-deductible insurance plans, and places where the physician already has name recognition. Some physicians also supplement their income by having contracts with local small companies that pay for their employees' memberships. Dr. Adame, a pediatrician, takes another approach. She reports more financial resistance to building a DPC practice in pediatrics than in family medicine. She charges higher membership fees, which helps her provide more services in her clinic, as well as keep costs lower for her pro bono members.

5. What is your strategy for marketing your practice?

   All our responders pointed to word-of-mouth as by far the best marketing strategy for rural DPC. Some used no other marketing strategy at all. Many also market their practice sparsely on social media or search engine ads, simply for their names to appear when primary care services are searched online by prospective patients. Dr. Schumacher also sponsored two town hall meetings to make the community aware of his new DPC practice before he opened.

6. How would you describe the patient population of your current practice?

   The patient population of a DPC practice consists of newborns to

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people in their 90's. The population is about half "blue collar" and "white collar." More than half of their patient populations consist of patients with traditional health insurance. The proportion of uninsured patients varied from about 10-50%. For pediatrics, almost all members hold private insurance plans, but choose DPC practice for the benefits gleaned from more personalized care.

7. What barriers do patients have when accessing care from your practice?

   The only barrier to a patient's experience in accessing DPC care is cost, which can be augmented depending on the scope of services provided at the DPC practice. All responders reported minimal or no barriers to accessing care once patients become members. At each practice, patients have 24-hour access to a physician, either by call, text, email, or even same-day office visits. Dr. Kenney reports that the only barrier to care she sees is helping her patients understand that primary healthcare can be affordable.

8. How has your quality of life changed after leaving traditional practice to start DPC practice?

   All surveyed physicians report that their quality of life is remarkably improved in DPC. They cited no longer having to sacrifice their hobbies, never having to miss a child's sports game, and even reversing plans to leave the U.S. to practice elsewhere. These DPC physicians also feel more fulfilled in their work in that they can adequately attend to all their patients' needs, sometimes providing services that would not have been possible in traditional models. These DPC physicians are no longer frustrated and angry as they were in traditional practice.

9. What differences do you see in patient satisfaction and outcomes between traditional practice and DPC?

   Responding DPC physicians report that patients are undoubtedly happier with their care. They feel they are treated like family and trust their physicians. They do not suspect that their physicians are tricking them into spending more money or wasting their time. DPC physicians have also noticed better health outcomes among their patients. Because DPC physicians have more time available to counsel on lifestyle modification, their patients engage in increased exercise, weight loss, and smoking cessation. Dr. Rosborough also notes that his patients with diabetes have lower average hemoglobin A1c levels. Dr. Adame reports that she is seeing her patients' families choose her as their pediatrician because they specifically want her care, not just because she happens to be in-network with their insurance plan.

10. What advice would you give to a physician considering starting their own DPC practice? What do you wish you had known before you started?

    Responders advise that a student or resident should be debt-free before starting a DPC practice. There is obviously no "sign-on" bonus as is typical in signing contracts with corporate practice groups. DPC can earn the physician more revenue in the long run, but the physician must have enough money saved to support living expenses while building their practice. Also, our responders advise building a panel of patients in your area for about 4-5 years in a traditional model before starting a DPC practice. This will give the physician name recognition in the area, which is invaluable in rural DPC. Most corporate practice groups would not have a negative view of this initial time with them and a switch later since the primary revenue for them is the continuing referrals for subspecialty care, lab, and imaging. Once practice patterns are established during the corporate 4-5 year "fellowship," they are likely to continue once the physician leaves for the DPC. DPC physicians should be open to other forms of income, including renting out part of their building, having contracts to provide care for small companies or schools, or holding other part-time jobs, especially as the practice is first being built. One responder suggests having an "exit plan" in case of an emergency by setting up the practice to be able to "function without you" if the physician must take a temporary leave of absence. Finally, anyone who is at least 80% sure they want to start a DPC practice should start the practice; they do not need to have "all the details figured out." Many resources are available for physicians to help build a DPC practice, including joining the DPC Alliance and finding a mentor, and going to the DPC summit to learn more.

Telemedicine with occasional need for a building and staff

Access to care can also be improved by providing mostly or all-telemedicine services. Baptist Health's CMIO, family physician Dr. Brett Oliver, advises physicians to use telemedicine to provide care to rural populations from wherever they live and work. He also points to many new technologies that will allow physicians to monitor their patients remotely, including wearable devices that measure patients' vital signs, artificial intelligence that can answer routine patient messages, and even facial recognition software that can accurately measure a patient's blood hemoglobin,

creatinine, and other values. Telemedicine using advanced technologies has already proved effective in managing patients with diabetes, noting lower hemoglobin A1C levels and lower costs to patients, as well as more efficient consults between family physicians and psychiatrists (12). When worked into a DPC or traditional practice, telemedicine would reduce overhead costs for the physician, eliminating the need to pay for a large office building, auxiliary staff, and medical equipment needed for traditional in-person practice, all of which could lower the membership fee needed to support DPC, or increase net profit for the traditional practitioner, allowing more time to be spent with each patient because of a smaller panel size needed to support overhead costs.

Hybrid Model

In Kentucky, we found only six DPC Coalition member practices, all in metro areas (13). Using the advice of others that have built rural DPC practices, a new hybrid DPC practice is being considered here in rural Madisonville as an extension of a local student-directed free health clinic. This teaching practice will target two populations: individuals who can afford to pay their own membership fees and have a need for prompt continuity care, and workers at small local companies or agencies who might cost share the membership fee to minimize lost work hours and facilitate recruitment and retention. The DPC practice could remain affiliated with the local practice group, and brief notes and orders for lab and imaging could remain in their EMR. Insured patients will use their insurance to cover sub-specialty consultations as well as lab and imaging, and low-income uninsured patients will use the existing payment options with the local hospital. The monthly membership fee can be kept low because of minimal overhead costs and will give access via return telephone, text, email, or EMR portal to a physician during daytime hours. Quick, simple advice will come within minutes, a telemedicine visit within hours, and an in-person visit within 24 hours of contact. As needed, a physician will meet patients at their places of work, including spaces designated for healthcare by employers. The goal of the practice is to allow students to see first-hand how DPC can give rural patients an alternative form of healthcare that will not be hindered by requirements set by third-party payers.

