In the 1999 Legislative session, the Newborn Infant Hearing Screening Act became law to ensure that every baby born in Kansas receives a hearing screening within days of birth.

Kansas is one of 22 states that now mandate universal newborn hearing screening. A surge in these laws – more than doubling the number from last year – reflects the importance of the issue.

According to the American Academy of Pediatrics, significant hearing loss is one of the most common abnormalities present at birth. It is 20 times more prevalent than phenylketonuria (PKU), a condition for which all newborns are currently tested.

In the United States, the age at which significant hearing loss is identified ranges from 14 months to two years. That is far too late, according to speech and language experts. Since language develops at an explosive rate from birth to three years, late identification significantly delays speech, language, cognitive, social and emotional skills.

Lori Michel, Ph.D., director, Children’s Developmental Services, Kansas Department of Health and Environment, is the chair of the state’s Early Hearing Detection and Intervention Task Forces, a group of 50 volunteers serving on advisory, screening, assessment and intervention task forces. Volunteers represent disciplines ranging from speech and language experts to rural hospital staff and physicians.

Michel said she is pleased with the initiative the task forces and Kansas hospital personnel have shown to implement newborn hearing screening. Hospitals, she said, have been encouraged to work with audiologists to develop screening programs, while simultaneously, task force volunteers have met to develop screening guidelines that outline “best practices” for the program.

The new law took effect July 1, 1999, and several hospitals have begun screening programs while others are working toward that goal.

“Some hospitals feel that until the regulations are in place, they will wait to do the screening,” Michel said.

The screening guidelines were distributed for a statewide critique that closed in late January 2000. Issues covered in the document include testing equipment, personnel training, recommendations for hospitals with low delivery-rate and data management.

Michel said low delivery-rate hospitals, defined as hospitals that have less than 75 births a year, want to provide the hearing screening; however, “for two or five or 10 births a year, it’s not cost effective for them to buy the testing equipment.”
Accreditation with commendations

The Commission on Accreditation in Physical Therapy awarded KU’s PT program a maximum eight-year accreditation with commendations last December.

The commendations came in part when the accreditation team made a special visit to Pittsburg to judge the distance education portion of the program.

“They were very impressed with our facilities, faculty, staff and students at Pittsburg,” said program chair Chukuka Enwemeka, PT, Ph.D., FACSM.

In Pittsburg, 16 students receive classes via two-way interactive video, interactive Internet technologies and other electronic media. The program is unique because it involves the delivery of an entire clinical curriculum via modern telecommunication technologies. The program graduated its first eight students last spring. Only four of the 237 PT programs in the nation have a similar distance program.

“This report should enhance the confidence of the students in Pittsburg and their future employers and patients. It confirms that these students are getting the same quality of education that they would have at the Medical Center,” Enwemeka said.

Grants for rural networks

The Alpha Center, a nonprofit health policy center, is requesting grant applications from rural health networks. The “Networking for Rural Health” grant program, funded by the Robert Wood Johnson Foundation, is an initiative to strengthen the rural health care infrastructure.

Five grants will provide support of up to $40,000 for consulting services needed to advance a network’s substantive activities, such as expanding access to services. Another six grants will support “Network Assessment Site Visits” to help leaders profile their organization’s strengths, weaknesses and technical assistance needs.

The application deadline is Feb. 15, 2000. For more information contact Katherine Browne at the Alpha Center, 202-296-1818, or browse their Web site at www.ac.org.

El Dorado physician honored

El Dorado physician Diane Nightengale, M.D., clinical assistant professor, Family and Community Medicine, was named the American Academy of Family Physicians Exemplary Teacher of the Year in the volunteer physician category last fall.

This was the latest of several awards to honor her teaching abilities. Last spring, she received the Outstanding Volunteer Faculty Award from Wichita medical students, and was also named the Kansas Academy of Family Physicians Exemplary Teacher.

In 1998-99, Nightengale mentored six fourth-year medical students, the most of any rural preceptor. “Although she has only been in practice 10 years, she has distinguished herself as a premier clinician and teacher,” said Rick Kellerman, M.D., chair, Family and Community Medicine, KU School of Medicine-Wichita.

This was the second time in two years that the AAFP award was given to a Kansas physician. Charles Stephens, M.D., clinical assistant professor, Minneola, was the 1998 winner.

“For both Dr. Nightengale and Dr. Stephens to be honored in consecutive years indicates national recognition of the quality of medical education at KUSM-Wichita,” Kellerman said.

Publication recognized

The Kansas Connections newsletter received a Certificate of Merit award in the annual Kansas Association of Health Care Communicators Emerald Award program last November.

Judges examined three consecutive issues, beginning with the Fall 1998 issue that introduced our colorful new design. The publication was specifically praised for its good focus on the target audience and reader-friendly layout.

Publication schedule

If you would like to contribute a news item to Kansas Connections or have an idea for an article, we welcome your input. Please send information to the KU School of Medicine-Wichita, 1010 N. Kansas, Wichita, KS 67214-3199. Ideas are also welcomed by telephone at 316-293-2649; fax, 316-293-2671; or e-mail, lvalenti@kumc.edu.

Deadline for the next issue is March 21, 2000.

If you know of someone who is not receiving the newsletter but might enjoy reading it, please let us know.

From The Director . . .
Lorene R. Valentine
In physician offices across Kansas, bookshelves are lined with medical journals and textbooks. Now, another important book, “IN THEIR OWN WORDS: Stories About the Origins of Family Medicine Education At the University of Kansas School of Medicine in Wichita and Affiliated Residencies,” needs to be added.

