

Arkansas AFP Annual Scientific Assembly June 14-16, 2012
Pre Assembly Course June 13, 2012 Doubletree Hotel, Little Rock

The ARKANSAS FAMILY PHYSICIAN

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Correspondence, articles, or inquiries should be directed to:
ARAFP, 11330 Arcade Drive, Suite 8,
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Instate Toll-Free: 1-800-592-1093
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Edition 58



Dear Academy Member,

As we begin another year, we focus our efforts on membership in the AR AFP. One of the areas we will be looking at will be membership recruitment and retention. A strategic planning session will be held in February at our regularly scheduled meeting of the board to plan for not only short term but long term for membership and for financial stability.

As usual, we would like your input! If you have suggestions for us to be more member friendly, how we can best represent you and areas that you would like our Board to focus on, please email our office!

We have as usual a lot going on! The Arkansas Chapter will host the Annual Multi State Meeting February 18-19 in Dallas. Maybe it is a sign of my age or I would like to think rather a sign of my nearly 30 years with the AAFP, but I am the only original member of the Multi State Meeting which began in 1986! The meeting will be held on Saturday afternoon and Sunday morning and will offer 5.5 hours of AFP Prescribed Credit. The meeting is attended by more than 50 officers, directors and chapter execs of 12 state chapters of the AAFP and we always learn something from each other!

A new website is now being developed that will be ready for you in January! It will be something to be proud of and offer you glimpses of national headlines, a direct link to the AAFP for a look at your hours and dues as well as Arkansas news of importance to you. We plan on posting lots of pictures of our members from meetings and events with updates on our Patient Centered Medical Home pilot programs in Heber Springs, Van Buren and DeQueen and our Journal will also be online for your convenience!

With our Annual Scientific Assembly being more than one month earlier in 2012 than usual, we hope that you will mark your calendars now and be with us at the Doubletree Hotel for another great CME event! At your request, we have changed the days too, not just the month and will begin the Assembly on Thursday June 14 and conclude on Saturday at Noon. For those of you that need additional hours and have the time to take, we will have an optional half day CME program on Wednesday, June 13 preceding the Annual Meeting. Dr. Rick Madden of New Mexico who is a member of the AAFP Board of Directors will be with us to install our officers and provide an update on the AAFP. Please plan to be with us June 14-16, 2012 for our Annual Scientific Assembly and for the Pre Assembly on June 13! The official program will be available in February.

On behalf of our officers and directors, we wish each of you a Merry Christmas and a safe and happy Holiday Season and New Year!! Thank you for being a member!!

Sincerely,

Carla Coleman
Executive Vice President

COVER IMAGE:

Ozark Mountain Barn in Winter.

The Arkansas Practice-Based Research Network

The health status of adults and children in Arkansas has been ranked 47th among the states (United Healthcare State Health Rankings, 2010) - the third worst in the US. Considering Arkansas' children only, Arkansas is ranked 49th (Macy Foundation, 2010). Arkansas' poor health rankings are based on the known relationship between health and a wide array of risk factors including the population's low educational level, poverty, crime, occupational and environmental hazards, and harmful lifestyle. There are also substantial health disparities in the state that place a proportion of the population at even higher risk for cancer, diabetes, and obesity.

The poor health status of Arkansas has generated an interest in improving our health status in innovative ways such as expanding the family physicians' capacity and effectiveness to address the state's health priorities. The University of Arkansas for Medical Sciences (UAMS), Division of Research and Practice Improvement chose to make use of a practice-based research network (PBRN), named the Arkansas Practice-Based Research Network (APBRN), as an organizational approach to test quality improvement and innovations in primary care offices throughout the state. Established in 2010 with support and direction from D. Mark Mengel, Vice Chancellor for Regional Programs and UAMS Chancellor Dr. Dan Rahn, the APBRN has conducted an organizational meeting with community providers, UAMS faculty and other institutional parties.

The Arkansas Practice-Based Research Network's (APBRN) mission is to support its members as they plan, conduct, and evaluate research and practice improvement projects and disseminate findings to improve the health of Arkansans. The APBRN is recruiting a network of members drawn from family medicine and other primary care practices statewide to assist in quality improvement and practice-based research initiatives. Nation-wide, there is increasing emphasis by federal health agencies to translate biomedical breakthroughs to

the primary care and community setting. The APBRN will serve as a structured access point between members from family medicine and faculty researchers from UAMS and other Arkansas institutions of higher education, staff from public health agencies, and community members to test novel ways to improve primary care treatment and prevention of many chronic diseases. The APBRN will provide resources to enhance the translation of these advances in biomedical sciences, sociology, public health, health organization management, informatics, nursing, and/or behavioral science into primary care office settings. Additionally, the APBRN will plan to become active in transitioning through the patient centered medical home (PCMH) and meaningful use requirements.

Benefits of APBRN Membership:

The APBRN leadership and staff will provide guidance to family medicine clinicians who are interested in practice-based research and quality improvement projects designed to improve the health of Arkansans by improving primary care delivery systems. Benefits of membership include:

- Structured access point for mutually beneficial collaborations between members and clients
- Incentives and/or monetary reimbursement for research project participation
- Resources and tools for designing, developing, implementing and evaluating practice-based initiatives
- Opportunities for local, state and national collaborations
- Access to practice-relevant CME related to meaningful use and patient centered medical home
- Quarterly APBRN newsletter, bulletins and email listserv

The APBRN will aid clinical sites in regulatory paperwork and processes required to participate in biomedical/behavioral research and quality improvement projects. Many family physicians have creative ideas about how to use their clinical skills and

community relationships to enhance quality of chronic disease management and preventive services in their practices. The APBRN supports and encourages physicians to take active roles in advancing practice improvement and sharing their knowledge among peers. The APBRN will assist teams in identifying financial resources to support quality improvement and office based clinical research projects. Additionally APBRN will assist in dissemination of findings and advancements throughout the state.

How to join:

Membership in the APBRN is voluntary and is open to any clinically active, primary care clinician (MD, DO, RN, PA, NP) whose practice is based in Arkansas. Primary care clinicians who meet these criteria may become members by agreeing to supply initial information about themselves and their practice through the APBRN Member Survey available on our website. APBRN strives to develop a reputable and sustainable practice-based research network to meet the demands of the evolving health care environment. The network encourages enhanced clinician involvement in practice-based initiatives with an emphasis on building robust state and national collaborations. A staff member from the APBRN is available to visit family practices to explore their interest in medical office based quality improvement and clinical research projects. Family physicians, their office managers, or quality improvement coordinators are invited to contact us for more information at 501-686-6195 or apbrn@uams.edu. Visit us online: www.ruralhealth.uams.edu/apbrn and www.facebook.com/apbrn

Robert Price, PhD, Director,
rdprice@uams.edu
Geoffrey Goldsmith, MD, Co-Director,
goldsmithgeoffrey@uams.edu
Marcia Byers, BSN, Assistant Director,
mabyers@uams.edu
Zuzana Gubrij, MA, Research Manager,
zgubrij@uams.edu

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CoxHealth is seeking BE/BC family medicine physicians in Cassville and Shell Knob, Mo.

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CMS Medicaid EHR Program

On Monday, November 7, 2011, the Medicaid Electronic Health Record (EHR) Incentive Program launched in Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota. This means that eligible professionals (EPs) and eligible hospitals in these six states will be able to complete their incentive program registration. More information about the Medicaid EHR Incentive Program can be found on the Medicare and Medicaid EHR Incentive Program Basics page of the CMS EHR website.

If you are a resident of Arkansas, Delaware, Montana, New Jersey, New York, or North Dakota, and are eligible to participate in the Medicaid EHR Incentive Program, visit your State Medicaid Agency website for more information on your state's participation in the Medicaid EHR Incentive Program.