Many staunch advocates for DPC question the feasibility of a hybrid of DPC within a corporate practice group. It will require a payment contract not based on traditional overhead costs and RVUs, but this might be attractive if it allows the group to recruit new primary care physicians and therefore generate more non-primary care

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revenue. A model many students find attractive right out of residency is 50% traditional care, 30% DPC, 10% free clinic care, and a day off each week. If this model is more attractive to the next generation of doctors, fewer may choose the inefficient and low-continuity jobs of urgent care, ED, and hospitalists in favor of "old-fashioned" continuity family medicine facilitated by "new-fangled" payment systems.

Conclusion

Although our survey respondents no doubt represent those who have been the most successful, their stories are energizing. We encourage other physicians, newly graduated or not, to consider including these novel styles in their practices. This may allow them to practice the kind of medicine they dreamt of when they started studying medicine in the first place.

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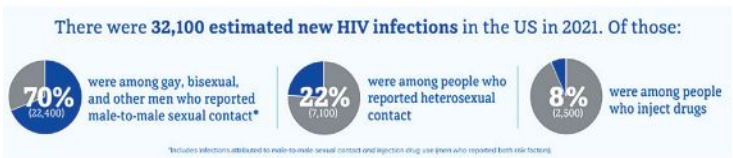
BY KAREN KRIGGER MD, MEd, FAAFP, AAHIV(S)

HIV Prevention in The United States

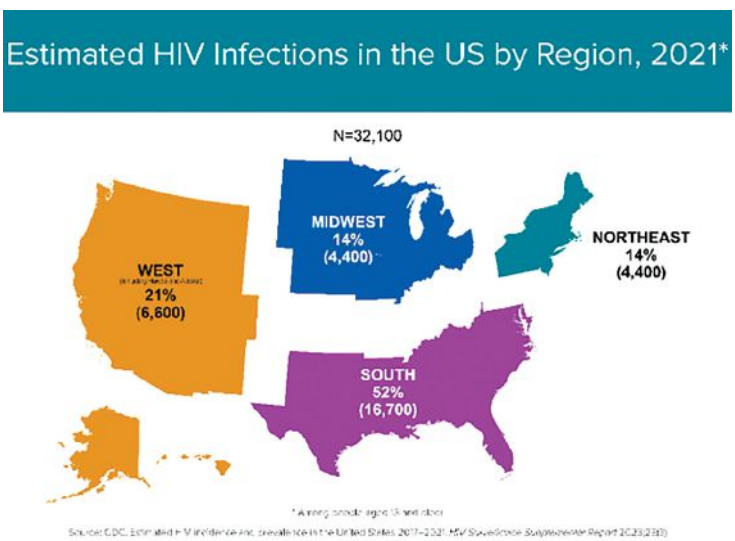
This article provides an overview of HIV demographics and the federal response to prevention. New approaches to HIV prevention are provided, including population recommendations, taking a sexual history, appropriate testing, 5 protocols for pre-exposure prophylaxis (PrEP), and service reimbursement. It is a call to arms against a disease present since 1981, still in epidemic mode, competing with many other viral ailments, but amendable to our primary care intervention.

Since 1981, 700,000 Americans have died from HIV/AIDS with 1.2 million HIV infected individuals currently living in the US. The CDC estimates thirteen percent are unaware of their HIV diagnosis. In 2021, 32,100 individuals received an HIV diagnosis in the U.S. U.S. populations of racial and ethnic minorities, gay, bisexual, and MSM continue to be disproportionately affected with the highest rates of new diagnosis continuing to occur in the southern states, which includes Kentucky.



HIV basics overview from the CDC[1]

In 2021 people aged 13 to 34 accounted for more than half (56%) of the new diagnoses. People aged 25 to 34 represented 37% of those newly diagnosed.[1] Family Practitioners saw more than 25% of US preventative care visits in 2018.[2] The expanse of family medicine scope of practice by age, influence, and sheer contact numbers make the specialty a formidable ally in HIV prevention.

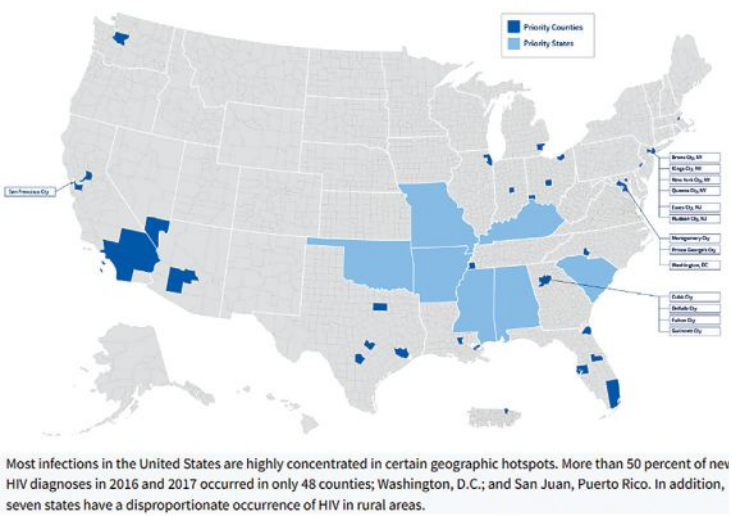


HIV basics overview from the CDC[1]

The U.S. Department of Health and Human Services (HHS) Initiative to End HIV Transmission

In 2019, the U.S. Department of Health and Human Services published a plan, *Ending the HIV Epidemic in the U.S.,* to reduce the number of new HIV infections by 75% by 2025 and at least by 90% by 2030, preventing 250,000 new total HIV infections. It was estimated, without a planned intervention, 400,000 more Americans would be newly diagnosed from 2019 to 2029 despite available HIV prevention strategies. Prior to 2019, the US spent $20 billion yearly in direct US health expenditures for HIV prevention and care. The four pillars of action of the 2019 *Ending the HIV Epidemic in the U.S* program were HIV **prevention**, HIV **diagnosis**, HIV **treatment**, and **rapid response to HIV outbreak**. Of these targeted actions, family physicians play a major role in HIV prevention and diagnosis, and if desired, HIV treatment. HIV treatment certifications are available to family physicians through the American Academy of HIV Medicine.

