New Officers and Directors for the Coming Year

Health Care Improvement Initiative Update

The Arkansas Family Physician

Volume 16 • Number 4

Dr. Lonnie Robinson, Our 65th President with his family, Stone, Robin, Caroline and Mari Claire

(See page 8 and 9)

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The Arkansas Family Physician

The Arkansas Family Physician is the official magazine of the Arkansas Academy of Family Physicians

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Edition 61

Dear Academy Member,

Another year has almost gone by with lots of activity this year!! The Annual Meeting is now over and was again a success although with an attendance of less than we have had in years. The Comprehensive Primary Care Initiative was announced, kicked off with participants selected in the next few days of who will be participating from Arkansas. This issue includes the announcement of the Arkansas Health Care Payment Improvement Initiative and newly elected officers and board members to lead the Arkansas AFP!!

A healthy profit was made from the Annual Scientific Assembly in spite of the lower attendance. We had already started to cut what we considered to be unnecessary expense and will be looking at the comments made by our attendees this year and hopefully from those of you that did not attend to see how we can do better and draw more of you to our annual assembly! Let us know why you did not attend and what we can do to attract you to our meeting!!

The days are not set in concrete for next year due to the Board's upcoming decision on whether to have it on Wednesday through Friday or Thursday through Saturday but the dates of June 12-15 are on hold until we determine the days the meeting will be held and will again be at the Doubletree Hotel in Little Rock. We would like to know your thoughts on what days of the week work best for you to attend!! We would also like to know if our current lecture type series is what you like or if you would prefer a combination of lectures and hands on workshops. The Installation of Officers event we will also review to determine how best to obtain a better attendance and other items to be considered include doing away with the printed syllabus and have a special function for residents and students such as a reception or separate event. We need your input to provide to the Board of Directors at our upcoming September meeting. Please email us your thoughts on the annual meeting to arafp@sbcglobal.net.

We will also be focusing the next couple of months on those of you due for re-election that do not have sufficient hours for re-election and on recruiting those dozens of members who were dropped the end of May for non payment of dues! If you are in need of hours or if you were dropped for CME or non payment of dues recently, please give us a call and we will do everything possible to assist in retaining your membership.

We value your opinions and suggestions and look forward to hearing from you! Please visit our website at arkansasafp.org!!

Sincerely,

Carla Coleman
Executive Vice President

COVER IMAGE:

DR. LONNIE ROBINSON, OUR 65TH PRESIDENT WITH HIS FAMILY

PHOTOGRAPHS BY: DARRICK WILSON PHOTOGRAPHY

Lonnie Robinson, M.D., President

President's Message
by Lonnie Robinson, M.D., President

Winds of Change

Like you, I have heard many theories over the past couple decades about how healthcare and its delivery is expected to change. I was a young, idealistic medical student in the early 1990's when Hillary Clinton initiated the public discussion on this. I can quite honestly say that as a student with a large amount of debt, the talk at that time of socialized medicine and capitation made me more than a little nervous.

As time went by and the noise of reform died down, I lulled myself into a comfortable denial through the rest of medical school and residency. I became assured somehow that status quo would be maintained and I would be able to cruise into my career with no major change disrupting the expectations of what my private practice would be like.

However, that noise that faded in the 1990's has returned in the last several years, and seems to be rising in volume, becoming more and more clamorous. The spark for this resurgence is the gloomy data that we have been hearing *ad nauseum* for the last couple of election cycles. We rank last globally among developing countries in quality measures despite spending the most on our healthcare. Our proportion of GDP spent on healthcare is growing at an unsustainable rate. Medicare will go broke within the next couple of decades. *Blah, blah, blah…*

As a physician, I find all this negative data offensive and demeaning. As an American, I find it to be downright embarrassing. As a husband, father and business owner, I find it more than a little concerning.

In discussing this issue with my colleagues, we seem to have arrived at various pacifying explanations for this American anomaly: our litigious environment leads to defensive medicine; our non-compliant/free-willed patients don't take care of themselves and over-utilize services; pharmaceutical companies charge outrageous prices for new drugs; insurance companies limit benefits but pay their executives outlandish salaries; the American Public demands the highest level of care and technology and will not settle for cost-effective care, etc., etc.