As of Monday, November 7, 2011, 39 states have launched Medicaid EHR Incentive Programs; and through October, 23 states have issued incentive payments to Medicaid EPs and eligible hospitals who

have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

For a complete list of states that have already begun participation in the Medicaid EHR Incentive Program, see the Medicaid State Information page on the CMS EHR website.

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that flu seasons are unpredictable and can be severe. Each year, it is estimated that 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations

occur in people 65 years and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. And remember, vaccination is important for healthcare workers too, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. **Get the Flu Vaccine—Not the Flu.**

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and <http://www.cms.gov/immunizations>.

New Physician Retention Campaign Results

In a continuing effort to meet the demands of our new physician members (those in practice seven years or less following residency completion), a targeted retention campaign was implemented in April for approximately 16,000 new physician

members. To gain insight into new physician members' goals and values, the theme of the campaign was "What Great Things Will You Do?" The new physicians were asked two questions, "What Great Things Will You Do" and "How Can the AAFP Help You?"

Nearly 750 responses were received and 734 new physicians updated their contact information. The campaign also collected 2011 membership dues for 68 new physicians – 6 in Arkansas!!

NHSC Students to Service Loan Repayment Pilot Program 2012 application cycle is now open!

The National Health Service Corps (NHSC) Students to Service Loan Repayment Program (S2S LRP) application cycle is now open!

We hope that you will help us spread the word about the program and the opportunities available to fourth-year medical students pursuing a career in primary care and who are committed to serving areas with

limited access to care.

NHSC S2S LRP recipients receive up to \$120,000 for three years of full-time or six years of part-time service. Upon completion of residency, S2S LRP recipients serve as primary care providers in an NHSC-approved site in a high-need Health Professional Shortage Area (HPSA).

Please feel free to forward

this announcement or direct prospective applicants to <http://nhsc.hrsa.gov/loanrepayment/studentstoserviceprogram/index.html> for more information regarding eligibility and to begin the application process.

As always, thank you for your support of the National Health Service Corps.

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NEWS FROM OUR FP RESIDENTS!

New ACGME Duty Hour Rules: Perspectives from Family Medicine Residents in Arkansas

By: Appathurai Balamurugan, M.D., MPH, Department of Family and Preventive Medicine, UAMS, Little Rock & Brandon Thurow, M.D., Area Health Education Center, UAMS, Pine Bluff Resident Representatives to the Arkansas AFP Board of Directors

Introduction

Residency is a phase of medical education where a medical student assumes the responsibility of caring for individual patients under the guidance and supervision of faculty physicians.¹ The resident duty hours are typically long, and it includes time spent on clinical work related to patient care; academic activities related to program requirements; administrative activities related to patient care; and on-call related duties. This does not typically include the time spent on reading and preparation required by the residency program.¹ The impact of long resident duty hours on resident health and patient care has been well documented in several studies over the years.²⁻⁵ Consequently, ACGME implemented the new duty hour rules effective July 2011. Some of the key changes in resident duty hours per the new duty hour rules include: The duty periods of Post Graduate Year -1 (PGY-1) residents are not to exceed 16 hours; PGY-1 residents should have 10 hours free of duty between their duty periods; PGY-1 residents will always need to be supervised

during their duty periods; the duty periods of PGY-2 residents or above may not exceed 24 hours with an additional four hours to ensure transition of care; and PGY-2 resident or higher should have at least 14 hours free of duty between their duty periods after a 24 hours of in-house duty. Further details on the new ACGME duty hour rule can be found at the ACGME website (http://www.acgme.org/acWebsite/dutyHours/dh_index.asp).

The Arkansas Academy of Family Physicians' resident committee was interested in assessing the perspectives of the family medicine residents in Arkansas. The Chief residents serve as the communication hub for the residents and the Family Medicine residency program staff. Hence, an email communication was sent to all the Chief residents of Family Medicine residency programs in the six AHEC programs and the University Family Medicine program in Arkansas. We did not receive responses from all the respondents. We have summarized the perspectives shared by the few Chief residents who responded to our email request; hence the views may not be representative

of all the Chief residents from different Family Medicine residency programs in Arkansas. However, the perspectives gives us a first snap shot view of the family medicine residents in the state and their views on the new ACGME duty hour rules.

Perspectives on the new ACGME duty hour rules

The Chief residents who shared the perspectives on the new ACGME duty hour rules expressed the views on how the interns (PGY-1) and the residents (PGY-2 or higher) felt about impact of the new ACGME duty hour rules. They also shared their experiences in coming up with a call schedule to abide by the new duty hour rules, as the Chief residents are the ones who are entrusted with developing a call schedule for the residency programs.

Often times, changes of this magnitude are bound to have some positive and negative effects on the system as whole. Below are some of the key perspectives, positives and negatives as reported:

Positive aspects

1. The interns felt that the supervised exposure during their PGY-1 year helps them to adjust to the new system/work ambience.
2. The interns also felt that restricting the duty hours

continued on page 10



Physician to Physician –

A personal note from Benjamin Nimmo, M.D.,

Medical Director at Pinnacle Pointe Behavioral Healthcare System . . .

Pinnacle Pointe Hospital is the leading child and adolescent behavioral hospital in Arkansas for many reasons. As Medical Director of this facility since March, I have had the privilege of working with five other psychiatrists, three of whom are boarded in child and adolescent psychiatry. With a limited number of psychiatrists in Arkansas who are certified within this specialty, I am pleased to lead a team that has attracted such qualified and reputable physicians in the field of psychiatry.

Acute and residential services, supported by less restrictive school-based mental health and day treatment programs, provide a full continuum of services to ages 5-17.

As you serve children and families in Arkansas, please know that we as a medical team at Pinnacle Pointe are available to assist you in facilitating services for children and adolescents in crisis.



*Benjamin Nimmo, M.D.,
Child and Adolescent
Psychiatry*



*Scott Hogan, M.D.,
Child and Adolescent
Psychiatry*



*Thomas (Chris)
Stinnett, M.D.,
Psychiatry*



*Jim Aukstuolis, M.D.,
Child and Adolescent
Psychiatry*



*Brian Kubacak, M.D.,
Child and Adolescent
Psychiatry*



*Lynn Thomas, M.D.,
Psychiatry*



ACHIEVEMENT AWARD 2011

to 16 hours decreases their stress level in an environment where they are already overburdened and taxed with numerous duties related to patient care.

3. The PGY-2 level or higher residents welcomed the new duty hours rule which restricts them to 24 hours of patient care unlike 30 hours of patient care earlier. As they felt stressed, when they had to attend a half-day clinic or in-patient care following a 24 hour call previously.

Negative aspects

1. The Chief residents felt that scheduling calls with a third of the residents not being

able to be on call without supervision was an absolute nightmare.

2. The PGY-2 level or higher residents are taxed with an increase in the number of calls per year due to the new ACGME duty hour rules. This was a widespread concern across the board among residents PGY-2 level or higher regarding this added burden.
3. The PGY-1 residents already are anxious about the sudden transformation which will occur on July 1, 2012, when they will be PGY-2 and must not only be able to take 24 hour calls but will also need to supervise the new PGY-1 residents. The current PGY-1 residents felt that there needs to be a transition

period (a few months), where they will be able to provide unsupervised patient care and build their decision making skills before they become PGY-2 residents, which is not possible with the new ACGME duty hour rules.

As the residents and the residency programs across the State and the Nation are trying to adjust to the new ACGME duty hour rules, it is important to remember that patient care always comes first in our journey to become a practicing physician.