The program involved participation by Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Indian Health Service (HIS), National Institutes of Health (NIH), Office of the HHS Assistant Secretary for Health (OASH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). This bipartisan initiative received support from both House and Senate at its conception, resulting in fiscal funding.



Most infections in the United States are highly concentrated in certain geographic hotspots. More than 50 percent of new HIV diagnoses in 2016 and 2017 occurred in only 48 counties; Washington, D.C.; and San Juan, Puerto Rico. In addition, seven states have a disproportionate occurrence of HIV in rural areas.

Goals for Ending the HIV Epidemic in the U.S.[3]

Ending the HIV Epidemic in the U.S. focuses on 57 geographic sites of most frequent transmission. These sites included 48 counties and 7 states, including Kentucky.[4]

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Human Trafficking Warning Signs

Warning Signs

- Signs of physical abuse (burn marks, bruises, cuts)
- Pelvic or abdominal pain; appears malnourished
- Tattoos or branding
- Possession of large amounts of cash, multiple cell phones and/or hotel keys ; offers to pay in cash
- Caught lying about age/possession of false ID; lacks official identification documents
- Avoids social interaction and authority figures/law enforcement
- Seems to adhere to scripted or rehearsed responses in social interaction; someone always speaks for them
- Unable or unwilling to give an address or information pertaining to parents/guardian
- Maintains sexually explicit profiles on social networking sites; over-familiar with sexual terms and practices
- Suicide attempt
- Bizarre relational dynamics/unsettling behavior
- Disorientated about date, time, and place
- Appears fearful, anxious, depressed, submissive, hyper-vigilant, paranoid, or excessively hostile
- Seemingly excessive number of sexual "partners"
- Multiple or frequent pregnancies and/or abortions
- Fearful attachment to a cell phone (often used for monitoring or tracking)

How Hospitals Can Help

What is Human Trafficking?

- Modern day slavery
- Exploiting a person through force, fraud or coercion
- Sex trafficking, forced labor or domestic servitude
- Human trafficking is happening everywhere around the globe to people of any age, gender, race, socioeconomic status or nationality
- Any person under the age of 18 involved in a commercial sex act

Identifiers of a Trafficker

- Significantly older than their female companions
- Encourages illegal activities and/or inappropriate sexual behavior
- Vague about his/her profession
- Demanding or pushy about sex
- Someone that exerts an unusual amount of control over the patient

How to Help a Victim of Trafficking

- Separate any companions from the patient and provide a quiet, safe place for the patient
- Attend to any physical needs of the patient; don't rush the patient
- Adopt open, non-threatening body positioning (sit at eye level, avoid touching patient unless given permission, be aware of body language, avoid crossing arms)
- Engage the patient with active listening skills, respectful and empathetic language; avoid judgment
- Educate hospital staff on the red flags and the protocol of actions to be taken
- Document suspected and confirmed trafficking using the new ICD-10 codes
- Invest community benefit dollars towards anti-trafficking initiatives
- Become acquainted with community groups/resources that help victims

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COUNTIES, TERRITORIES, AND STATES

COUNTIES

Arizona
Maricopa County

California
Alameda County
Los Angeles County
Orange County
Riverside County
Sacramento County
San Bernardino County
San Diego County
San Francisco County

Florida
Broward County
Duval County
Hillsborough County
Miami-Dade County
Orange County
Palm Beach County
Pinellas County

Georgia
Cobb County
DeKalb County
Fulton County
Gwinnett County

Illinois
Cook County

Indiana
Marion County

Louisiana
East Baton Rouge Parish
Orleans Parish

Maryland
Baltimore City
Montgomery County
Prince George's County

Massachusetts
Suffolk County

Michigan
Wayne County

Nevada
Clark County

New Jersey
Essex County
Hudson County

New York
Bronx County
Kings County
New York County
Queens County

North Carolina
Mecklenburg County

Ohio
Cuyahoga County
Franklin County
Hamilton County

Pennsylvania
Philadelphia County

Tennessee
Shelby County

Texas
Bexar County
Dallas County
Harris County
Tarrant County
Travis County

Washington
King County

Washington, DC

TERRITORIES

Puerto Rico
San Juan Municipio

STATES

Alabama

Arkansas

Kentucky

Mississippi

Missouri

Oklahoma

South Carolina

Specific Counties and States of Focus [4]

Rethinking HIV Positivity and Prevention

Methods of HIV prevention include **treatment as prevention** (TasP). Undetectable = Untransmittable (U=U) is a HIV prevention strategy confirmed by studies conducted since 2008. U=U is a game changer for HIV stigma. If a HIV+ person is on durable antiviral therapy for 6 months or more, has a non-detectable viral load (originally set at less than 200 copies/mL), and keeps their appointments for surveillance every 6 months, their risk of sexual transmission of HIV is negligible - less than 1%, but not zero. Primary care physicians educating HIV patients about U=U promotes medication adherence in the populations, while decreasing stigma and enhancing quality of life.

Risk of HIV Transmission With Undetectable Viral Load by Transmission Category

Transmission Category	Risk for People Who Keep an Undetectable Viral Load
Sex (oral, anal, or vaginal)	Studies have shown no risk of transmission
Pregnancy, labor, and delivery	1% or less[†]
Sharing syringes or other drug injection equipment	Unknown, but likely reduced risk
Breastfeeding	Substantially reduces, but does not eliminate risk.

[†] The risk of transmitting HIV to the baby can be 1% or less if the pregnant person takes HIV medicine daily as prescribed throughout pregnancy, labor, and delivery and gives HIV medicine to their baby for 4-6 weeks after giving birth.

Estimated Risk of Transmission with Undetectable Viral Load[5]

Preexposure Prophylaxis

Pre-Exposure Prophylaxis (PrEP) constitutes a protocol of medication, scheduled laboratory surveillance, and safer sex strategies. While there is no "safe sex," "safer" sexual practices can mitigate risks. Safer sex practices include mutually monogamous sexual partners with prior STI/HIV testing; latex, nitrile, or polyurethane barrier male or female condoms; water based or silicon lubrications; dental dams; and limited sharing of sexual toys with proper cleansing. Patients should be educated concerning enhanced transmission of HIV with sheep skin/ lamb skin condoms, oil-based lubrications, expired condom dates, and suboptimal storage conditions. Optimal condom storage conditions are cool, dry places and out of direct sunlight. "Female" condoms can be used for both vaginal and anal sex. Condoms containing spermicides can cause skin irritation increasing susceptibility to HIV infection. Condoms should not be reused or "washed" for further use. Identifying injection drug use (IDU) and substance abuse with referral to chemical dependency programs and clean needle exchange sites prevents HIV. Identification and treatment of mental health disorders, reporting intimate partner violence or sex trafficking are within family medicine scope of practice and are useful in HIV prevention. These conditions, with unstable housing or limited social support, increase patient susceptibility to behaviors increasing HIV exposure.