After all, it can't be our fault… we provide the best healthcare in the world…no one should question our ability to deliver a quality product as physicians, right? There must be something wrong with either the system or our patients, because the fault can't possibly lie with us!

All of this depressing information can really make it easy for a doctor to become cynical and pessimistic. Trust me, I've been there.

But I think there is some reason, especially for Primary Care, to be optimistic in the current environment when there's very little else to be optimistic about. My personal awakening to this new optimism occurred in 2011 while listening to Dr. Rick Kellerman, a member of the AAFP Board of Directors, address our chapter at the Scientific Assembly. He was speaking on healthcare reform and the value of family medicine to this effort. He made a systematic and compelling argument that Primary Care has the answers to the problems that have plagued our system for so long.

In his evaluation of the common denominators in these other countries to which we are so often compared, Dr. Kellerman noted that several interesting findings can be found. As the number of Generalists increase in a given population, quality improves and costs decrease. Conversely, as the number of Specialists in a given population increases, the quality and cost ratio becomes unfavorable. As previously noted, the United States ranks last in quality and first in cost. We also rank last in the number of primary care physicians per capita. Unless this trend is reversed, we can expect no improvement in our nation's standing in delivering high quality, low cost healthcare.

Two factors have been clearly demonstrated to reduce an individual's risk of healthcare disparity: having health insurance and having a primary care physician. The Affordable Care Act of 2011 was an attempt to address the former; the latter is going to be extremely difficult to address unless there is some change in our system of reimbursement. We have a significant shortage of Primary Care Physicians in this country, and medical students will continue to choose to sub-specialize unless something is done to incentivize a choice for Primary

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continued from page 4

Care. The best and fastest way to increase the number of Primary Care Physicians in our country is to increase their pay – and do this in a way that facilitates a lifestyle that is favorable. In the past, the only way a Primary Care Physician could increase their income was to increase volume by seeing more patients, often in practices that are already too busy. We are all aware that increasing volume decreases quality, so this option is not going to help the overall system.

I believe – and this is not an original thought; I am clearly not alone – that the winds of change are picking up and they are blowing in a favorable direction for Primary Care. New payment models are being implemented and some of them signal a bright future for our specialty. Specifically, a blended payment model seems to be the direction many are pointing to as the future of healthcare reimbursement and delivery. The days of fee-for-service as the sole means of payment are rapidly moving into the past. The new era is likely to see a blending of fee-for-service, management fees and shared savings.

Yes, there will be some "quality hoops" to jump through. We will no longer be able to say, "I'm a great doctor" and be taken for our word… we will have to prove it! We will definitely have to change in order to meet the challenges of the new system.

But I hope that as you look with me to the future, you will choose to see the silver lining in the clouds of healthcare reform, and embrace the good that you can find in the change that is surely coming. Family Physicians are uniquely qualified to be the leaders in the transition of our healthcare system into a model of efficiency. If we choose to embrace this change *and own it*, taking up the banner of the Patient Centered Medical Home and some of the other innovations our colleagues are promoting across the country, I think it could be the dawn of a bright future for Primary Care in general, and Family Physicians in particular.

Though change can be scary (and my natural bent is definitely towards cynicism rather than optimism) I can't help but be excited about what these changes could mean for our specialty. I am sure that there will be challenges and difficulties, but I suspect that none of us can recall a time when anyone outside our ranks has offered to recognize and increase the value of our specialty, and to reward us for doing what we do best: taking care of the whole patient.

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Dr. Lonnie Robinson Installed AR AFP President

The Robinson Family.

Doctor Lonnie Robinson of Mountain Home was installed the 65th President of the Arkansas AFP by Doctor Richard Madden of Belen, New Mexico, a Board Member of the American Academy of Family Physicians. This event was held on Friday night June 15 at the Installation of Officers Banquet during the Annual Scientific Assembly at the Doubletree Hotel in Little Rock.