References

1. Accreditation Council for Graduate Medical Education. ACGME duty hours. 2011 Standards. Common Program Requirements. Accessed at http://www.acgme.org/acwebsite/home/Common_Program_Requirements_07012011.pdf on November 14, 2011.
2. Philibert I. Sleep loss and performance in residents and nonphysicians: a metaanalytic examination. *Sleep*. 2005; 28(11):1392-1402.
3. Landrigan CP, Rothschild JM, Cronin JW, et al. Effect of reducing interns' work hours on serious medical errors in intensive care units. *N Engl J Med*. 2004; 351(18):1838-1848.
4. Fletcher K, Reed D, Arora V. Systematic Review of the Literature: Resident Duty Hours and Related Topics: ACGME; 2009.
5. Jefferson Medical College Duty Hours Review Group. Systematic Review of the Literature on the Impact of Variation in Residents' Duty Hour Schedules on Patient Safety: ACGME; 2009.

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ARKANSAS CHAPTER NEWS

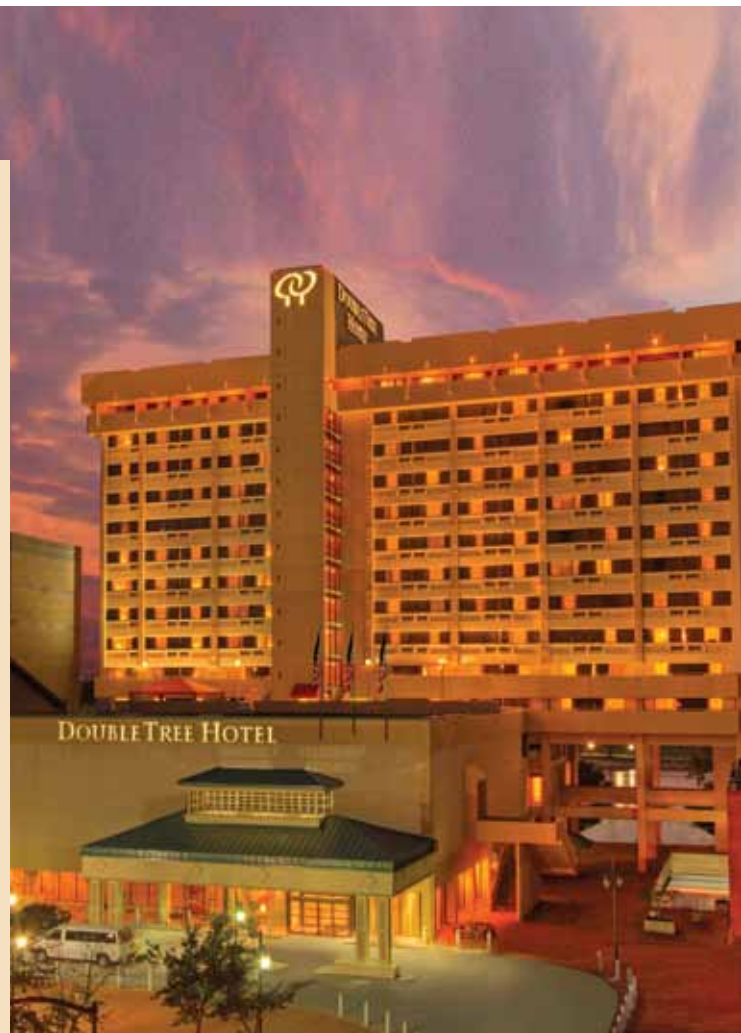
- ❖ A new and much needed website for the Arkansas Chapter will be unveiled the first of the year. It will be colorful, have links to join or to access the AAFP membership site as well as many other items to assist you in your membership!! The Website will still be ArkansasAFP.org!! Please visit the new site in January!
- ❖ Dr. Barry Pierce of Mountain View was reappointed to the Governor's Trauma Advisory Council for a three year period.
- ❖ The Arkansas AFP Board of Directors approved supporting Midwest Dairy's "Fuel up to Play 60," a school based nutrition and physical fitness initiative. The Board also approved membership in the Arkansas Oral Health Coalition, Inc.
- ❖ The Arkansas Chapter co-hosted a welcome reception for Andy Allison, Arkansas' new Medicaid Director. Mr. Allison began work the week of December 5 and came to us from Kansas where he was the Medicaid Director there as well as the President of the National Association of Medicaid Directors.
- ❖ Our chapter will host the Annual Multi State Conference in Dallas the weekend of February 18 . This meeting is a two day meeting of chapter officers and directors to share ideas and learn from each other. Chapters in the Multi State Group are: Kansas, Iowa, Oklahoma, New Mexico, Arizona, California, Nebraska, Colorado, Texas, Missouri and Arkansas.

ARKANSAS AFP ANNUAL SCIENTIFIC ASSEMBLY

**JUNE 13-16, 2012 - DOUBLETREE HOTEL, LITTLE ROCK, ARKANSAS
NEW FORMAT, NEW MONTH - ALL AT YOUR REQUEST!!**

Due to many requests of attendees of our Annual meeting and from members of the AR AFP, we have changed the format for 2012 to accommodate your schedules! **The official Assembly will be held Thursday through Saturday Noon, June 14-16** at the Doubletree Hotel in Little Rock!! For those of you that need additional CME hours, we will offer a 4 hour optional program on Wednesday, June 13. Exhibitors will move in that afternoon and display on Thursday and Friday 'til Noon. With a change in the days, our Installation of Officers Banquet will be held on Friday night, June 15.

PLEASE MARK YOUR CALENDARS AND PLAN TO BE WITH US FOR ANOTHER GREAT ANNUAL MEETING !!!



Arkansas Department of Health's Proposal for Expedited Partner Therapy in Arkansas

Expedited Partner Therapy (EPT) is "the practice of treating the sex partners of persons with sexually transmitted diseases (STD) without an intervening medical evaluation or professional prevention counseling" (Centers for Disease Control, 2006).

The two most commonly reported communicable diseases in the U.S. are gonorrhea and chlamydia, with 1,244,180 cases of chlamydia reported in 2009 and an estimated 2 million infections that go undetected because most chlamydia infections in both male and females are asymptomatic. In 2009, there were also 301,174 cases of gonorrhea reported, and just as many cases that went unreported. Genital infections can lead to pelvic inflammatory disease (PID), chronic pelvic pain, ectopic pregnancy, and preventable infertility in women. Repeat gonorrhea infections, which increase the risk of complications, occur in up to 11% of women and men within six months after treatment. Patients with these infections are also at increased risk of acquiring HIV.

In 2010, Arkansas reported 15,425 cases of chlamydia and 4,765 cases of gonorrhea, and currently ranks in the top ten in the U.S. for both of these sexually transmitted diseases. Seventy three percent of the reported chlamydia cases and 57% of the reported gonorrhea cases in Arkansas are in women. Approximately two-thirds of reported gonorrhea cases in the U.S. are among African Americans. Reported chlamydia rates are seven times higher in African American women than white women and eleven times higher in African American men than white men.

For Arkansas Department of Health (ADH) patients with chlamydia, fewer than 40% of their partners came in for treatment in

2010, with this percentage being even lower for partners of patients diagnosed with gonorrhea. These infections are easy to treat, yet more than half of partners to patients with confirmed infections go untreated. The current practice for getting partners in for treatment consists of asking the patient to inform their partner about the need for evaluation and treatment. This is not working.

EPT is an innovative treatment option for the partners that now go untreated, and it has been proven to increase treatment rates and decrease re-infection rates. To elaborate more on the CDC definition listed above, EPT is when a patient delivers either medication or a prescription to his/her sexual partner. The partner is not examined by the doctor or health care provider. Since 2005, the Centers for Disease Control and Prevention (CDC) has been recommending the use of EPT as an option for treating partners of patients diagnosed with chlamydia or gonorrhea. Heterosexual patients with uncomplicated gonorrhea and chlamydia infections have lower rates of re-infection when their sexual partners are provided with EPT, according to published research supported by CDC.