The 289-page book, edited by Rick Kellerman, M.D., professor and chair, Family and Community Medicine, KU School of Medicine-Wichita, includes personal interviews with family medicine pioneers, and letters, stories and old newspaper clippings contributed by doctors, residents, their spouses, and KU and Kansas Academy of Family Physicians staff. It captures the feeling of the times as it documents the transition of general practice into family practice during the 1960’s and 70’s, and the key role Wichita and the state of Kansas played in the national family practice movement.

“I was concerned that if we did not document these stories, they might be lost,” Kellerman said.

He initially wanted to document the origins of family medicine education in Wichita. It was impossible, however, to extricate that history from the origins of the Kansas Academy of Family Physicians, the Department of Family Medicine in Kansas City and the national family practice movement.

Notable contributors to the book include George E. “Ned” Burket, Jr., M.D., the first president of the American Academy of Family Physicians; Gayle Stephens, M.D., founding director of the Wesley Family Practice Residency Program; and the late Gene Wilcox, first executive director of the KAFP. In all, 37 people contributed to the book.

“The people in this book are exceptional,” said Kellerman. “I learned about perseverance from them. They just kept going forward with the ideas of family practice and community-based training even when they were met with skepticism and disdain.”

“The stories are my favorite part of the book. Many people are mentioned in the book and some don’t even know they are mentioned,” he said.

The late Gerhart Tonn, M.D., past chief of medical staff, Wesley Medical Center, shared memories of a relative who treated wounds with homemade penicillin, and how he financed his education by organizing a window washing business and eventually graduated from medical school with no debt.

The book includes historical information, but some inclusions are just historically funny. Kathy Bruner, for example, wife of Steve Bruner, M.D., former St. Joseph Family Practice resident, reminisced about their residency years. “... like the time the residents took out a wall with a cast saw in the Family Practice Clinic, got into trouble from Sister Mary Anne and sold pieces of the wall to the attendings to pay the bill Sister assessed for damages.”

The book was published through a grant from the Kansas Academy of Family Physicians. You can receive a copy of “IN THEIR OWN WORDS” by designating a $100 donation to either the Department of Family and Community Medicine, or the Kansas Academy of Family Physicians-Foundation.

Checks should be mailed to KU School of Medicine-Wichita, Department of Family and Community Medicine, 1010 N. Kansas, Wichita, KS 67214, or to KAFP-Foundation, 889 N. Maize Road, Suite 110, Wichita, KS 67212.

For additional information, contact Family and Community Medicine at 316-293-2607.
Since July 13, 1999, every newborn baby at Newton Medical Center has had its hearing tested.

Newton Medical Center made its tiniest patients a priority by having an infant hearing screening program in full swing just days after the State of Kansas instituted a law mandating the testing of all newborns. The hospital is ahead of many others in Kansas because it began to develop a testing program as soon as it heard the bill was likely to pass, and because it did not wait for state issued guidelines, which are still being finalized.

Cheryl McCart, R.N.C., maternal child and surgical nurse manager, is in charge of the infant screening program. Initially, she said, “What I knew about newborn hearing screening, you could have fit on the head of a pin.” After hours of research and many talks with speech and hearing experts, McCart is well informed and has high praise for the program. “The testing is going well,” she said. “I think it’s one of the best things the state has passed.”

From July through December 1999, more than 200 babies had their hearing screened at Newton Medical Center. Two babies did not pass the test and were referred to an audiologist for further testing. According to McCart, both infants were full-term and did not possess any of the high-risk conditions associated with infant hearing loss. Therefore, their possible problems would not have been discovered without the new test.

According to the American Academy of Pediatrics, significant hearing loss is one of the most common major abnormalities present at birth. If undetected, it will impede speech, language and cognitive development. The use of high-risk questionnaires, as the state of Kansas mandated prior to July 1, 1999, can only identify 50 percent of newborns with significant hearing loss.

Newton Medical Center tests for newborn hearing loss with a high-quality system known as the auditory brainstem response (ABR). The ABR system, which measures EEG changes in response to sound, is conducted when the infant is sleeping and only takes about five minutes.

“The system we use is the same type used at the Via Christi-St. Francis campus, and was recommended by an audiologist,” said McCart.

The painless procedure involves a nurse placing headphones on the baby’s ears and taping electrodes to several areas on the baby’s head. The electrodes sense a baby’s response to sounds through the headphones. The results are recorded in a computer and interpreted by a software program that analyzes the baby’s hearing capabilities.

When a baby does not pass, a nurse sits down to talk with parents and also makes the baby a follow-up appointment with an audiologist. McCart said the nurses have been trained to explain the need for further testing and that many problems can be corrected or minimized with early interventions, such as hearing aids.

“My nurses are really compassionate and caring women,” said McCart.

Newton Medical Center has included information about the hearing screening in its prenatal booklet because it believes it is the best time to inform new mothers. “New moms are inundated with paper after a birth,” said McCart. “When women are pregnant, that is when they are hungry for information and have more time to read.”

The new program is running without a hitch, perhaps because it overcame a major obstacle while still in the planning stages. According to McCart, her original plan had been to follow the National Institute for Hearing’s guidelines for testing newborns. Those guidelines call for testing with two types of automated equipment, with the second being a back up for infants who fail the first test. Though the hospital’s medical committee supported that plan, a budgeting crisis occurred when the equipment turned out to be much more expensive than the estimate McCart had been quoted. Even when she scaled back her plan to solely use the “gold standard” ABR screening system, the new program was still considerably over budget. 