Doctor Robinson presented to Doctor Jeff Mayfield, immediate past President a plaque of appreciation for his year of service to the AR AFP and presented a short power point presentation of the issues facing family medicine and the AR AFP in the coming years. He spoke of the need to reach out to family practice residents and newly practicing family doctors with information about the benefits of membership in the Academy and how important it is to inform medical students about the joys of family medicine and how a family doctor can do just about anything they wish as long as they are adequately trained.

Dr. Madden congratulates Dr. Robinson with his wife, Robin and daughter looking on.

Doctor Robinson has practiced since 2000 in Mountain Home and does the full spectrum of family medicine including obstetrics. He graduated from UAMS in 1997 and completed his family medicine residency at UAMS AHEC Jonesboro in 2000. He has served on the AR AFP Board since 2002, is a Diplomate of the American Board of Family Medicine, a Fellow of the AAFP and a member of several other medical related organizations. He also was the 2011 recipient of the Dr. Faye Boozman Award bestowed annually to an Arkansas Physician who exemplifies strong Christian faith and commitment to community and service and public health.

New Officers and Directors Installed for Coming Year

Dr. Madden, Dr. Floyd, Dr. Dixon, Dr. Dawson, Dr. Pierce, Dr. Wagner, Dr. Knight, Dr. Alexander, Dr. Bala, Dr. Macechko and Ms. Boman.

Dr. Richard Madden of Belen, New Mexico installed our newly elected Officers and Directors for the coming year at the Installation Banquet on June 15 as follows:

Dr. Barry Pierce of Mountain View was installed President Elect of the Academy for the coming year. A graduate of UAMS, he completed his family medicine residency at UAMS Pine Bluff. He is a Diplomate of the American Board of Family Medicine and has served in various offices of the AR AFP since 1996. He is currently in Emergency Room Medicine .

Dr. Daniel Knight of Little Rock was elected Vice President . A member of the AR AFP Board since 1996, he is Chairman of the UAMS Department of Family and Preventive Medicine and a Diplomate of the American Board of Family Medicine. He received his medical degree from UAMS and completed his family medicine residency at the UAMS Department of Family and Preventive Medicine.

Dr. J. Drew Dawson of Pocahontas was elected Secretary. A member of the AR AFP Board since 2005, Dr. Dawson graduated from UAMS and completed a Family Medicine Residency at AHEC NE Jonesboro. A Diplomate of the American Board of Family Medicine he along with two other physicians (Dr. Tommy Wagner and Dr. Chris Montgomery) formed "First Response Physicians" to respond to the need for medical care to victims of the hurricane in New Orleans and Biloxi in 2005.

Dr. Tommy Wagner of Manila was elected Treasurer. In this position he will also serve as Finance Chair of the AR AFP the coming year. A graduate of UAMS, Dr. Wagner completed a family medicine residency at AHEC NE in Jonesboro and is a Diplomate of the American Board of Family Medicine. He has served as Chair of the AR AFP's Legislative/Governmental Affairs Committee for four years.

Newly elected Directors to the Board installed June 15 were: **Doctor Rebecca Floyd** who graduated from UAMS and completed a Family Medicine Residency at UAMS Little Rock. Dr. Floyd is one of three Academy Members who was selected to participate in the AAFP Foundation's Patient Centered Medical Home Project last year. She practices Family Medicine at Sophia Meyer Family Medicine Clinic in Van Buren. **Dr. Michael Macechko** of Fayetteville was elected as the AHEC representative to the Board for the coming year. He graduated from UAMS and completed a Family Medicine Residency at AHEC NW in Fayetteville where he now serves on the faculty. **Dr. A. Balamurugan,** a third year resident at UAMS Department of Family and Preventive Medicine at UAMS was re-elected as Resident Representative to the Board. **Jera Boman Smith** of Little Rock was re-elected Student Representative to the Board. She is a fourth year medical student at UAMS. **Dr. John Alexander** of Magnolia was re-elected as Delegate to the AAFP Congress and **Dr. Rodney Mark Dixon**, of El Dorado, was re-elected Alternate Delegate to the AAFP Congress. Directors continuing to serve with terms on the ArAFP Board are: Doctor **Angela Driskill** of Alexander: Doctor **Len Kemp** of Paragould: **Dr. James Bryan** of Little Rock; **Dr. Timothy Killough** of Searcy; **Dr. E. Andy Gresham** of Crossett: **Dr. Jason Lofton** of DeQueen; **Dr. Senthil Raghavan** of Augusta and **Dr. James Chambliss** of Magnolia; **Dr. Julea Garner** of Hardy as Alternate Delegate and **Dr. Richard Hayes** of Jacksonville as Delegate.