A "Dear Colleague" letter dated May 11, 2005 from Dr. John M. Douglas Jr., Director of the CDC Division of STD Prevention, stated that the "CDC has concluded that EPT is a useful option to facilitate partner management, particularly for treatment of male partners of women with chlamydial infection or gonorrhea." Dr. Douglas' letter urged state health departments to work toward removing legal and administrative barriers that prevent use of EPT.

Currently, thirty states in the U.S. allow EPT, including Texas, Mississippi, Missouri, Louisiana,

and Tennessee. South Carolina and Massachusetts are the most recent states to remove their legal and administrative barriers to allow the use of EPT. There are only seven states that CDC says clearly have legal and administrative barriers that do not allow EPT. Arkansas is one of these seven.

EPT is endorsed by the following organizations: CDC, American College of Obstetricians and Gynecologists, American Medical Association, Society for Adolescent Medicine, American Bar Association, and most public health departments. These organizations support the use of EPT because they know that many infected partners will not come in to the clinic to be treated and that EPT is effective for treating gonorrhea and chlamydia. They also know that EPT decreases re-infection rates for patients. EPT is effective for chlamydia and gonorrhea because each can be treated with a single oral dose of appropriate antibiotic (azithromycin or cefixime, respectively) with minimal risk of side-effects or allergic reactions.

Below is the CDC guidance for use of expedited partner therapy:

- Gonorrhea and chlamydial infection in women: EPT can be used to treat partners as an option when other management strategies are impractical or unsuccessful. Symptomatic male partners should be encouraged to seek medical attention, in addition to accepting therapy by EPT, through counseling of the index case, written materials, and/or personal counseling by a pharmacist or other personnel.
- Gonorrhea and chlamydial

infection in men: EPT can be used to treat partners as an option when other management strategies are impractical or unsuccessful. Female recipients of EPT should be strongly encouraged to seek medical attention, in addition to accepting therapy. This should be accomplished through written materials that accompany medication, by counseling of the index case and, when practical, through personal counseling by a pharmacist or other personnel. It is particularly important that female recipients of EPT who have symptoms that suggest acute PID, such as abdominal or pelvic pain, seek medical attention.

- Gonorrhea and chlamydial

infection in men who have sex with men: EPT should not be considered a routine partner management strategy, because data are lacking on the efficacy in this population, and because of a high risk of co-morbidity, especially undiagnosed HIV infection, in partners. EPT should only be used selectively, and with caution, when other partner management strategies are impractical or unsuccessful.

- Syphilis: EPT is not recommended for routine use in the management of patients with infectious syphilis.

With the proven effectiveness of EPT, various organizations supporting its use, Arkansas' rank

within the top ten states in the U.S. for both chlamydia and gonorrhea, and the partner treatment rate for chlamydia in Arkansas being less than 40% and the gonorrhea treatment rate being even less, the Arkansas Department of Health is also supporting the use of EPT. For these reasons, we are asking that the Arkansas State Medical Board consider granting a specific waiver to the Arkansas Code State Medical Board Regulation 2(8) to allow physicians to prescribe EPT for a person with whom the physician has not established a proper physician/patient relationship.

ADH intends to follow CDC guidance on EPT and will only be offering treatment to heterosexual partners of patients diagnosed with chlamydia or gonorrhea infections.

* The Arkansas Chapter has endorsed EPT.

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First "Health Home" Program Gets CMS Approval Arkansas Looking in Same Direction

By David Ivers, J.D. , Mitchell Blackstock Ivers Sneddon PLLC

The first health home program to get approval from the Centers for Medicare and Medicaid Services offers an important roadmap for similar efforts in Arkansas, including methods for reimbursing providers. Mental health and developmental disabilities providers as well as primary care physicians and nurses play crucial roles in this model.

The Centers for Medicare and Medicaid Services (CMS) approved the Missouri program (called "Healthcare Homes") in a letter dated October 20, 2011, accompanied by a press release and news conference. The approval means that for those beneficiaries with qualifying chronic conditions, the federal government will pay 90% of their health home services for two years starting January 1, 2012. After that, the regular state-federal match will apply.

The Missouri program is the first one approved under Section 2703 of the Affordable Care Act.

Arkansas Medicaid received a \$500,000 planning grant under this same section of the Act back in February. The state has brought in a consultant and is in the process of hiring a health homes planning coordinator. Health homes are a popular concept, with pilots underway in

the private sector as well.

The Missouri program includes several methods of reimbursement to providers for health home activities -- activities that payers do not traditionally reimburse. It also includes helpful delineations of job functions for a health home team. While Arkansas may differ in the reimbursement amounts or job titles and other details, the Missouri program is likely to serve as an important model.

The term "health homes" is sometimes used interchangeably with "medical homes." However, the term "medical home" usually refers to a primary care practice while "health homes" involves a mental health, developmental disability, or other ancillary provider with linkages to primary care physicians and other providers.

The goal is to reduce hospital admissions, ER visits, duplicate tests, and excessive referrals to specialists; reduce reliance on institutional care; improve overall health and satisfaction; and reduce costs. Care coordination and wellness activities are hallmarks of this evolving model.

Missouri estimates savings of 16% over expected costs without health

homes. Missouri piloted an earlier health home model, with a study indicating that costs increase at first, but decline later as the health home efforts take hold.

To obtain the temporary 90% match under the Affordable Care Act, beneficiaries must meet the following criteria:

- (1) Have two chronic conditions; or
- (2) Have one chronic condition and at risk for another; or
- (3) Have a serious and persistent mental illness (SMI or SED).

The Missouri program is focused on serving those beneficiaries dealing with one serious mental health condition, or less severe mental illness in conjunction with other chronic conditions, namely diabetes, chronic obstructive pulmonary disease, cardiovascular disease, obesity, tobacco use, or developmental disability. However, a state is free to target different populations, and Arkansas appears to be looking in particular at behavioral health and developmental disabilities populations for health homes. Arkansas officials also have advocated the broader use of medical homes or health homes for all Medicaid beneficiaries as part of its Payment Improvement Initiative or "Transformation."

States may vary from the requirements in the Affordable Care Act, but they will not then receive the temporary enhanced match. In the Missouri program, the state predicts that the vast majority, but not all of those in the mental health system will qualify for health home services.

Behavioral Health, Developmental Disabilities, PCPs, RNs, and LPNs
Providers in Arkansas, particularly



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mental health and developmental disability providers, may want to consider the health home approach for a number of reasons:

- The state's outpatient Medicaid program, called rehabilitative services for persons with mental illness (RSPMI), no longer pays for significant case management and care coordination services, which has left many individuals without needed supports, or providers without reimbursement if they provided those services anyway. These services would be reimbursable again under the health homes program.
- Arkansas Medicaid is looking at implementing another outpatient mental health program through 1915(i) of the Social Security Act for individuals with serious and chronic mental illness. Many of the coordination, care management, and community supports features in 1915(i) are well-suited to a health home.
- The state has struggled for years with how to mandate and measure quality outcomes and cost efficiency by mental health providers. Consequently, the program is now burdened by excessive layers of complex regulations and is administratively top heavy. The health homes program addresses the state's concerns in a way that might appeal to providers since it provides reimbursement for what are now considered basically unfunded mandates.
- While the Missouri model focuses on behavioral health, much of it transfers easily to the developmental disabilities population. Indeed, Missouri went out of its way to include individuals with dual diagnoses (mental illness and developmental disabilities) in its program because they are often medically

fragile and high utilizers of medical care who see many different providers. The same is true in Arkansas. Developmental disabilities providers have urged Arkansas Medicaid to implement DD health homes. In addition, the state and DD providers are attempting to address a crisis at the Arkansas State Hospital involving dually diagnosed children.