Updated documents from the US Public Health Service and CDC original publications of 2014 covered several new recommendations for HIV Prevention in the United States.[6,7] The remainder of this article focuses on current practices of HIV prevention and testing, including 5 pharmaceutical PrEP protocols.

August 22, 2023, the U.S. Preventive Services Task Force gave a grade A recommendation to PrEP. The USPSTF recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.[8] However, this is not much different from their 2019 pronouncement and is incongruent with current CDC recommendations.[6] The *Pre-Exposure Prophylaxis for the Prevention of HIV Infection in the United States -2021 Update: Clinical Provider Supplement* includes recommendations to inform **all** sexually active adults and adolescents about PrEP.[6]

There are currently 5 different pharmaceutical protocols for PrEP: Daily Oral PrEP, 2-1-1 PrEP; Telehealth PrEP, Same Day PrEP, and Injectable PrEP. As with any primary care encounter, establishing the patient's history, physical, and lab work are paramount. Taking a complete sexual history is an important first step in determining optimal laboratory screening and medication assignment.

Sexual History and Lab Screening

Family physicians are astute in developing rapid patient rapport. Getting answers to gender affirming questions hastens the process of HIV prevention by establishing pronouns (he, him, his / she, her, hers/ they, them, theirs) and avoiding assumptions about gender identification, sexual orientation, and preferred sexual partners. A person may identify as 'Cis' (short for Cisgender) meaning whatever gender assigned at birth is the preferred gender identification of that person now. This term is applicable to both men and women. While it is verbally helpful responding to the patient's obvious preferred physical gender expression, as primary care providers, we utilize the gender **birth** identification for prostate, cervical, and breast cancer screening.

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Mercyhealth is Seeking Primary Outpatient Care Physicians to Join Our Expanding Practices in Illinois, with Additional Openings in Wisconsin. Close to Chicago, Milwaukee, and Madison!

Mercyhealth is an award-winning, multi-regional, integrated health system comprising of 7 hospitals, more than 700 employed physicians, over 85 outpatient clinics and other service sites that provide care to residents in more than 55 communities throughout northern Illinois and southern Wisconsin. We provide over 125 specialty and sub-specialty services, including adult and pediatric critical care, neonatal intensive care, neurosurgery, heart and vascular care, cancer care, plastic and reconstructive surgery, Da Vinci robotic surgery and much more.

Opportunity:

- Join an expanding Multi-Specialty Outpatient Practice.
- Family Medicine Practice with limited or no Pediatrics (Pediatricians on-site).
- Walk into a full panel of patients with the support of Nurse Practitioners.
- Practice in a newly renovated Clinic which also includes OB/Gyn, Pediatrics, Urgent Care, Lab & X-Ray.
- We promote and support a private-practice model. Craft your practice!
- Call is minimal and shared among Mercyhealth Rockford region Family Medicine Physicians.
- Because we provide a robust Hospitalist program, hospital rounding is not required.
- No restrictions on procedures - build the practice to your specifications.
- Admitting hospital is Mercyhealth Javon Bea Hospital – Riverside, Opened in 2019 with state-of-the-art accommodations and equipment.

Full Time Compensation & Benefits:

Mercyhealth offers a highly competitive initial salary guarantee (based on MGMA guidelines) leading to a production-based model after the first year, along with an outstanding benefits package:

- Paid CME, malpractice and licensure!
- Excellent health, dental and vision insurance for Physician and family
- 100% match on 4% retirement plan contribution + additional discretionary 2%, up to 6% Day one!
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- 20 days of PTO + 5 days for CME during initial guarantee for a full-time Physician
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EOE&AA/M/F/Vet/Disabled

Community:

Rockford Illinois is the third-largest city in the state of Illinois. Settled on the banks of the Rock River, Rockford is notable for its economic diversification into automotive, aerospace, and healthcare industries, as well as the undertaking of various tourism and downtown revitalization efforts.

Rockford is known for various venues of cultural or historical significance, including Anderson Japanese Gardens, Klehm Arboretum, the Coronado Theater, and the Burpee Museum of Natural History. Rockford has been recognized as one of the most affordable housing markets in the nation less than an hour and a half drive from downtown Chicago and Milwaukee and less than an hour from Madison, Wisconsin.

Roscoe Illinois, just ten miles north of Rockford, Roscoe is a village in Winnebago County, Illinois, a suburb of Rockford. The village is in a suburban area along the Rock River. As of the 2010 census, the village population was 10,785, up from 6,244 at the 2000 census. The area has been undergoing a period of rapid growth. Roscoe is also hometown to Danica Patrick - IndyCar Series Racer, as well as a landmark automobile museum and a plethora of outdoor activities.

Mercyhealth™
A passion for making lives better.™

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These questions help providers identify patient's sexual practices of vaginal, oral, and anal (insertive/receptive) penetration. Adequate sexually transmitted infection (STI) screening involves laboratory surveillance of all involved sites. It is also important to know how the patient finds their sexual partners, their number of partners in the prior 12 months, and the length of time from the last sexual encounter. This information assesses infection risk and applicability of screening test windows for HIV and STIs. Inquire about the type of STI and pregnancy protection used in sexual acts, as well as the frequency, history, and results of HIV and STI testing.