The Arkansas Practice-Based Research Network

By Marcia Byers, RN, BSN

Regardless of your position on the Supreme Court ruling regarding the Affordable Care Act, the critical role that primary care clinicians serve in transforming health care systems and bridging gaps in quality care is progressively gaining attention at both the state and national level. Recent initiatives including Patient Centered Medical Homes (PCMH) and Meaningful Use (MU) are influencing funding agency announcements and directing research towards comparative effectiveness, patient centeredness and experimental reimbursement models, therefore increasing the relevance of practice-based research. As Westfall, et al. pointed out in "Practice-Based Research-Blue Highways on the NIH Roadmap":

Practice-based research may be the best setting for studying the process of care and the manner in which diseases are diagnosed, treatments initiated, and chronic conditions managed. It is in practice-based research where effectiveness can be measured, where new clinical questions may arise, where readiness to change and adopt new treatments can be studied and addressed, where patient knowledge and preferences are encountered and managed, and where the interface between patients and their physicians can be explored and medical care improved. Practice-based research is the final common pathway for improving individual patient care and outcomes.

Visitors from partnering practice-based research networks have stated that the atmosphere in Arkansas is optimal to accomplish goals related to better health, better health care and lower costs. The Arkansas Practice-Based Research Network (APBRN) is available to help your practice explore all of the possibilities listed above and connect you to resources related to PCMH, MU and continuing medical education. UAMS has re-introduced the APBRN to increase clinician engagement in research and practice improvement activities. The APBRN is a research network within UAMS Regional Programs' Division of Research and Practice Improvement. Its mission is to support its members as they plan, conduct and evaluate research and practice improvement initiatives and disseminate

findings to improve the health of Arkansans. Small pilot funds are now available to assist members in exploring and expanding their research interests! Contact one of the APBRN staff members below for information on how to apply. Additionally, researchers interested in projects related to primary clinical care, education, prevention, etc. can contact us for assistance with practice recruitment and initial proposal development that is sensitive to patient flow and clinic needs.

How to join

Membership in the APBRN is voluntary and is open to researchers, clinicians and students in Arkansas. A membership survey is necessary for tracking the demographic reach to clinicians and patients and enhancing the generalizability of APBRN studies. A staff member from the APBRN is available to visit practices to explore their interest in practice-based quality improvement and research projects. For more information, please call or email an APBRN staff member at: 501-686-6195 or apbrn@uams.edu. Visit us online: http://ruralhealth.uams.edu/apbrn and www.facebook.com/apbrn.

APBRN Projects

If you are: 1) interested in learning about current projects; 2) Interested in partnering with other clinicians and researchers; or 3) Interested in leading your own study, please contact Marcia Byers at 501-686-7871 or visit http://ruralhealth.uams.edu/apbrn to join the network.

Robert Price, PhD, Director, rdprice@uams.edu

Marcia Byers, BSN, Assistant Director, mabyers@uams.edu

Zuzana Gubrij, MA, Research Manager, zgubrij@uams.edu

Reference

Westfall JM, Mold J, Fagnan L. Practice-Based Research—"Blue Highways" on the NIH Roadmap. *JAMA*. 2007;297(4):403-6

Letter from Glen Stream, AAFP President

Many of you have probably read in the mainstream media about a backlog at the U.S. Department of Veterans Affairs in processing applications for disability benefits — a backlog now totaling 558,000 claims. These delays are due in part to a generation of Iraq and Afghanistan veterans with more complex claims, and a decision two years ago to expand compensation for Agent Orange-related illnesses. Claims also increase in a poor economy.

The White House has asked the AAFP to increase awareness of this issue among our members, and to encourage the nation's private physicians to help in filling out Disability Benefit Questionnaires (DBQs) for their patients who are veterans.