No matter which populations are targeted, primary care physicians and nurses likely will be in strong demand to help guide the health homes. RNs and LPNs will be needed as full-time employees in the health homes, providing the vast majority of care coordination and wellness services. Each health home likely will have to retain a physician at least on a part-time consulting basis.

Of course, no health home program will attract sufficient provider interest

unless the state comes up with an adequate reimbursement. With this new approach, which will be viewed by many providers as risky, it will be imperative that the state provide assurances that it will review reimbursement rates early after starting the program and that it will make needed rate adjustments much more quickly than the usual process.

Health Home Teams

Health home teams in the Missouri program include:

Nurse Care Managers will perform the bulk of the work. They will develop wellness and prevention initiatives; participate in initial treatment plan development for enrollees; coordinate with medical providers and hospitals for admission/discharge; provide training to staff on chronic diseases, treatments, and medications; monitor health information technology tools and reports; and monitor

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and report performance measures and outcomes. While some care managers may be LPNs, each health home must have at least one RN. However, it appears that in smaller organizations, an RN can serve as both care manager and health home director.

A **health home director** is in charge of the implementation and monitoring of the health home activities.

A **consulting physician** provides medical leadership by participating in treatment planning, consulting with the team psychiatrist, consulting regarding specific consumer health issues, and assisting in coordination with external providers.

Administrative support staff will be needed, especially for the extensive patient data requirements.

Payment Methodology

The payment methodology works like this, according to documents submitted

to CMS and other information provided by the state:

(1) Time-limited infrastructure payments to cover the start-up costs associated with recruiting, training new and existing staff, and IT changes. Amount based on two-thirds of projected auto-enrollment.

(2) Ongoing infrastructure payments to cover the cost of the health home director and support staff. Quarterly payments for actual costs incurred.

(3) "Per member per month" (PMPM) payments for each enrollee to cover the costs for nurse care managers and the physician consultant and new support staff. These may be adjusted later or tiered based on patient condition.

Nurse Care Manager (\$105,000/yr):
PMPM \$35.00

1 FTE per 250 enrollees.

Health Home Director (\$115,000/yr):
PMPM \$19.17

1 FTE per 500 enrollees.

Primary Care Physician Consultant (\$150/hr): PMPM \$12.50

1 hour per enrollee per year or .25 FTE per year per 520 enrollees

Administrative Support: PMPM \$12.07

(4) Possible pay-for-performance allowing providers to share in any savings.

Missouri noted that even these payments will not cover all the training and technical assistance costs of implementing health homes, and that private foundations, providers, and state agencies are spending over \$1.5 million more for the program.

Arkansas is also trying to develop bundled payments for episodes of care, so it is not clear whether the bundled payments would include the health home activities or whether the health home activities would be structured as supplemental reimbursement. Either way, costs for these services will have to be determined.

Other Features

Missouri officials and CMS worked out a number of the thorny issues that state officials and providers face as they attempt to develop health homes. Important features include the following:

- After starting services as a health home, providers will have 18 months within which to become certified as a health home by a national accrediting body or through a state program.
- Electronic health records (EHR) are not required, but providers "will be hard pressed to perform successfully as Healthcare Homes in the long run if they do not have an electronic health record."
- Whether they have their own EHR system or not, all health homes must use the state's EHR

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to conduct care coordination and prescription monitoring; track state-specified performance measures; utilize pharmacy management system; and complete status reports on an individual's housing, legal employment status, education, custody, etc.

- Practice transformation will be required, including open access scheduling to expedite appointments, increased patient input, significant increases in data reporting and outcomes measurements, evidence-based practices, patient registries, automatic care reminders, and exception reports.
- Health homes will use patient registries to track dates of delivered and needed services, laboratory values, and general health status; patient risk stratification; analysis of patient population health status and individual patient needs; and various other data reporting requirements.
- Health homes must submit quarterly reports documenting performance on quality measures and practice transformation, and undergo six and 12-month assessments by the state
- Clinicians in the health home are assigned "patient panels," so that a patient sees the same team of providers each time rather than whoever is available.
- Beneficiaries for whom certain types of claims were filed in each of the three previous months will be assigned to a previously accessed provider for health home auto enrollment, but will be given information on alternative health home providers and the choice to opt out of health home status.
- When an individual has more than

one avoidable hospitalization within a 12-month period, he or she will be added to "a list of persons to be actively sought for engagement."

- The state will use a "disease management analytics contractor" that will process a daily list of hospital admissions and discharges against a list of those individuals on the "active engagement" list. The matches from the list will be sent to the health home for that region each day. A similar process will be followed for individuals who frequently use the ER.
- The state generates for the health home an electronic history of care on an individual for the previous three years, including prescription drug history, adherence, and interactions, plus all inpatient and outpatient clinical episodes

with date, provider, diagnosis and procedure.

- A health home provides treatment and care coordination on behalf of Medicaid and is therefore entitled to Medicaid beneficiaries' protected health information without violating HIPAA.
- The state's timetable is ambitious: Training of providers started in July, with submission of the plan to CMS; health homes are to begin operating in December. However, the state had piloted a similar program ahead of this.

While Missouri is far ahead of Arkansas in this area, the Missouri program provides a wealth of ideas for how Arkansas might chart its course. More details on the Missouri program are available at: <http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm>.



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ACGME Study Highlights Impact of Potential Cuts to GME Funding

By Sheri Porter Posted: 11/15/2011, 5:45 p.m.

As the Joint Select Committee on Deficit Reduction, known as the “super committee,” goes about its budget-trimming business in Washington, the Accreditation Council for Graduate Medical Education, or ACGME, released the results of a survey aimed at assessing the impact that potential cuts to GME funding, which currently are under consideration by the supercommittee, would have on America’s educational pipeline for physicians.

The survey findings are outlined in [“The Potential Impact of Reduction in Federal GME Funding in the United States: A Study of the Estimates of Designated Institutional Officials”](#) The report paints a picture that greatly concerns ACGME Executive Director and CEO Thomas Nasca, M.D. “We will actually reduce the number of physicians who are trained in the United States at a time when all workforce studies are demonstrating a mounting deficit of physicians,” said Nasca in an interview with *AAFP News Now*. “That will place us in a position where our physician-to-population ratio in 2020 and beyond is below (that of) most of the developed countries in the world.” Nasca pointed out that program reductions were not confined to what he called the “GME-heavy states” in the Northeast and on the West Coast. “They are across the country, which indicates that rural family medicine and general internal medicine programs will equally be harmed,” he said.

Story Highlights

- The Accreditation Council for Graduate Medical Education, or ACGME, recently released a study based on survey responses from institutions representing nearly 70 percent of all U.S. ACGME accredited programs.
- The study assesses the impact of potential GME funding cuts being discussed by the Congressional “supercommittee” on the U.S. educational pipeline for physicians.
- Core residency programs, such as family medicine and general internal programs, likely would see dramatic reductions in residency positions, which could leave underserved communities without access to medical care, according to the study.

In addition, Nasca noted, “There was a more dramatic reduction than we expected in core (or specialty) residency programs -- which has huge implications for the country.” Perry Pugno, M.D., M.P.H., AAFP vice president for education, agreed. “The fact is that any cuts to GME that go across the board are going to hurt primary care -- especially those of us who disproportionately take care of adults with chronic illnesses,” said Pugno. “In communities where primary care residency programs are present, those programs become the access point for the poor and disenfranchised of the area. That’s the reality.” Pugno pointed out that it’s not unusual for family medicine residency programs to see patients who live both in poverty and with numerous chronic illnesses. “The payment for taking care of those patients is so low that the local medical community often doesn’t want to provide that care,” said Pugno. “But residency programs take all comers.” Survey responders also spoke to this issue. “In the comment section of the study, we heard from a large number of institutional officials that their ability to provide access to the poor and underserved would be dramatically and adversely impacted, and that is true whether it’s a large urban inner-city hospital or whether it’s a rural community,” said Nasca.