Patients and providers should be cognizant of the types of HIV tests available and their windows of average earliest detection post-HIV exposure. HIV testing windows are the amount of time from exposure to a positive test result. Home HIV tests are 3rd generation (HIV antibody testing) and have a 3-month window as opposed to the 4th generation (HIV antibody and HIV antigen) tests, generally available in provider offices, with windows of 18-45 days. The nucleic acid (NAT) test, essentially a HIV viral load determination, provides the shortest HIV detection window of 10-33 days. HIV tests administered by finger stick tests have a longer latent window of positivity than venipuncture; consequently, laboratory testing is preferred over rapid testing.[6] HIV testing should be performed with the 4th generation and HIV viral load. If PrEP is prescribed based on a rapid test, a confirmatory laboratory HIV test, preferably 4th generation and HIV-1 RNA viral load (NAT) should be performed. For exposure prone activity within 4 weeks of HIV testing, it is very important to assess the patient for signs and symptoms of acute HIV infection and perform HIV-1 RNA viral load (NAT) testing with the 4th generation screening. Signs and symptoms of acute HIV infection include fever, fatigue, myalgia, skin rash, headache, pharyngitis, cervical adenopathy, arthralgia, night sweats, and diarrhea. Additional patient questions include methods of protection from STIs, history of STIs, and pregnancy intentions and goals.

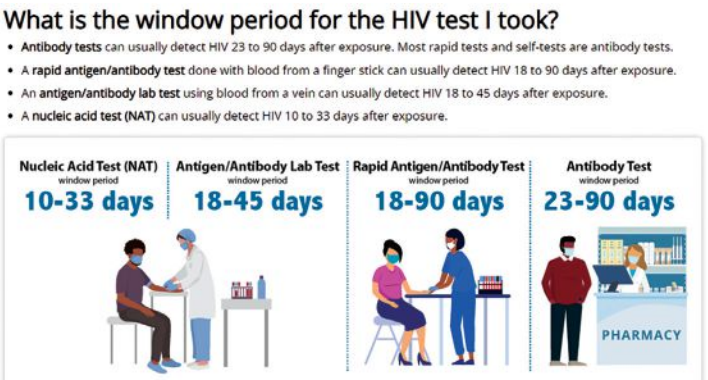
In review, the CDC's **5 P's of taking a sexual history** are as follows: [9]

Partners – Men, Women, Both? Number of partners in the prior 12 months? How do you meet your partners? Do any of your partners use drugs? Does your partner have HIV? If they have HIV, do you know their viral load, drug resistances? This is important because PrEP drug choice should **not** be a drug with demonstrated resistance by the partner. The PrEP choice of this drug would be ineffective.

Practices – Do you use drugs or EtOH during sex? Have you ever exchanged sex for support; have you ever been forced to have sex or do something you did not want to do? Do you practice vaginal, oral, or anal sex? If a participant of anal sex, are you insertive or receptive? Both? Note there is a greater risk of HIV acquisition from receptive sex, both anal and vaginal, due to microtears.

Protection from STIs – Do you use barrier protections? Consistently? What kind and how? What is your vaccination history for Hepatitis A, B, HPV, monkey pox?

Past History of STIs?



Windows of HIV Detection[9]

Pregnancy Intentions?

The general history of the patient should include use of prescribed and over the counter nephrotoxic drugs. Previously, creatinine clearance was assessed for all patients every 3-6 months. New oral PrEP recommendations require the estimated creatinine clearance is to be performed every 12 months for persons less than 50 years of age or with an eCrCl greater than 90 ml/ min at PrEP initiation. Persons with eCrCl less than 90 at PrEP initiation or age greater than 50 should have eCrCl performed every 6 months.

Current recommendations for HIV testing include a dual surveillance use of HIV antigen/antibody (Ag/Ab) and ribonucleic acid (RNA) viral load for all patients on PrEP. A pregnancy test should be performed with an acute Hepatitis panel, a Hepatitis B quantitative antibody screen, a Hepatitis C antibody with reflex viral load testing, and Hepatitis A serology. Positive Hepatitis B and C testing should be reported to the Kentucky state information exchange within 1- 5 business days.[10] To report a HIV case by phone, use the **HIV/AIDS Case Reporting Line at 1 (866) 510-0008. HIV reporting forms can be accessed at** https://www.cdc.gov/hiv/pdf/guidelines/cdc-hiv-adult-confidential-case-report-form-2019.pdf 11. Reporting of HIV is required by medical practitioners under 902 KAR 2:020. Use of Disease Interventional Specialist (DIS) workers is at the patient's discretion for notification and testing of sexual contacts and can be reached through local health departments. The patient's name will not be used in the contact case action. Patients should be offered vaccinations or information for acquiring vaccines for Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), and Monkey Pox, if applicable. Hepatitis A vaccines are recommended for MSM and transgendered individuals. Kentucky had the greatest outbreak of Hepatitis A in US history in 2017, 2018, and 2019. Hepatitis B vaccination is now recommended from birth through 59 years. It remains recommended for individuals ≥60 years with risk factors for Hepatitis B although it is appropriate for individuals ≥60 years without risk factors for Hepatitis B.[12] Both oral PrEP medications, Truvada (Emtricitabine/tenofovir) and Descovy (Emtricitabine/tenofovir alafenamide), are used to treat Hepatitis

B. Establish Hepatitis B status before PrEP, and if negative, offer the vaccine series. Abrupt withdrawal of Truvada or Descovy may precipitate Hepatitis B exacerbation in the presence of the disease. HPV vaccine is indicated to age 45 for MSM.

Bacterial STI screenings include syphilis, gonorrhea, and chlamydia. Bacterial STI screenings should be repeated every 3 months for MSM/transgender patients and every 6 months for CIS women and men. Dexa scans, liver function tests, hematologic assays, and urinalysis are optional under current recommendations.

During physical examination look for atrophic candidiasis, oral thrush, oral hairy leukoplakia from Epstein Barr Virus (EBV), post cervical adenopathy, syphilitic, herpetic, and oral/genital HPV lesions. While some of these signs/symptoms may result from use of oral steroids, chronic antibiotics, or other immune compromised states, they have historically been associated with HIV disease. The skin is the first line of defense from HIV. Breaks in the skin or the presence of sexually transmitted diseases make it easier to acquire HIV infection.