These DBQs solicit the medical information necessary to evaluate veterans' medical conditions. The VA has developed more than 70 DBQs, specific to various conditions such as hearing loss or arthritis that veterans can take to private physicians to fill out. Completed DBQs will help speed the processing of veterans' disability compensation and pension claims. According to the VA, the streamlined forms use check boxes and standardized language so that the disability rating can be made accurately and quickly. DBQs can be viewed on the VA website.

All physicians with active medical licenses who are treating veterans can complete the DBQs. The VA will not reimburse physicians for helping veterans complete their DBQs — veterans are responsible for any related costs.

I encourage all family physicians to seek out their patients who are veterans and volunteer to help them fill out the appropriate DBQs. This will help the VA determine the appropriate benefits to these national heroes and is one way we can honor their service. Thank you in advance.

Regards,

Glen Stream, MD, MBI, FAAFP AAFP President

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The Primary Care of Fetal Alcohol Syndrome

G. Bradley Schaefer, MD
Professor of Genetics and Pediatrics, University of Arkansas for Medical Sciences

It is unfortunate that Fetal Alcohol Spectrum Disorders (FASDs) are quite common. It is estimated that at least 4,000 births per year in the United States are children with 'full' Fetal Alcohol Syndrome (FAS). The spectrum of alcohol related birth defects extends beyond the FAS phenotype to much more subtle presentations. As such, this group may actually account for 30% of all neuro-developmental disabilities. This clearly makes alcohol-related birth defects the most common cause of neuro-developmental disabilities. The clinical impact and societal effects are tremendous. The lifetime additional health care costs for one person with FAS are around $750,000. Current estimates suggest that the treatment of individuals with FAS cost around $6 billion per year in the United States. This figure does not include the services needed for the more mildly affected individuals.

The most important aspect of FASDs is that they are entirely preventable. Family practitioners in their participation in the health of patients across the lifespan are extremely well suited to effect real change in the prevention of these conditions. Possible areas that family practitioners can effect change include:

1) The education of women of child bearing age prior to conception
2) Screening for alcohol use during pregnancy
3) Intervention to stop alcohol use in pregnancy if identified
4) The recognition of features of FASDs in infants and children
5) Coordination of needed services for individual affected with FASDs

Preconception counseling

As already mentioned, the most important aspect of FASDs is that they are entirely preventable. All health care providers should be prepared to provide the accepted standard counseling of complete abstinence from alcohol during pregnancy and while trying to conceive. Abundant data exist to suggest that the most important factor in changes in behavior before and during pregnancy is advice from the woman's health care professional. Stated another way, the best way to keep a woman form drinking during pregnancy is for her to hear this advice from 'her doctor.' This point can't be over-stated. Family Practitioners need to be aware of the great influence that their advice carries. They should take advantage of this and encourage all female patients of child bearing age to abstain from alcohol during pregnancy. Another important note is that pregnancies are often not identified until 8-10 weeks of gestation. Women should be counseled to abstain for alcohol if there is any chance that they might conceive.

Screening during pregnancy

While pre-conception intervention is the ideal, it is usually not easily accomplished. Few women present for pre-pregnancy advice. When a woman presents for her first visit with a diagnosed pregnancy, any health care provider that will be helping with her care should be prepared to ask targeted questions. There are several well established tools that require as few as five quick questions that are quite good at getting a clear answer. There is no one method or tool that works best for every practice. Simply, it is encouraged that every health care setting that cares for pregnant women have a formal policy for obtaining the requisite answers. Recognition of high risk pregnancies and appropriate intervention may prevent or at least attenuate significant exposures.

Intervention during pregnancy

Of course screening without intervention is a wasted effort. If a pregnant woman is identified as using alcohol during the pregnancy, the health care professional should be prepared to assist her in quitting. Few practices are equipped with the social and mental health services needed to accomplish this. Thus, each practice is encouraged to have a current list of facilities to which a referral can be made. As simple as all of this sounds, the impact is amazing. Asking the right questions and making the correct referrals can prevent a tremendous amount of disability. It is well worth the effort.