Thankfully Newton Medical Center has a philosophy that puts the patient first,” said McCart. “When I went to the committee and told them the cost was going to be twice as much as originally planned, they still approved it.

Now we know why all the newborn babies at Newton Medical Center are smiling!
CONTINUED ON PAGE 5

Low delivery-rate hospitals will likely develop protocols to have their infants hearing screened as outpatients at larger facilities. Each year less than 2,000 births occur in Kansas’ hospitals that deliver fewer than 100 babies yearly.

Technology Advances Hearing Screening

Advanced computer technology has made newborn hearing screening easy and cost efficient. Thirty years ago, audiologists identified hearing loss in infants and toddlers by careful observation of responses to sound. It was not a scientific or reliable way to diagnose mild-to-moderate degrees of hearing loss.

Later, Auditory Brainstem Response (ABR) became the preferred method to assess the auditory system. Although it was reliable, it required considerable time and expertise so its use was limited to infants who were considered high risk for hearing loss.

More recently, testing for ear “echoes” (called Otoacoustic Emissions or OAEs) became possible. Now, ABR and OAE testing have been automated with computer technology and can be used in combination or alone to screen hearing. Each system takes about five minutes or less per ear and is done while the baby sleeps.

The ABR and OAE tests screen for hearing loss, but they do not confirm hearing loss, emphasized Michel and Judith Widen, associate professor, Hearing and Speech, KU Medical Center. Working with the infants primary care physician, newborns who do not pass the hearing screening will be referred for a full assessment to confirm a hearing loss.

Michel hopes reporting data to the state about the hearing screening program will be as automated as the in-hospital screening procedures. She applied for federal grant funding that would allow the state’s electronic birth certificate system to be enhanced to include hearing screening information. The four-year grant, if received, would be awarded in April.

The Benefits of Early Detection

Members of the task forces say a massive education effort is needed to help people understand the benefits of early detection and intervention.

“The law itself speaks only to the screening, but we will fail miserably if we don’t have a plan for intervention,” said task force member Widen.

People who perform the test will need to be well-versed in hearing loss, as well as family physicians and other health professionals who will have contact with babies identified with hearing loss.

In Kansas, which has approximately 37,000 births per year, it is estimated that 110, or one-to-three babies per 1000, will have a hearing loss.

“Some physicians and other health professionals are not aware of the importance of early identification of hearing loss,” Widen said. “Not even all audiologists or ENT doctors have experience with infant hearing loss.”

Lack of experience, in most cases, said Widen, is because past systems have not done a good job of identifying newborns with hearing loss. “Traditional high-risk questionnaires used to screen for hearing loss have only identified 40 to 50 percent of babies with significant hearing loss. Doctors can go for years without seeing an infant with hearing loss,” she said.

Universal screening programs strive to identify hearing loss by three months of age and start appropriate intervention by six months. “Direct therapy is minimized by fitting babies with hearing aids early,” said Widen. “A baby as young as four weeks old can be aided.”

Physicians particularly need to be involved in assessment, said Widen. A significant number of children acquire hearing loss after birth and many parents of deaf or hard of hearing children echo stories of frustration that their most trusted health professionals dismissed their initial concerns. “If a parent expresses concern about hearing loss, they are likely to be right,” said Widen.

Support for Intervention

Once infants are identified with poor hearing, parents will need information on hearing loss, communication choices and service options.

In Kansas, 37 community-based Networks already serve infants and toddlers statewide, so these Networks, as well as family physicians, will likely see many referrals for information and service. Task force member Jane Schwartz, teacher of the hearing impaired and deaf, Rainbows United, said the state plans to provide in-service training for at least one person from each of these Networks and for other care providers as well.

A resource guide is planned too. It would be distributed throughout the state to inform caregivers as well as families. “Every family needs basic information on how to get started, who to contact, what are the communication choices,” said Schwartz.

By hosting in-service training and developing the guide book, Schwartz said, “Rural areas will have the materials and training to be able to provide the same service that urban areas afford.”

Resource Links

Marion Downs National Center for Infant Hearing
http://www.colorado.edu/slhs/mdnc

National Center for Hearing Assessment and Management
http://www.infanthearing.org

Sounds of Texas Project
http://www.tdh.state.tx.us/audio/audiology.htm
The fourth annual Kansas Practice Opportunities Conferences last fall attracted more than 188 medical students and residents interested in learning more about practicing in rural Kansas. Those attending the annual Kansas Practice Opportunities Conferences, held in Kansas City and Wichita, were able to get information from exhibitors representing 24 communities and their practice opportunities. In the afternoon, panel discussions on the “Anatomy of a Successful Practice Match” answered attendees’ questions about locating in rural areas.

The conferences help carry out the mandate of the Kansas Legislature that the mission of KU Medical School be to supply physicians to all parts of the state, according to Lorene Valentine, director, Rural Health Education and Services.

“Students who matriculate from here choose primary care, and a large percentage of those go into residency with the hope they’ll return to Kansas,” she said.

The panel discussions were moderated by KU School of Medicine faculty Rick Kellerman, M.D., professor and chair, Family and Community Medicine; and Maureen Dudgeon assistant professor, General and Geriatric Medicine. Panel members included Randy Mijares, M.D., WaKeeney; John Moore, administrator, Hiawatha Community Hospital; Robert Moser, M.D., Tribune; David Phelps, M.D., Fort Scott; Jackie John, vice president for resource development, Great Plains Health Alliance, Phillipsburg; Mary Beth Miller, M.D., St. Francis; and Sarah Ragsdale, D.O, resident, Olathe Family Practice Residency Program.