Study Highlights

The study is based on e-mail survey

responses from 306 institutions representing nearly 68.9 percent of all U.S. ACGME-accredited programs and 68.4 percent of all resident positions available in 2011. The survey instructed responders -- designated institutional officials, or DIOs -- to indicate how federal funding would affect their institutions’ programs and positions. DIOs were asked to estimate the potential impact under three different funding scenarios:

- funding to remain stable at 2011 levels,
- funding to be reduced by 33 percent and
- funding to be reduced by 50 percent.

Stable funding did not produce dramatic changes in programs and positions. However, the outlook worsened when cuts were introduced into the equation. With a 33 percent reduction in GME funding


- 68.3 percent of responders said they would reduce the number of core residency positions,
- 60.3 percent would reduce the number of subspecialty fellowship positions,
- 4.3 percent would close all core residency programs, and
- 7.8 percent would close all subspecialty programs.

Core residency programs and their positions include specialties -- such as family medicine or general internal medicine -- that lead to initial board eligibility by an American Board of Medical Specialties certifying board. Subspecialty programs and subspecialty fellowship positions involve training that occurs after initial board certification. Significantly, even though there were fewer core, or specialty, programs, core positions (2,783) outnumbered subspecialty positions (1,151); therefore, the majority of positions lost would be core positions. The number of those core positions would drop from 2,783 to 1,656 with this level of funding cut. The numbers dropped even lower with a 50 percent reduction in GME funding. At this level,

- 82.3 percent of responders would reduce the number of core residency positions,

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- 76.2 percent would reduce the number of subspecialty fellowship positions,
- 14 percent of responders would close all core residency programs, and
- 20.9 percent would close all subspecialty programs.

A 50 percent funding cut would result in the elimination of 3,037 core medical specialty positions.

Looking Forward

Nasca said that the increase in U.S. medical school enrollment in recent years was a step forward in finding a solution to the nation's looming physician deficit. However, he added, GME positions have not been increased. "Now we're talking about significant reductions in the number of GME positions, to the point where we may not even have enough residency positions for the graduates of our domestic allopathic and osteopathic medical schools," said Nasca. He pointed out that another 3,700 U.S. citizens enter the United States after training in Caribbean medical schools. "There would be no spaces for any of those individuals under some of these scenarios," said Nasca. The ACGME also is concerned that just discussing cuts in GME funding could cause a reduction in programs and positions, even if cuts don't materialize. Residents represent a significant financial investment, said Nasca, and the anxiety about possible removal of funding "might cause institutions to either limit their growth or even begin to reduce just to be on the safe side." "I think the irony is that the graduate medical education community is responding to the needs of the public, as expressed in the new (ACGME) competencies and a whole series of other areas, to meet future needs. At a time when we need a stable training environment, we're forced into a situation of talking about dramatic reductions in funding," Nasca said.

Follow-up Capitol Hill Visit Focuses on Medicare Payment Fix, Adequate GME Funding

By James Arvantes • Washington, D.C. Posted: 11/15/2011, 5:40 p.m.

AAFP President-elect Jeffrey Cain, M.D., of Aurora, Colo., returned to Capitol Hill on Nov. 9 to continue pressing for a long-term Medicare payment solution and adequate funding for graduate medical education, or GME, programs during meetings with key congressional staff members.

AAFP President-elect Jeffrey Cain, M.D., recently visited Capitol Hill to press Congress for a long-term Medicare payment solution and adequate funding for graduate medical education.

Cain last visited Capitol Hill on Oct. 20 with several other AAFP leaders, including AAFP President Glen Stream, M.D., M.B.I., of Spokane, Wash., AAFP Board Chair Roland Goertz, M.D., M.B.A., of Waco, Texas, and AAFP EVP Douglas Henley, M.D. The group met with a variety of congressional leaders and staff to push for a repeal of the SGR, a stable Medicare payment rate for a fixed number of years, and a higher payment rate for primary care physicians within that rate.

During this latest series of meetings, Cain met with a senior health care policy adviser for Rep. Allyson Schwartz, D-Pa., who soon is expected to introduce a bill that calls for a repeal of the SGR. Cain reiterated the Academy's position on Medicare physician payment, which includes instituting a stable payment rate, an increase for primary care and repeal of the SGR.

"We have to make sure family physicians are paid a fair price for taking care of Medicare patients," Cain said in an interview with *AAFP News Now*.

Cain's Capitol Hill visits came as the Joint Select Committee on Deficit Reduction, also known as the "supercommittee," continues to meet to develop a plan to achieve reductions in the federal deficit. If the government fails to enact the committee's recommendations by Dec. 23, across-the-board cuts totaling \$1.2 trillion will be triggered automatically.

Story highlights

- AAFP President-elect Jeffrey Cain, M.D., recently made a follow-up visit to Capitol Hill to emphasize the AAFP's pursuit of a Medicare payment fix.
- Cain, who met with a variety of staff members of congressional

representatives, reiterated the message spread by AAFP leaders last month: a repeal of the sustainable growth rate, a three-to-five year stable payment rate for Medicare, and within that rate, a higher rate for primary care physicians.

- Cain also stressed the importance of stable funding for graduate medical education programs, particularly for primary care residency programs.

Cain also met with a senior policy adviser to Rep. Steny Hoyer, D-Md. The two discussed Medicare payment issues and the need to protect funding for GME programs as a way to sustain and strengthen family medicine residency programs. Hoyer is a member of the House Democratic leadership.

Cain said he described the SGR as "broken" during the meeting and noted that he hoped the Democratic leadership would encourage the bipartisan supercommittee to repeal the flawed payment formula as part of its final recommendations. Cain also discussed GME funding with the Hoyer aide, explaining that across-the-board reductions in GME would disproportionately harm family medicine residency programs.

Both Congress and the Obama administration have proposed cuts in GME funding as part of deficit reduction proposals. Cain pointed out that although subspecialist residency programs generate income for teaching hospitals that receive GME funds, family medicine residency programs often are not recognized as generating revenue and, thus, may be eliminated if GME funds are reduced.

"Primary care residencies rely on GME funds to be able to keep their doors open," said Cain.

Cain also met with health care aides to Sen. Robert Casey, D-Pa., about prescription drug abuse. Casey is co-sponsor of a bill introduced by Sen. John Rockefeller, D-W.Va., that would require physicians to undergo mandatory CME as a condition for prescribing certain drugs, such as opioids.

"We know that the diversion of (prescription) drugs involves a small number of physicians and a small number of patients," said Cain. "Requiring all physicians to undergo CME to prescribe targeted narcotics is taking a sledgehammer approach to a problem that would be better addressed with a scalpel."

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Medicare 10th Statement of Work: New QIO program aims for bold goals, system-level transformation

By Pam Brown, BSN, RN, CPHQ

As Arkansas's Medicare Quality Improvement Organization, the Arkansas Foundation for Medical Care (AFMC) has a long record of collaborating with the state's health care providers to improve care in Arkansas. Our newest contract with the Centers for Medicare & Medicaid Services (CMS)—the 10th Statement of Work (SOW), in effect from August 2011 through July 2014—marks a dramatic departure from how QIOs have historically approached the task of improving health care.

This change is characterized by: bold goals; transformation at the systems level; a patient-centered philosophy; collaborative learning; and breaking down organizational, cultural and geographical barriers to quality improvement.