Recognition

All health care providers who work with children (and adults) with special health care needs should be alert to the features of FASDs. Early recognition and interventions are associated with better outcomes. The key to early identification and recognition is a high index of suspicion. The family practitioner should always consider FASDs in the setting of *in utero* growth retardation, post-natal growth failure, microcephaly, problems with neonatal adaptation, developmental delays, neurobehavioral disorders, and dysmorphic facies. Obviously, a maternal history of exposures should warrant careful consideration.

Some health care providers (and families) request an "FAS test" for a child. However, the diagnosis of FASDs is still solely a clinical diagnosis. Currently the

only way to identify an FASD is by the use of clinically accepted standards. The CDC FAS criteria of 2004 are still considered the standard for diagnosis. Below are the three major components of the diagnosis of FAS.

1. The diagnosis requires the presence of three specific facial changes: flat philtrum, a thin vermillion and shortening of the palpebral fissures. These features are not dramatic and can be easily overlooked in those children who are typically considered cute and often described as having "pixie features."

2. Growth deficiency, < 10th percentile on length and weight growth charts. This can be prenatal, postnatal or both. The postnatal growth pattern is best described as a primordial short stature (weight is appropriate for length), *not* failure to thrive (weight is less than it should be given the length of the child).

3. Central nervous system effects, including structural changes (microcephaly (head circumference < 10th percentile on growth charts) and varying degrees of cerebral dysgenesis). It is important to note that these changes are often midline. There is, however, no specific pattern of cerebral dysgenesis in children with FAS. Functional CNS changes may also occur including problems with cognition, seizures, memory, coordination and neuro-behavioral disorders.

One important point to consider is that a history of alcohol exposure is important, but not essential to making the diagnosis of an FASD. The diagnosis can be made in those cases in which the features are sufficiently strong that a drinking history is not needed to make a diagnosis. If the family practitioner has questions about the diagnosis on a particular case, consultation with a geneticist/dysmorphologist may prove helpful.

Coordination

Treatment of these disorders begins with an accurate diagnosis once an FASD is identified in a specific patient, prompt referrals and enrollment in indicated services are necessary to achieve the best outcomes. As with all developmental interventions, early initiation of treatment and individualization of interventions will increase the likelihood of progress. The greatest challenges for treatment may fall into the behavioral and cognitive domains and should be treated with a combination of behavioral and environmental modifications.

Individuals with FASDs face a wide array of challenges that hold the potential for poor life outcomes. However, one should not lose sight of the fact that with proper interventions many persons with FASDs have good outcomes. The key is starting treatment early in life and tailoring the treatment plan to the specific needs of the individual.

Comprehensive Primary Care Initiative Draws 116 Applications From Arkansas PCP's

A total of 116 Arkansas Family Physicians made application with CMMS for the Comprehensive Primary Care Initiative announced in June with applications ending July 20.

To get the word out to all of our members, we had a town hall meeting during our annual assembly with representatives from Blue Cross Blue Shield, QualChoice, the Department of Human Services Medicaid Division, the Ar Foundation for Medical Care to participate in a Q and A session. Humana is also a participating insurer of the CPCI. In addition, we did several blast emails and participated in three conference calls and webinars with CMMS, the American Academy of Family Physicians that allowed our members to ask questions about the CPCI.

In June the Centers for Medicare and Medicaid Services Innovation Center announced the process to apply for the CPCI, a four year Multi payer initiative aiming to strengthen primary care practices' role in promoting health, improving care and reducing overall health care costs. The entire state of Arkansas was one of seven markets selected in the U.S. to participate along with Colorado, New Jersey, Oregon, New York's Capital district, Ohio and Kentucky's Cincinnati Dayton region and the greater Tulsa, Oklahoma region. The markets were selected based on a diverse pool of applicants from commercial health plans, state Medicaid agencies and self insured businesses who hoped to work alongside Medicare to support comprehensive primary care.

Under the CPCI, CMS will pay primary care practices a care management fee initially set at an average of $20. Per Medicare beneficiary per month to support enhanced coordinated services. Simultaneously, participating commercial, State and other federal insurance plans are also offering an enhanced payment to primary care practices that provide high quality primary care.