PrEP Daily Treatment Options

There are two offerings for daily oral PrEP: Truvada (emtricitabine/tenofovir disoproxil fumarate) and Descovy (emtricitabine/tenofovir alafenamide). Truvada can be used with males or females. It cannot be used in patients with a GFR of less than 60ml/min. Rectal tissue concentrations for both drugs are adequate at 7 days from initiation. Truvada protection is adequate at approximately 20 days for cervicovaginal tissue and IDU risks. Descovy is only recommended for use with MSM and transgendered females, not for receptive vaginal sex. It requires a lipid profile every 12 months. It can be used with GFRs down to 30 ml/min. Do not use Descovy for protection of patients who have receptive vaginal sex. Initiation of oral PrEP should be within one week of a negative HIV test. Consider bringing the patient back in a few weeks to assess for side effects, adherence, and need to repeat labs, like HIV testing. Side effects of diarrhea, headache, abdominal pain, asthenia, and nausea are generally mild, peaking at a month and resolving in 3 months. Both medications can be used with adolescents at least 35 kg or 77 lbs.

Do not give more than a 90-day supply at a time for oral daily dosing. Bring the patients back every 3 months for dual HIV testing of antigen/antibody and viral load and screen for signs or symptoms of acute HIV disease. Bacterial STI surveillance should be done every 3 months for MSM/transgender and every 6 months for Cis women and men engaging in heterosexual activity. Developing a medication adherence plan at each visit includes review of medication scheduling and reminder devices, organizational skills for storage/travel, and household support or/and disclosures. Also, discuss adherence, risk reduction, and side effects. Criteria for PrEP discontinuance includes a + HIV test, development of renal disease, non-adherence to medications or appointments, and change in behavior negating PrEP need. In the discussion of the injectable PrEP to follow, injectable PrEP discontinuation requires HIV viral load testing every 3 months for a year post discontinuation secondary to an 18-month long medication residual tail. CAB has been associated with delayed seroconversion and antibody formation, consequently antibody based testing, including 4th generation, is less reliable than the HIV viral load testing. All PrEP patients, oral and injectable, should be fully screened at 12 months for continued PrEP needs.

"PRN" PrEP Regimens

An alternative oral PrEP protocol is the protocol 2-1-1. While not endorsed by the FDA currently, this option now appears in the 2021 PrEP guidelines. 2-1-1 is recommended for **MSM only. Truvada is the only recommended medication.** This protocol is for use with infrequent sexual encounters. Two tablets are taken 2-24 hours before the anticipated sexual encounter, then 1 tablet taken a day later, and the final pill 2 days later. Limit medication to 30-or-less-day supply at the visit.

Same Day PrEP

Conditions for same day PrEP initiation occur when the patient has limited availability to return to clinic for follow up results or immediate high-risk conditions. To provide same day PrEP initiation, medical offices must provide point-of-care (POC) HIV testing with preferences for antigen/antibody (4th generation) fingerstick, laboratory-based venipuncture, or, optimally, HIV-1 RNA testing. Do not use oral fluid HIV testing. POC creatinine may be used. Draw blood for laboratory creatinine and HIV testing when same day HIV and creatinine test results are not available. STI specimens need to be collected from all sites that day for laboratory testing. Offices can aid with medication access through medical insurance or medication assistance programs. Providers should be able to provide rapid follow-up contact for deleterious lab results, i.e., abnormal kidney function, + HIV test results, or + STI screenings. None of the PrEP medication offerings are sufficient in and of themselves to adequately treat HIV disease and may promote drug resistance complicating future HIV treatment. The patient must be scheduled for follow up appointments. Same day PrEP is **not** appropriate for ambivalent patients, those from whom blood cannot be drawn, those who have signs/symptoms or sexual history of possible acute HIV infection, or those with history of renal disease or associated conditions, such as hypertension or diabetes. Patients must have a confirmed means of contact, be cognizant to understand PrEP requirements, such as adherence and follow up, and be able to get the medication that day. Very recent possible HIV exposure without signs and symptoms of acute HIV disease, such as rape, may require evaluation for nPEP (non-occupational Post Exposure Prophylaxis) and should not be offered PrEP. Access within Kentucky to nPEP protocol with provision for medications and exams for rape victims are provided at https://www.safeta.org/page/kyprotocol/.[13] nPEP involves assigned medications and lab surveillance for 30 days after exposure. Safer sex precautions are recommended for patients' sexual partners during this period.

continued on page 26

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Telehealth PrEP

Telehealth PrEP protocol was necessitated by the COVID-19 pandemic lockdown. In this scenario, the provider conducts PrEP screening, initiation, or follow up visits by phone or video conferencing. The patient comes to the office for collection of HIV, STI, and other labs for specimen collection only or, alternatively, home collection specimen kits for fingerstick, swabs, and/or urine samples are mailed to the patient's home for return to the medical office for evaluation. After confirmation of the negative HIV test, a prescription for a 90-day supply is written rather than 30 days with 2 refills to minimize pharmacy trips. As a last resort (due to the low sensitivity of oral antibody tests), if a patient has no possible access to a lab (in-person or by mail) the patient can conduct a home test and report HIV results to the clinician with a photograph of the lab results.

Injectable PrEP

Injectable PrEP, Cabotegravir (CAB) branded Apretude, is a PrEP option for all adults and adolescents age 18 years or older at risk of HIV. 600 mg of CAB is injected into the gluteal muscle by medical personnel every 2 months using a 1.5-inch needle. For patients with a BMI greater than 30, the 2-inch needle is needed. The drug is FDA approved for gluteal site administration by medical personnel only, **not for self-administration**. Drug absorption cannot proceed through silicone gluteal implants (Brazilian Butt Lift). The 30 mg daily oral preparation is an option for a 4-week lead-in in lieu of the first injection. However, CAB cannot be prescribed as an ongoing daily oral medication option. Do not co-administer with rifampicin, rifapentine, carbamazepine, oxcarbazepine, phenytoin, or phenobarbital. For patients interested in "same day" PrEP, giving a 4-week oral lead-in until labs are returned is preferable to using the injection initially: you cannot pull back an injectable dose in the presence of subsequent abnormal lab results.