“It’s never too early to get started looking,” advised Miller, the mother of three, who always knew she wanted to practice in a small town. Her spouse is from St. Francis so the northwest Kansas community was a logical choice for her.

Other panel members had no such intention. “Being in WaKeeney and being an internist was the furthest thing from my mind,” said Mijares, who expected to be a big-city cardiologist. Being a physician in a rural community hadn’t even been an option, but he now touts the advantage of smaller communities.

Mijares had covered weekends in WaKeeney, which ended up making him an offer he couldn’t refuse. He and his wife decided to try it for a year.

“Six months into it we started looking for a place to build a house,” Mijares said, with a laugh. They now have an 18-month-old baby, a home in the country and a lifestyle they wouldn’t trade for anything. His wife, who is from Wichita, also had never considered living in a rural area.

Selling spouses on the idea is as important as recruiting the physician, pointed out John, who works with a consortium of 26 rural hospitals.

“Many spouses are professionals and that can be a barrier,” she said. “You need to treat the spouse as a person and not an appendage. They also experience stress in building a practice.”

When a male student from the audience questioned whether it would be difficult for a single person to relocate to a rural community, John light-heartedly replied, “People will be very interested in helping you find just the right relationship,” but then acknowledged the reality of being single in a family-oriented rural environment without city entertainment options.

Mijares added, however, that he would have moved to WaKeeney even if he’d been single.

Moser recommended a community recruiting committee to organize community and family activities. “You need to talk about something besides medicine (to the spouse),” he said.

“Coming to a small community is an enriching experience, not a limitation,” Phelps added. “It didn’t take long for my wife and I to become involved. Look for key things in the community that will make you both happy.”

Other concerns raised by those attending were having no nearby physicians to help with consultations or emergencies as well as treating friends and acquaintances.

Phelps said it was possible to keep the roles of physician and friend separate if needed, and Moser said the “Oh, by the way, Doc” syndrome really didn’t bother him. “It’s all part of being in a small town.”

But the small-town climate has its advantages, even when there’s an emergency, Miller noted. “It’s a whole different climate than in the city,” she said. “People come out of the walls to help in an emergency. It doesn’t matter who’s on call.”

Miller, who has been practicing about six months, said the isolation was her biggest fear. “There were no colleagues to run things past,” she said. But with
Retired Rural Physicians Make Endowments

The communities of Greensburg and Kingman aren’t too far apart on the map, and their retired physicians aren’t too far apart in their thinking either. Both men, and their wives, have made endowments to the Department of Family and Community Medicine Department at the KU School of Medicine-Wichita.

J. Roderick Bradley, M.D., and his wife, Shirley D. Bradley, R.N., Greensburg, established a charitable remainder trust of $50,000 to finance scholarships, purchase equipment or meet other needs determined by department leaders.

Likewise, George E. (Ned) Burket, Jr., M.D., and his wife, Mary E. Burket, Kingman, donated $45,000 to establish two endowment funds. A $25,000 endowment will be used to purchase books, journals and teaching modalities for use in family medicine education; and a second $20,000 fund will endow the Distinguished Ned Burket Student Award, which Family and Community Medicine gives each year at graduation.

Dr. Bradley, a native of Greensburg, received his bachelor’s degree from KU in 1945 and a medical degree in 1947. He established his Greensburg practice in 1950 and served as a School of Medicine volunteer preceptor for 35 years.

Shirley Bradley served as a scrub nurse for surgeries Dr. Bradley and his partner, Melvin Waldorf, M.D., performed at Kiowa County Memorial Hospital.

“Dr. Bradley was my family physician when I was a kid in Greensburg,” said Rick Kellerman, M.D., chair, Family and Community Medicine, KU School of Medicine-Wichita. “He was a fantastic role model for me as a child growing up. He inspired many of my Kiowa County schoolmates to pursue careers in medicine. Now, he and his wife are inspiring a new generation with this generous gift. The department and the school are deeply grateful,” he said.

Dr. Burket is a 1937 graduate of the KU School of Medicine. He practiced in Kingman for 32 years and was a preceptor for 23 years. He was a KU School of Medicine-Kansas City faculty member from 1973 until his retirement in 1981.

Dr. Burket was a key figure in the movement to define family practice as a distinct specialty and served as a consultant to the committee that developed the KU Department of Family Practice. He holds the honor of being the first president of the American Academy of Family Physicians and was also elected to the Institute of Medicine Academy of Sciences in 1975.

Dr. Bradley, a native of Greensburg, received his bachelor’s degree from KU in 1945 and a medical degree in 1947. He established his Greensburg practice in 1950 and served as a School of Medicine volunteer preceptor for 35 years.

John advised the students to be honest about what they want to do. “Don’t try to fit a square peg into a round hole,” she said.

Miller agreed. “Don’t settle,” she said. “You’re not doing yourself a favor and you’re not doing the community a favor. You can find a niche.”

Loan forgiveness is sometimes available and can be used as a negotiating tool, Mijares noted. But even if that’s not available, a rural practice can make enough to pay off loans, he said.

But the money isn’t everything. “You should also examine the community dynamic,” he said. “Money doesn’t equate to happiness if it’s not a good practice match.”