Using these new approaches, AFMC will focus its efforts on three critical areas: better patient care, better population health, and lowering health care costs through improvement. These areas of focus align with the U.S. Department of Health and Human Services' National Quality Strategy, part of the Affordable Care Act, and the Partnership for Patients, a new CMS public-private partnership working to improve hospital care. As a Medicare QIO, AFMC will pursue four "aims" identified by CMS as keys to system-wide improvement.

AIM 1: MAKE CARE BENEFICIARY AND FAMILY CENTERED

Patient-centered care is the

QIO program's top priority. AFMC will be working with providers to promote responsiveness to beneficiary and family needs, encourage listening to and addressing beneficiary and family concerns, and provide decision-making resources for patients and caregivers.

This aim has three main parts:

Empowering beneficiaries and families to be more engaged in health care decision-making. The Patient and Family Engagement Campaign, set to begin Aug. 1, 2012, will include tools and strategies to help providers engage patients and families, as well as self-advocacy information for patients and families.

Contributing to safer, more effective care through quality improvement work with providers. AFMC will use what we learn from reviewing quality complaints to improve the way providers deliver health care. We will also work to increase patients' access to care regardless of socioeconomic, cultural or educational background.

Providing a streamlined process for making and reviewing quality-of-care complaints. Instead of contacting AFMC directly to file complaints and appeals, patients and their advocates will go through the newly established Beneficiary- and Family-Centered Care National Coordinating Center

(BFCCNCC). The center will then send the appropriate cases to AFMC for review or refer beneficiaries to another agency for help.

Upon request, AFMC will also assist providers who are required to perform a root cause analysis, implement systems change or develop a quality improvement plan to resolve any quality of care concerns identified.

AIM 2: IMPROVE INDIVIDUAL PATIENT CARE

This aim has four main goals:

Reduce health care-acquired infections (hospitals). Work will begin with central line-associated blood stream infections (CLABSI) and then move on to other HAIs, such as *Clostridium difficile* infections (CDIs) and surgical site infections.

Reduce health care-acquired conditions (HACs) by 40% (nursing homes). The first phase (through January 2013) will focus on reducing pressure ulcers and the use of physical restraints. The second phase (January 2013-July 2014) will take on other HACs such as catheter-associated urinary tract infections and falls.

Eliminate adverse drug events. As part of the Health Resources and Service Administration's Patient Safety and Clinical Pharmacy

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Collaborative, AFMC will work with a small group of communities in Arkansas to improve care coordination and medication reconciliation as beneficiaries move among care settings. This effort integrates evidence-based clinical pharmacy services into the care of high-risk, high-cost, complex patients.

Quality reporting and improvement. Data can tell us much about the state of quality and safety in hospitals. In the 10th SOW, AFMC will continue to provide technical support in reporting clinical data to Medicare's Hospital Inpatient Quality Reporting Program, and will assist with the Hospital Outpatient Quality Reporting Program as well. These programs both include financial incentives for successful participation—as much as 2% extra payment from Medicare. In addition, the Medicare Value-Based Purchasing Program will incentivize hospitals based on quality as of Oct. 1, 2012. Hospitals will be paid not just for the services they provide, but for how well beneficiaries fare under that care. These payments will be calculated using data from the quality reporting programs.

AIM 3: INTEGRATE CARE FOR POPULATIONS

Avoidable hospital readmissions strain patients and families and increase costs unnecessarily. Beginning Oct. 1, 2012, more of those costs will be shifted to hospitals: Under the Readmissions Payment Reduction Program, hospital DRG rates will be decreased if hospitals meet CMS criteria for “excess readmissions.”

AFMC will work with hospitals and other health care facilities to

improve care transition processes and reduce readmissions within 30 days of discharge by 20% over three years. We will use proven interventions and focus on communities with the highest 30-day hospital readmission rates. We will also work with community groups to encourage wider adoption of improved practices.

AIM 4: IMPROVE HEALTH FOR POPULATIONS/COMMUNITIES

The goal of this aim is to improve health at the community level—to keep Medicare beneficiaries as healthy as possible for as long as possible through system-wide changes to processes of care in physician practices.

AFMC will work with physicians on three areas:

Using electronic health records (EHRs) to improve preventive care. EHRs can be used to coordinate preventive services, increase utilization rates, and report data to CMS' Physician Quality Reporting System (PQRS—formerly PQRI), which ultimately will help boost the quality and safety of ambulatory care. Medicare is providing financial incentives for physician practices to participate in PQRS: up to 2% of estimated Part B charges, in addition to standard Physician Fee Schedule rates. Starting in 2015, Medicare will penalize practices that don't report data to PQRS. For more information, visit www.cms.gov/pqrs.

Reduce cardiac risk factors. AFMC and other QIOs will be launching a national campaign to improve cardiac health through aspirin use, blood pressure monitoring, lipid management, and smoking cessation.

Integrate health information technology into clinical practice.

AFMC will collaborate with HITArkansas, the state's Health IT Regional Extension Center, to promote physician office EHR adoption and participation in CMS' EHR incentive program. For more information about this program, visit www.cms.gov/ehrincentiveprograms.

DRIVERS OF CHANGE

Under the 10th SOW, AFMC will be using some new approaches in our work. We will be de-emphasizing the technical assistance model, focusing instead on the creation of topic-specific “learning and action networks.” These networks will bring providers, beneficiaries and other stakeholders together to spread best practices and spark change through peer-to-peer learning and sharing of solutions.

We will also be using the CRISP model—Care Reinvention through Innovation Spread—to integrate strategic communications into the 10th SOW initiatives. One example of a CRISP activity is identifying project successes and channels for rapidly sharing those successes.

In the 10th SOW, AFMC will be working on goals and priorities shared by a number of national groups. The participation of Arkansas's providers and stakeholders is crucial to this effort, and AFMC looks forward to building on our existing relationships in the 10th Statement of Work.

Pam Brown is assistant vice president for the Health Care Quality Improvement Program (HCQIP) at the Arkansas Foundation for Medical Care.

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Policy Changes Affecting Antipsychotic Prescribing in Children and Adolescents

By Mark E. Helm, M.D., MBA, FAAP

The opinions, conclusions, summaries and recommendations herein are Dr. Helm's alone. They do not represent the opinion or official policy of any agency or institution of the State of Arkansas. This commentary has not been reviewed or endorsed by any state agency. Links to official policy are provided.

Beginning **November 8, 2011**, children insured through ARKids (up to age 18) who begin treatment with antipsychotics are covered by new policies. These policy changes are designed to increase baseline and ongoing monitoring for adverse effects of antipsychotics and to ensure that complete informed consent for parents/guardians and/or patients is provided and documented. **DHS' official notice is [here](#)**, but this commentary provides information relevant for PCPs and background (Appendices 1 and 2).

Fiscal Note and Patient Impact

Antipsychotic medications are the **largest single category of medication expenses** for Arkansas Medicaid. The majority of this cost pays for medications for children, not for treatment of serious psychiatric disorders in adults. Total spending for newer antipsychotics by Medicaid accounted for **\$57 million in 2009** – of this approximately **\$30 million was for use in children**. Historical data revealed around 3500 to 4500 children treated with antipsychotics in any given month, with a total patient count **exceeding 12,000 individual children in 2007** (likely higher since that time).

Many children are started on these medications and use them for only a few weeks or months. High medication discontinuation rates are seen though reasons for this are not clear. Both systematic and case reviews have revealed that these medications are frequently used without behavioral or

family therapy.

The policies effective November 8, 2011 will **apply only to newly treated patients**. DHS estimates that between one third and one half of the children currently receiving antipsychotics have used these medicines for more than 18 months. Still several hundred children each month are newly started on antipsychotics.