Because of the long duration of the drug exposure, acute HIV infection must be ruled out by the most sensitive screen-the HIV-1 RNA assay. Patients previously on oral daily PrEP may start injections as soon as the HIV-1 RNA is returned negative. Give the first injection or oral lead-in within one week of the negative HIV test. If same day start (based on a negative rapid 4th generation test) is enacted, confirmatory serum tests including HIV RNA assay with baseline STI testing should be performed. Patients should return to office 1 month after the first CAB injection, or the 4-week oral lead in, for the 2nd injection of CAB, HIV-1 RNA testing, acute HIV surveillance, and to ask any questions. There is no clinical data as to the length of time to achieve rectal/vaginal/cervical protection as reported in oral medication usage. After the first 2 doses, subsequent injections are given every 2 months. With the 3rd injection visit, repeat an HIV-1 RNA test, assess for signs/symptoms of acute HIV, provide access to drug treatment services/clean needles, and if applicable, respond to new questions, and discuss benefits of persistent CAB PrEP. Beginning with the 3rd injection, screen at least every 4 months (every other injection month) for bacterial STIs in MSM and transgender women at all involved sites, including blood tests. Beginning with the 5th injection or at least every 6 months, screen heterosexually active Cis men and women for STIs with vaginal, rectal, urine and blood tests, as indicated. At 12 months post first injection, assess the patient's desire to continue injectable PrEP. Injectable PrEP protocol discusses cases of PrEP discontinuation and handling missed injections.

These tests are optional before starting CAB injections: creatinine, eCRCl, Hepatitis B serology, lipid panels, liver functions, Hepatitis A serology, and Hepatitis C serology. As family physicians, however, we should protect our patients with vaccinations for Hepatitis A and Hepatitis B as applicable. Injectable CAB can be used with compromised renal function.

Additionally, providers should offer PrEP with Truvada (Emtricitabine-tenofovir) to all women desiring pregnancy, pregnant, or breastfeeding, if their partner is HIV + or the HIV status is unknown or detectable. Studies supporting these recommendations were performed on Cis women with their male partners maintaining viral loads of less than 200 copies/ml. While the World Health Organization has historically allowed HIV + mothers to breast feed, the CDC recent statements include "for mothers on antiretroviral therapy (ART) with a sustained undetectable HIV viral load during pregnancy, the risk of transmission through breastfeeding is less than 1%, but not zero." Hence the CDC endorses breastfeeding in HIV + mothers with surveillance and guidance by their providers for the first time.[14]

PrEP Therapy Reimbursement

For office reimbursement, billing codes for ICD-10 for PrEP include Z11.4 "encounter for HIV test," Z11.3 for "STD screening," and Z20.2 for "exposure to STD." Billing strategies for ICD-10/CPT are included on pages 34-37 in the Pre-Exposure Prophylaxis for the Prevention of HIV Infection in the United States – 2021 Update *Clinical Providers' Supplement.* The supplement offers provider and patient checklists for inclusion in medical charting, in addition to educational PrEP patient instructions and provider patient risk assessment sheets.[7]

At each subsequent visit for any form of PrEP, patients should be engaged in strategies for maintaining adherence to their chosen regimen. Discussion should include sexual risk reduction and injection drug use harm reduction strategies. Optimally, condoms should be offered, and if needed, substance abuse and injection drug use treatment referrals. Screen for any side effects of the medications and manage, as needed.

Finally, according to the KY HIV/AIDS Annual Surveillance Report 2022, the majority of HIV cases (67%) reported the

primary route of exposure as Male to Male Sexual Contact (MMSC), while among adult/adolescent women, 47% reported exposure through heterosexual contact with a person with HIV or at high risk for HIV infection (e.g. a person who injects drugs.[15] As family physicians, our mission involves promoting the health and safety of our patients and community through prevention, both primary and secondary. In primary prevention, we prevent acquisition of illness. In secondary prevention, we prevent dissemination of illness. We can achieve both of these important aims by recognizing that all injection drug users and all sexually active adolescents and adults are at risk of HIV disease. Compassionate and effective primary and secondary prevention involve knowing our patients and their risks of disease (via sexual or IDU exposure) and responding to that risk by educating our patients about prevention actions we can take together. Consider incorporating PrEP services for your sexually active and IDU patient populations of all ages.

Preplanning in your office can help seamlessly incorporate PrEP in your practice. The National Clinicians Consultation Center PrEPline is available at 1-855-448-7737 or their website at National Clinician Consultation Center (ucsf.edu).[16] On this site you will find information on PrEP and nPEP (Non-Occupational Post Exposure Prophylaxis) for clinicians. The CDC HIV website for clinician resources is https://www.cdc.gov/hiv/clinicians/index.html.[17]

As Kentucky has been identified as a targeted state it is imperative for local family physicians to actively engage the actionable recommendations of the *Ending the HIV Epidemic* plan through prevention, diagnosis, and, if desired, HIV treatment within the scope of their primary care practices.

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BY JAMES ROSSI, MD

Fleet Award recipient

CARING FOR PEOPLE ISN'T MERELY A CHOICE; IT'S INTEGRAL TO MY SENSE OF SELF-WORTH. I BELIEVE THIS HOLDS TRUE FOR MANY HEALTHCARE PROVIDERS BECAUSE I'VE SEEN IT FROM PROVIDERS AT FAMILY PRACTICE ASSOCIATES AND WHERE I TRAINED AT UK.

While unexpected, the Fleet Award holds special meaning for me at this point in my life. I associate awards with my college self, not the physician and soon-to-be father that I've become. In my mind awards are something you strive for, but this particular honor was not something I actively pursued. I am deeply appreciative and validated that I am becoming the person I want to be. It was a patient who initiated the Fleet Award to challenge new physicians to add those personal touches that help develop relationships and heal those they care for. To her, most of all, I am grateful.

The concept of having a personal, dedicated doctor appears to be diminishing in our collective consciousness. So long assumed a fundamental aspect of healthcare, societal pressures have made it less common. The concept of primary care has evolved into a cost-offsetting mechanism for the hospital-centric healthcare system that insurance companies have been keen to adopt. But I wouldn't know anything about that. At least, I didn't when I ventured into this career. My few childhood experiences with doctors shaped my perception of what a provider should be.

The doctors in my hometown followed a certain model: They worked in a clinic and developed ongoing relationships with their patients. They also saw those same people in their church or Kmart and thus extended respect for those they cared for outside of the clinical setting. There are fewer limits when you work in a small town. Sometimes you're the only option, the only one who answers a question. Sometimes you're the only one who sees the whole picture of someone's health. Great examples to guide a young, goal-oriented college student into a patient-centered physician.

Caring for people isn't merely a choice; it's integral to my sense of self-worth. I believe this holds true for many healthcare providers because I've seen it from providers at Family Practice Associates and where I trained at UK. Being singled out for an award, while an honor, feels somewhat incongruent because caring for patients isn't an uncommon or extraordinary act. It's not unusual to make a phone call to someone or to seek out a pharmacy that can fill a prescription promptly. It's patients who let you know, though, when to step up and do something more meaningful.