After 20 years of clinical experience, Phelps told the group: “Looking back, I wouldn’t trade anything.”

practice, comes confidence. “It’s a very freeing experience. I didn’t think I had enough experience. But you will find the colleagues you need. You’ll find you’re not as isolated as you thought it would be.”

Moser agreed: “Don’t rule out rural practice just because you think it’s too hard. You do know enough to practice out there even without the latest equipment and consultations. Don’t dismiss it because of fear. You can handle it.”

Mijares recommended covering in a community for a weekend if a physician is interested in locating there. “There is no better way to know except by being there,” he said. “You can get to know the staff, other docs, emergency room, patients. By far the best way is to spend a weekend there.”

When looking for a new physician, communities search for someone who is good with people as well as a good physician and someone who can work as part of a group, Phelps said.

John advised the students to be honest about what they want to do. “Don’t try to fit a square peg into a round hole,” she said.

Miller agreed. “Don’t settle,” she said. “You’re not doing yourself a favor and
Kansas’ veterans are reaping the benefits of a reformed Veterans Health Administration that has dramatically increased access to care. The key to this reformation is community-based clinics.

Kenneth Kizer, M.D., M.P.H., under secretary for health, VHA, began a successful transformation of the veterans health care system in 1995, and it continues today. He stressed that in order to remain viable, the VHA had to embrace a “Patients First” focus.

The number of veterans seen monthly at the clinics range from 250 in Liberal to 700 in Dodge City and 900 in Hays. Parsons is expected to have a monthly patient load of nearly 1,800.

Since October 1996, patients have witnessed a big difference. The VHA has opened more than 200 community-based clinics in the United States and overhauled its health care eligibility criteria to allow all veterans access to the system.

In this new era of care, traditional VA hospitals, such as those in Leavenworth, Topeka and Wichita, remain an important, but less central component of a community-based network of care. The community-based approach addresses the health care environment’s shift from inpatient to outpatient care in recent years.

In Kansas, the way community-based care is being delivered depends on location. The Colmery-O’Neil VA Medical Center, Topeka, has contracted with rural hospitals for clinic space to which it sends its own medical teams. These teams consist of a physician assistant, nurse, social worker and administrative support person.

The Topeka VA opened its first community-based clinic in Chanute in January 1998. It systematically brought nine additional clinic sites on board in Abilene, Emporia, Fort Riley, Garnett, Holton, Junction City, Lawrence, Russell and Seneca. All of these operate out of the local hospitals.

“The administrators at these smaller regional hospitals have welcomed us with open arms,” said Bonnie Riley, L.M.S.W., program supervisor for medical outreach teams, Colmery-O’Neil VA Medical Center.

Riley said, “We feel we have an edge by providing our own staff which specifically serves veterans. We provide mental health services at every site.”

The Topeka VA allows veterans access to its community-based clinics after a primary care physician at the VA hospital has seen them. “If someone wants to be seen in a satellite clinic, they must ask their primary care physician for permission. It ensures that we don’t see critical patients,” said Riley.

Veterans who receive care from the traveling medical teams are clearly satisfied. In a survey conducted by Riley, out of more than 250 responses, there were virtually no complaints. “It’s almost been unbelievable,” she said. “A lot of our people are elderly, which makes it more difficult for them to travel, so they really appreciate the community services.”

The number of days an outreach clinic is open depends on need. In Chanute, the clinic operates five times a month. Other sites are open between two and three times a month.
The Wichita VA Medical Center has taken a slightly different approach to community-based care in the areas in its jurisdiction. “We go into a community and see if a provider wants to establish a contract with us to provide primary care services. We don’t want to be in competition with local providers,” said Jim Cole, staff assistant to the Wichita VA director.

In communities where a local provider cannot be established, the Wichita VA hires local health professionals to staff its community-based clinics. They receive their training at the Wichita VA Hospital so that they are familiar with the entire VA system.

Currently, the Wichita VA has established outreach clinics in Dodge City, Liberal and Hays. It plans to open another clinic in Parsons in February. The number of veterans seen monthly at the clinics range from 250 in Liberal to 700 in Dodge City and 900 in Hays. Parsons is expected to have a monthly patient load of nearly 1,800.

Unlike the Topeka system, Cole said veterans enter any of the Wichita-managed community-based sites without being seen by a VA hospital physician. One reason Cole feels confident about this practice is because the VHA has all medical records online. “The electronic medical record is great because it links the 173 VA hospitals in the nation. The people in Hays can call up any veteran’s medical record in a matter of seconds,” he said.

The electronic medical record allows continuity of care from any location. It can be used to enter progress notes, consultation requests and charges for each veteran. It can also track preventive care, identify patient risk factors and even generate patient education handouts.

The Topeka VA medical teams, as well as contracted personnel, say the electronic medical record allows everyone to be informed and have all pieces of information needed to provide the best care for veterans. “It’s very much a consultative process,” said Riley.

When the Hays clinic was preparing to open a year ago in October, a town hall meeting drew more than 400 people. A similar meeting in Ness City packed its community building as well. “Community clinics improve their access to health care,” said Cole, who noted that since patients are seen close to their homes, the weather is no longer a factor.

About 25 percent of the veterans using community clinics are new to the VA health care system, said Cole. These veterans are using the system because of the ease of access and because an eligibility law passed in 1996 eliminated many cumbersome eligibility rules. Now, any honorably discharged veteran may seek care in the VHA system.

“The veterans service organizations are very pleased. We think it’s a win-win situation for all,” he said.