Policy Changes

- 1) **DHS raises the age at which an antipsychotic can be prescribed without psychiatrist case review from 5 to 6 years of age.** This policy change was based on their own internal review. This change may make it marginally more difficult for 5 year old children to obtain Medicaid coverage of newer antipsychotic medications. Some providers will continue to respond to this policy by prescribing older or generic antipsychotics, initiating treatment with samples, or simply telling parents and guardians to purchase antipsychotics for their preschooler themselves.
- 2) **Requirement for prior authorization for new antipsychotic medication use.** Based on treatment standards advocated by the **American Academy of Child and Adolescent Psychiatry**, Medicaid coverage of an antipsychotic for a child will require documentation of informed consent and on-going monitoring of medication safety. Any prescribing provider may obtain authorization for coverage of an antipsychotic medicine providing:
 - a. **Informed consent is documented.** Informed consent includes

documentation of the medication, initial dose, targeted symptoms, and that discussion about the risks, effects, and role of medication in the context of comprehensive treatment has been provided. Standard forms for informed consent were developed and are available for provider use.

- b. **Initial/baseline information for safety/adverse effect monitoring is collected and documented.** Baseline weight, height, and lab values must be collected prior to start of antipsychotic medication in children. This information must be documented on a single "flowsheet" document.
 - c. **Informed consent and documentation of baseline monitoring must be submitted to the UAMS College of Pharmacy Prior Authorization Call Center.** Submission of this information results in a prior authorization, assuming compliance with other existing policies. Specifics on this process are available by calling the PA Call Center at (501) 526-4200 or (866) 250-2518
- 3) **Metabolic monitoring must continue through at least the first two years of treatment.** A flowsheet for safety monitoring information was developed to facilitate data collection. Various monitoring protocols are advocated by different organizations ranging from the medical specialty organizations in the US and Canada, the State

of Texas and several European country health systems (for references, contact Dr. Helm). In all cases, the **monitoring protocols advocated by other authorities are more rigorous** than the minimum Arkansas DHS requirement. Elements of appropriate monitoring include:

- a. **Patient weight, height and BMI** – recommended with every visit. Monitoring weight changes is especially important early in treatment or when medications or doses change. An increase of weight of more than 5 to 7 percentage points in a short period is a cause for concern.
- b. **Blood pressure** – monitoring is recommended prior to treatment and as often as practical (at least every three months according to most recommendations).
- c. **Blood sugar** – fasting and long-term measures of blood glucose control (HbA1c) at baseline and as often as every three months following initiation of treatment.
- d. **Lipid profile** – including LDL, HDL and triglycerides at baseline and every 6 months according to most recommendations.
- e. **ECG, TSH, LFTs, prolactin, insulin levels** – these and a few other laboratory tests are advocated in some monitoring guidelines. Generally the recommendations advocate obtaining this information at baseline and every six months. Prolonged Q-T interval has been documented for some antipsychotic medications, and may be a greater risk with concomitant medication use. Pituitary adenoma and hyperprolactinemia/galactorrhea are documented complication of

certain antipsychotics.

f. Evaluation for extra-pyramidal symptoms and other complications –

These signs and symptoms should be evaluated on every visit, and are a significant concern. Signs can be subtle and varied. Recognition of these complications is especially challenging in children who may lack the vocabulary or awareness to communicate symptoms which may be medication related. If movement disorders occur, they may become permanent. The lab monitoring flowsheet developed for DHS does not include assessment for EPS, akathisia, sedation or cognitive impairment, though specific questionnaire tools exist to aid detection of problems.

Why should PCPs Care?

These policy changes can help primary care physicians in several ways.

- 1) Documentation of the **reasons for starting antipsychotics will be accessible** from the initial prescriber or from the PA Call Center.
- 2) PCPs may participate more completely in **safety monitoring and lab interpretation.**
- 3) The medication **informed consent document can be used for anxiety, depression or ADD/ADHD treatments** by PCPs – in the event of a medication-related adverse outcome, this documentation may help to establish the prescriber provided adequate counsel on medication risks.
- 4) In time, PCPs may gain more **information about practice styles of mental health provider** consultants.
- 5) Patients will be less likely to “fall through the cracks” regarding unmonitored use of antipsychotic medication.

Minimizing risks of complications should lower costs.

Limitations of the Policy

Significant issues not addressed by this policy include, but are not limited to,:

- **Primary Care and Mental Health Provider Communication** - This policy creates an opportunity for more dialog and cooperation, but does not ensure that more cooperation and information exchange will occur. At a minimum the policy can provide access to a standard document which explains why a medication was started.
- **Medication Treatment Link To Disability Determination** - Parents are aware that a major factor in SSI disability determination for a child is whether or not the child is treated with a “mental health” medicine. Some parents desire their child to qualify for disability and may resist treatment with behavioral approaches even if these may be more appropriate.
- **No Assurance of Comprehensive Care** – The great majority of children’s mental health authorities agree that any child “sick enough” to consider antipsychotic medication is also “sick enough” to need counseling interventions for the patient, family or both. The policy as it stands does not build a link between medication treatment and participation in comprehensive behavioral therapy or mental health treatment. Primary care providers should discuss the need for comprehensive care with their consultants and patient families. There are several simple mechanisms which could be implemented by mental health providers to reduce the likelihood “medication only” treatment.

continued on page 28

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April 26	Georgetown, Grand Cayman	07:00 AM	04:00 PM
April 27	Cozumel, Mexico	10:00 AM	05:00 PM
April 28	Fun Day At Sea	--	--
April 29	New Orleans, Louisiana	08:00 AM	--

POE TRAVEL

continued from page 27

- **Previously Treated Patients are Omitted** - Children previously treated with antipsychotics for extended periods in the past will be largely exempted from any requirements of the new policies. In most cases, primary care providers have no documentation of why a medicine was started, and it is possible that for many there may be no need for continuation. These "pre-existing" patients represent a considerable number of the children treated. Primary care providers should feel encouraged to push for re-evaluation of patients who have been treated for many years, in some cases this may be done best by referral to a board-certified child and adolescent psychiatrist.
- **Psychiatric Hospital Response To "Disruptive Behavior"** -

This policy does not stem the tide of parents seeking help with an "out-of-control" child at the emergency room. This scenario typically leads to a psychiatric hospital stay. In Arkansas, it is rare for a child to be discharged from a psychiatric hospital without psychotropic medications (most often including an antipsychotic).

- **Identification of "At-Risk" Patients** - Primary care providers do not have tools to identify all of their assigned children who receive antipsychotic (or other psychiatric) medications. Identifying treated children would assist in instituting monitoring protocols to identify and manage complications. Record review activities may qualify as billable coordination of care services. Provider relations representatives of the Arkansas Foundation for Medical Care may be a resource.

Related Resources:

For questions on behavioral or psychiatric problems in children or adolescents, Contact UAMS' [Psych TLC](#) program at (501) 526-7425 or (866) 273-3835.

For questions about forms, monitoring or patient medication use history, contact the Prior Authorization Call Center at (501) 526-4200, or (866) 250-2518.

Final Note

As the primary driving force behind these changes, Dr. Helm is keenly interested in comments and thoughts from providers regarding DHS' new policies on antipsychotic medication use. Please forward your comments and experiences to mehelm@ymail.com. Note that Dr. Helm is not affiliated with DHS or the Division of Behavioral Health Services, and confidential patient-specific information should not be shared.

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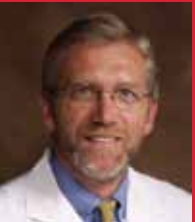
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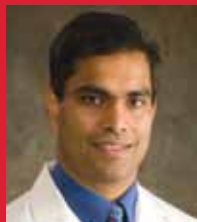
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