We all know that feeling after a long shift: mentally exhausted, eager to return home, brain pulled in 40 directions. Despite the desire to relax, we make that extra effort to document for a motorized wheelchair. We choose to look up an obscure physical exam finding to provide reassurance. We find out what that MRI from 15 years ago showed, all to help us understand a little more, to connect a little bit more tightly. If we don't do it, they suffer, or their care is delayed. It continues to surprise me when someone thanks me for calling them, for updating their FMLA or for listening just a little longer. It's all necessary to ensure the best outcomes for those patients and yet somehow the expectation is being lost.

Allow me to interject a heart-warming story about a particular patient couple that represents what I'm saying. The story revolves around a devoted husband and his wife who came to me from Michigan. It begins with the worsening dementia that led to her death. Her health declined steadily, and it became evident that her time was limited. Yet, in her presence, there was an undeniable sense of peace, a calm acceptance of the inevitable. Her dignity and strength throughout her illness were humbling. I had numerous conversations with the husband, a man who was unwavering in his commitment to supporting his beloved wife during her final journey. It was evident that he understood the gravity of the situation but rose to the occasion even at 93 years old. We adjusted treatment plans and discussed the importance of her time at home, always with the aim of enhancing her quality of life. She couldn't communicate but he and I built a strong relationship through this. In the midst of this emotional and challenging journey, it was the conversations we had beyond the realm of medical treatments that proved to be the most impactful. We delved into the profound questions about life, its meaning, and the purpose behind it all. He shared with me his perspectives on love, duty, and the beauty of their shared journey. Months later, it was me pushing hard to get her admitted to the hospital when he couldn't take care for her any longer. I didn't know what was wrong, but she was no longer herself and he was so grateful for her to be at peace while they determined which infection was making her act in such a way. I recall I was back in Corbin, KY when he

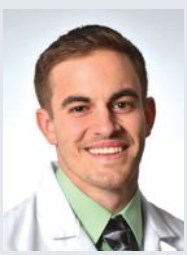
told me she had passed. Our relationship now so far beyond the clinic. As if willing to do so, his own health began to deteriorate; as though he had carried the weight of multiple cancers, heart failure and life until her passing. Soon, it was his daughter calling me with questions about his care. Not a neurologist. Not a cardiologist. She called me. She talked about dad making it to 94 or going on a final trip to Hawaii. He would counter what mattered most to him was the love he had experienced, the memories created, and the time he had shared with everyone he cared for including me. He emphasized the importance of cherishing the moments we have and of embracing the people we hold dear. He wanted me to understand that more than he wanted anything else. He passed away within six months of his wife, grateful to join her. But not without more conversations. At this point, we were as likely to talk about his memories as much as about my wife and our pregnancy. Certainly, there was fear every time he called. Fear that I might not have an answer or that it might be time to receive horrible news. But he could put all that fear away quickly with a good joke or the proclamation that I was never going to stop him dying. He made my life better as I made his better. He fanned that flame inside me for the next patient in need.

I realized I was doing exactly what I'd been shown to do as a child by those small-town doctors. This family's story is a poignant reminder that being a patient-centered provider extends beyond medical treatments. It's about honoring the choices and values of our patients and providing the support and compassion they need during their most vulnerable moments. It is nothing more than most people reading this already know.

I learned that the essence of being a personal physician is found in the shared experience of life, not in the newest medicine or procedure.

In a medical landscape that has become increasingly transactional, primary care assists people without attaching a price tag to every act of kindness. I believe the only way to truly be a patient-centered provider is to work in general practice. Sadly, I'm told daily not to lose that part of me: both from patients and from those that have lost this part of themselves. I've seen the clinics that could no longer provide this type of care and also pay their staff. Sub-specialties rarely have these problems. Hospital systems have long since lost their way. I have this inevitable sense that healthcare as we know it is already over. That I won't have this job in 15 years because it won't exist. Of course, I am here now, here with countless others, showing up and finding a way to give people what they expect: a personal physician. This award ensures I will try a little harder even if I'm only one of a vast number that deserve it.

A great thank you to the KAFP for allowing me to involve myself. Being a member allows me a voice. If we don't do something, there won't be time for those phone calls. There will be too much red tape to have a real visit with a patient. Patients will lose our personal touch and we will lose our autonomy. For those that would like to contribute to the future of Kentucky healthcare, consider being a member of the KAFP. Your dues alone contribute to our initiatives and to our influence on policy.



James Rossi, MD is a Kentucky native and Wildcat fan. He is the first physician of his family, graduating from The University of Kentucky and now in his 7th year with Family Practice Associates in Lexington and Nicholasville.

BY CHRIS ZOWTIAK, MD

The Between Place

The Between Place

In a dark, stuffy sick room
Full of waiting, the awkward watching
Of a human being lying restless
In the Between Place,
I recognize a person hovering, unsure.
I walk up close, execute the motions:
Stethoscope to skin, fingers to wrist,
Not for him,
For the beloved Watchers.
For him, I lean close and whisper my greeting,
Tell him his time is near, it's okay.
I wonder if he feels confused, lost, unsure what to do next.
I press my lips to his sweaty temple and idly think
"Infection Control would frown."
His skin is so hot, like a toddler helpless with fever,
And my thoughts stray to my 5 precious boys.
I wonder,
I hope,
Someone will kiss them and hold them like this
When I am long gone and they are grandfathers lingering
In the Between Place.
"It is time to be with your wife, it's okay,"
As I press my hand to his cheek,
This baby-boy-man-daddy-grandfather-lingerer
Finds a sudden stillness, a recognition, a focus
And breathes a long exhalation.
How did I get here, from crying in my 8 year old bed at night,
Pondering loss, anticipating grief, fearing dying,
Now Death's arbiter, its attendant,
The intimacy so sudden and shocking,
That I move away from the bed, shaking, and indicate
The Watchers should take my place?
I have delivered hundreds of babies,
And been midwife to many deaths,
Yet what a weight, what a heavy ownership
Even after all these years
In those naked moments
In the Between Place
When Life and Death and the arc in between
Ride your shoulders.

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