The Dwight D. Eisenhower VA Medical Center, Leavenworth, which covers parts of Kansas and Missouri, began focusing on community-based care in November 1998. It has opened three clinics in Missouri and one in Louisburg, Kan. The Leavenworth VA followed Topeka’s lead in choosing to send its own medical teams to staff the clinics.

According to Cole, providing health care in communities is a top goal of the entire VHA. Veterans who are interested or have questions about the community-based clinics can call 1-800-574-8387 for more information.

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VA Health Care In Kansas

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VA Medical Centers
- Wichita - Wichita VA Medical Center
- Topeka - Colmery-O’Neill VA Medical Center
- Leavenworth - Dwight D. Eisenhower VA Medical Center

Community-based VA Clinics

Future Community-based VA Clinics
Physicians Encourage Kids To Be Tobacco Free

More physician-volunteers needed for school program

Star Wars was fought in outer space. Tar Wars is being fought in the classroom.

Unlike the galactic war in the George Lucas film, Tar Wars is not fictional. It is a nationally recognized education program to fight tobacco use among youth. The American Academy of Family Physicians, along with the Kansas Academy of Family Physicians, sponsors the program.

Tar Wars presentations combat the fact that every day 3,000 children try tobacco for the first time. For many, tobacco use becomes a lifelong addiction.

Carolyn Gaughan, executive director, KAFP, said youth in Kansas, specifically fifth graders, traditionally hear the pro-health tobacco free lesson from family doctors. Now, however, the KAFP has partnered with the KU School of Medicine-Wichita to involve future physicians. Fourth year medical students are required to make at least one Tar Wars presentation on their family practice rural rotation.

“The idea is that the presentation is a way for students to give back to the communities that host them, plus it is an active way to participate in the concept of community health,” said Rick Kellerman, professor and chair, Family and Community Medicine.

Even with the addition of medical students, Gaughan said more volunteer instructors are needed. This year, rather than relying on physicians to make contacts with schools, the KAFP promoted the Tar Wars program to school districts. The response has been so great that there are 2,600 children, many who attend rural schools, who could potentially hear the Tar Wars message if enough instructors are found.

The need for instructors is accentuated by the fact that 20 percent of middle school students in Kansas are current users of tobacco, according to the 1999 Kansas Youth Tobacco Survey, a report sponsored by the Kansas Department of Health and Environment in cooperation with several other organizations. The report provides baseline information that will be vital in monitoring trends and evaluating the impact of tobacco-use prevention programs such as Tar Wars.

The Tar Wars lesson takes 45-to-60 minutes to present. It focuses on the short-term effects of tobacco use, the reasons people use tobacco and the images that tobacco companies use to market their products. The Tar Wars program is interactive and encourages student participation. For one activity, Gaughan said children are given drinking straws to breathe through while holding their noses. The students breathe standing in place and then running in place. “It demonstrates that when people smoke, they lose the ability to hold enough oxygen and have difficulty breathing,” she said.

The KAFP supplies the instructor and the school with a curriculum guide. Gaughan said most physicians, or other health professionals, can be ready to present the curriculum with 30 minutes to an hour of preparation.

Following the presentation, students are invited to design posters that express the positive effects of not using tobacco products. Schools are encouraged to send their top three entries to a state competition sponsored by the KAFP.

In 1999, after hearing a presentation by Marla Ullom-Minnich, M.D., Moundridge, fifth grader Matthew Stucky, Moundridge Middle School, won first place in the Academy’s state poster contest. His entry went on to win the national Tar Wars poster contest in Washington D.C., which had a grand prize of a family vacation to Disney World worth up to $2,500.

To sign up to be a school presenter, please contact Marina Spexarth, Tar Wars coordinator, KAFP, at 1-800-658-1749.

At press time, instructors were still needed in the communities of Andover, Augusta, Coffeyville, Derby, Dodge City, Edgerton, Ft. Riley, Goddard, Halstead, Holton, Independence, Junction City, Lakin, Leawood, Manhattan, Medicine Lodge, Overland Park, Paola and Smith Center. In some cases, multiple presenters are needed for a single school because 200 to 500 children are slated to participate in the program.

<table>
<thead>
<tr>
<th>PERCENTAGE OF STUDENTS WHO SMOKE</th>
<th>6TH GRADE</th>
<th>7TH GRADE</th>
<th>8TH GRADE</th>
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<tr>
<td>6TH GRADE</td>
<td>11.4</td>
<td>14.5</td>
<td>21.4</td>
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Youth Smoking

The prevalence of cigarette smoking increases with increasing grade level. The percentage of eighth graders who smoke cigarettes is almost twice that of sixth graders.

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
1999 KANSAS YOUTH TOBACCO SURVEY REPORT

Don’t Light the Fire

- A sixth of all deaths — 434,000 a year in America — are attributable to smoking.
- Three in five smokers who undergo surgery for heart disease continue to smoke.
At the KU School of Medicine-Wichita, patients are helping train future physicians. These patients, however, are more akin to actors than actual patients. They are participants in the Standardized Patient Program.

A “standardized patient” is a healthy person who has been trained to consistently portray the symptoms and emotions that accompany various medical conditions. By simulating an illness or condition, a standardized patient allows medical students to practice every aspect of their training from bedside manner to clinical diagnosis.

In Wichita, the KU School of Medicine uses a Standardized Patient Program to expose third-year students to difficult cases that might not be seen in community-based physicians offices. “This program lets us be sure that every student sees the kinds of cases that faculty feel are crucial,” said Doug Woolley, M.D., associate professor, Family and Community Medicine.

For example, he said, it is important that students learn to give patients troubling news, discuss sexuality, be sensitive to ethnic populations and recognize family conflict situations.

To teach lessons such as these, Woolley and other Family and Community Medicine faculty developed more than a dozen case scenarios for patients to portray. The volunteers are asked to portray patients who have similar backgrounds, age and physical characteristics to those in the case scenarios.

It takes about three one-hour training sessions before a volunteer is ready to see students, said Jackye Feldman, R.N., teaching associate and standardized patient coordinator, Family and Community Medicine, who has trained a cadre of 30 people to be standardized patients.

Most volunteers portray only one character, but as the program grows, Feldman intends to enroll more volunteers as well as ask some to learn more than one case. “I have to be careful that a student doesn’t see the same person as a different patient—to keep up the realism,” she said.

The School of Medicine has three rooms in which students see standardized patients. The rooms replicate actual exam rooms, except these are equipped with small cameras. The cameras, which can be adjusted remotely, permit faculty to observe the physician-to-patient interaction as it takes place. The visit is also recorded on video for the student to privately review later.

“Every standardized patient case demands that students use significant clinical knowledge as well as problem-solving skills at clinical, interpersonal and social levels,” said Woolley.

Students see two to three patients consecutively, as they would in real practice. Then, they gather with faculty to review each case in detail. In addition to the verbal feedback, faculty and standardized patients record their thoughts in writing.

Feldman said students appreciate and learn from the comments made by standardized patients. One constructive criticism for a student, for example, was that his handshake was very firm, but too firm for the standardized patient’s arthritic hand.

Carol Moreland, Wichita, has been a standardized patient since the program’s inception. As a self-described “ham,” she has found her appointments with students to be both relaxing and fun. She said the students keep her from getting bored with her scenario because someone invariably asks something new.

Though each medical student’s performance with a standardized patient is not graded, it could be in the future. The National Board of Medical Examiners has plans to incorporate standardized patients into its testing. In fact, the School of Medicine is one of more than 30 pilot sites that the

CONTINUED ON PAGE 12
NBME is working with to develop and perfect this future exam.

“I think that within three years, standardized patients will be part of board examinations, so there will need to be formal test sites in every region of the United States,” said Woolley.

Because of Wichita’s central location, it would be an ideal site for the testing of students from several south central U.S. medical schools, said Wooley.

Just within the city of Wichita, the standardized patient program is proving useful to other institutions. Last November, the trained patients and special facilities were used for the first time by the Wichita State University Family Nurse Practitioner Program to test nurses’ clinical skills.

Also, the standardized patient program is helping foreign medical graduates hone their skills before taking the exam administered by the Education Council for Foreign Medical Graduates.

Feldman and Woolley agree that the standardized patient program is a great teaching tool. If you, or someone you know, would be interested in being a standardized patient, please contact Family and Community Medicine, KU School of Medicine-Wichita, 316-293-2607.

Wooley noted that a small stipend is given to each standardized patient for the time he or she spends in training and in the simulation office visits.

Third year medical student Kate Gilliland meets with a standardized patient who simulates an illness to help Gilliland hone her clinical skills.
NORTHWEST
CITY: Atwood
POSITION(S): Medical Records Tech or Medical Transcriptionist
CONTACT: Don Kessen/Delma Jenick, 785-626-3211

CITY: Hays
POSITION(S): Orthopedic Physician (spine), Pathologist, Pediatrician, Physical Medicine and Rehabilitation Physician
CONTACT: Myron Applequist, 785-623-5753

CITY: Hays
POSITION(S): Step-Down ICU Registered Nurses, ICU Nurses, Medical/Surgical Nurses
CONTACT: Julie Huelsman, 800-690-1560

CITY: Hoxie
POSITION(S): Family Physician
CONTACT: Brian Kirk, 785-675-3281

CITY: Phillipsburg
POSITION(S): Family Physician, Internist, Pediatrician
CONTACT: C.D. Knackstedt, D.O., 785-543-5800

CITY: Phillipsburg
POSITION(S): Family Physician w/OB, Internist w/OB
CONTACT: Rhonda Kellerman, 785-543-5211

CITY: Phillipsburg
POSITION(S): Family Physician
CONTACT: Mark Bieberle, 316-291-4378

CITY: Russell
POSITION(S): Family Physician w/OB
CONTACT: Earl D. Merkel, M.D., 785-483-2178

CITY: Russell
POSITION(S): Family Physician w/OB, General Surgeon, Plastic Surgeon
CONTACT: Bruce Garrett, 785-483-2323

NORTHEAST
CITY: Blue Rapids
POSITION(S): Family Physician
CONTACT: Kenneth Duensing, D.O., or William Buck, M.D., 785-363-7292

CITY: Clay Center
POSITION(S): Family Physician (OB preferred but not required)
CONTACT: Ray Frigon, 785-632-2181

CITY: Concordia
POSITION(S): Family Physician w/OB
CONTACT: Cathy Dunham, 785-243-4272

CITY: Emporia
POSITION(S): Family Physician, Orthopedic Surgeon, Psychiatrist
CONTACT: Terry Lambert, 316-343-6800, ext. 601

CITY: Horton
POSITION(S): Family Practice Physician w/OB
CONTACT: Ty Compton, 785-486-2642

CITY: Lawrence
POSITION(S): Obstetrician/Gynecologist, Oncologist
CONTACT: Charlene Droste, 785-840-3155

CITY: Lawrence
POSITION(S): Family Physician w/OB
CONTACT: D.A. Strathman, 785-749-6133

SOUTH CENTRAL
CITY: Anthony
POSITION(S): Family Physician
CONTACT: Cindy McCray, 316-842-5111

CITY: Conway Springs
POSITION(S): Dentist, Optometrist
CONTACT: Ruth Busch, A.R.N.P., 316-456-2411

CITY: El Dorado
POSITION(S): General Surgeon, Pediatrician, Otolaryngologist
CONTACT: Jim Wilson, 316-322-4557

CITY: El Dorado
POSITION(S): Social Worker (Part-time)
CONTACT: Gay Kimble, 316-322-4568

CITY: Ellinwood
POSITION(S): Family Physician w/o OB or OR, Pharmacist
CONTACT: Marge Conell, 316-564-2548

CITY: Halstead
POSITION(S): Pharmacist
CONTACT: Mary Heaton, 316-835-4606

CITY: Halstead
POSITION(S): Family Physician, Cardiologist, Internist, Pulmonologist/Critical Care
CONTACT: Ron Lawson, 800-475-1042

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<tr>
<th>CITY</th>
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<tr>
<td>Hutchinson</td>
<td>Nuclear Medical Technologist, Registered Vascular Technologist, Clinical Pharmacist, Echo Technologist, Medical Technologist, Registered Nurse (Cath Lab), Cath Lab Technician</td>
<td>Loretta Fletchall, 316-665-2032</td>
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<tr>
<td>Hutchinson</td>
<td>Family Physician w/o OB</td>
<td>Sally Tesluk, 316-663-8484</td>
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<tr>
<td>Hutchinson</td>
<td>Cardiologist, Rheumatologist, Urologian</td>
<td>Lynn Harris, R.N., 316-669-2579</td>
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<tr>
<td>La Crosse</td>
<td>Family Physician w/OB, Part-time R.N.'s</td>
<td>Craig Hanson, 316-382-2177</td>
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<tr>
<td>Pratt</td>
<td>Family Physician, Orthopedic Surgeon, Radiologist</td>
<td>Susan Page, 316-672-6476</td>
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<tr>
<td>Salina</td>
<td>Pediatrician</td>
<td>Dirk Hutchinson, 785-827-9631</td>
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<td>Salina</td>
<td>Internal Medicine</td>
<td>Darrell Wilson, 785-822-0251</td>
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<tr>
<td>South Haven</td>
<td>Family Physician</td>
<td>Roger Cox or Marilyn Flanders, 316-892-5513</td>
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<tr>
<td>Stafford</td>
<td>Family Physician</td>
<td>Douglas Newman, 316-234-5221</td>
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**SOUTHWEST**

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<tr>
<td>Dodge City</td>
<td>Family Physician, Internist, Pulmonologist</td>
<td>Howell Johnson, M.D., 316-227-1371</td>
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<tr>
<td>Elkhart</td>
<td>Nurse Anesthetist</td>
<td>Rhonda Boone, 316-697-5229</td>
</tr>
<tr>
<td>Garden City</td>
<td>Internist, Orthopedist, Oncologist, Pediatrician, Dermatologist, Anesthesiologist</td>
<td>Jeff Forrest, 316-272-2422</td>
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<tr>
<td>Garden City</td>
<td>Director of Nursing</td>
<td>Pam Selman, 785-222-2545</td>
</tr>
<tr>
<td>Lakin</td>
<td>Nurse Anesthetist to work in Lakin, Leoti, Tribune and Syracuse</td>
<td>Laura Dykstra, Steve Reiner, 316-355-7111</td>
</tr>
<tr>
<td>Larned</td>
<td>Family Physician</td>
<td>Scott Chapman, 800-657-5733</td>
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<td>Lakin</td>
<td>Family Physician</td>
<td>Ed Finley, 316-375-2233</td>
</tr>
<tr>
<td>Liberal</td>
<td>Otorhinolaryngologist</td>
<td>Kim Harris, 316-629-6335</td>
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<tr>
<td>Minneola</td>
<td>Family Physician</td>
<td>Ron Baker, 316-885-4264</td>
</tr>
<tr>
<td>Ness City</td>
<td>MT/MLT Laboratory Personnel</td>
<td>Clyde T. McCracken, 785-798-2291</td>
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<tr>
<td>Eureka</td>
<td>CFO, Materials Manager</td>
<td>Mellissa Campbell, 316-583-7451</td>
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<tr>
<td>Eureka</td>
<td>General Surgeon</td>
<td>Emmett C. Schuster, 316-583-7451</td>
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<tr>
<td>Fredonia</td>
<td>Family Physician</td>
<td>Mark Bieberle, 316-291-4278</td>
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<td>Girard</td>
<td>Family Physician</td>
<td>Gene Sallsbury, 316-724-8291</td>
</tr>
<tr>
<td>Parsons</td>
<td>Family Physician</td>
<td>Darren Allison, 316-331-8855</td>
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<tr>
<td>Pittsburg</td>
<td>Primary Care Physician</td>
<td>Lisa Deines, 316-235-3527</td>
</tr>
<tr>
<td>Pittsburg</td>
<td>Staff Pharmacist</td>
<td>Jody Henderson, 316-232-0147</td>
</tr>
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**NOTE:** To list practice opportunities in Kansas Connections, please mail or fax a Kansas Practice Opportunities form to the Office of Rural Health Education and Services, 316-293-2671. Forms are accessible through the Rural Health Web site, http://ruralhealth.kumc.edu, or by calling at 316-293-2649.