Approximately 75 practices in each market area will be selected to participate. Announcements of the practices in Arkansas selected will be made in mid August.

Our appreciation to everyone that assisted in getting the message out and to Dr. Randal Oates who served as our facilitator at the town hall meeting and on a phone-in conference call!

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RESIDENCY PROGRAM DIRECTOR NEEDED!!

The University of Arkansas for Medical Sciences Department of Family and Preventive Medicine is looking for a dynamic, forward-thinking faculty member to join the department in Little Rock as residency program director. The department is a leader in quality patient care, is the first NCQA level 3 recognized PCMH in the state, and serves as the campus leader in medical informatics. We have robust programs in community research and continuing medical education and are leaders in on-campus student and employee health areas.

The position is challenging and will involve establishing the direction of the residency and the department, providing patient care, and teaching residents and medical students. The ideal applicant will have broad academic interests, including scholarly activity.

Women and underrepresented groups are encouraged to apply. Contact Daniel Knight, M.D., Department Chair (daknight@uams.edu) for additional information and/or to apply for this position.

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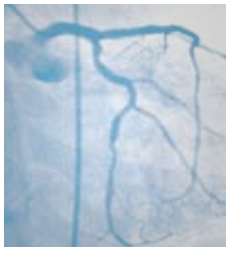

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Update on the Arkansas Health Care Payment Improvement Initiative

I have lots of news to share about the Arkansas Health Care Payment Improvement Initiative.

First, the initial rule changes needed to implement the Medicaid portion of the initiative received favorable legislative review earlier this month. State Medicaid Plan amendments also have been submitted to the Center for Medicare and Medicaid Services (CMS), and that agency has indicated that we should receive a response soon. Our conversations with CMS have been very positive.

Additionally, the Center for Medicare and Medicaid Innovation recently announced a long-awaited opportunity for technical assistance, program flexibility and federal grant funding related to this initiative. The deadline for submitting our application is Sept. 17.

Most exciting is that we officially launched the preparatory period of the initiative, which means providers who are designated as Principal Accountable Providers (PAP) for the first wave of episodes can access comprehensive reports of their average quality, costs, and utilization for the previous year through the Provider Portal as of today. The portal is a HIPAA-compliant online tool that allows hospitals, physicians, mental health providers and other providers to access reports and submit a limited set of additional quality metrics data that will to be tied to the initiative's financial incentives.

To access reports, providers can go to http://www.paymentinitiative.org/portalProvider/Pages/default.aspx and follow the instructions. For the initial reports, the Department of Human Services also will mail paper copies to providers in early August. Reports from Arkansas Blue Cross and Blue Shield will be accessible through the Provider Portal this afternoon. Reports from QualChoice of Arkansas will be available this fall. To help providers navigate the reports, we have created an easy-to-understand guide that uses an illustrative example.

We know that providers may have additional questions as they read through their reports. I want to encourage those with questions or concerns to contact our knowledgeable customer service team at ARKPII@hp.com, 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of-state).

I also want to encourage providers and others who may be interested to attend one of the 10 town hall meetings DHS, Arkansas Blue Cross and Blue Shield and QualChoice of Arkansas will be hosting in August. These meetings were scheduled to give stakeholders, providers and others across the state with the information they need about the initiative. There will be ample time for questions at each event. There has been one date change since we first announced the town hall events. The Springdale town hall will now be held Aug. 23 from 4 to 6 p.m. in the same location. Because of scheduling issues, we have canceled the Springdale town hall that was set for Aug. 15. To see the full schedule, go to http://www.paymentinitiative.org/calendar/Pages/default.aspx.

Lastly, I wanted to share Andy Allison's analysis of the Medicaid-related impact of the Patient Protection and Affordable Care Act with Medicaid expansion. As leaders in the health care community, I know you may get questions about the implications of expansion. So here you can find the analysis summary as well as a more detailed spreadsheet. The decision to implement expansion rests with the Governor and Legislature and likely won't be made before next year. In the meantime, we at DHS continue to move forward with the payment initiative to help better manage Medicaid costs and improve the quality of care patients receive.

As we move to the next phase of this initiative, I want to take this opportunity to thank all of you for the important input you have provided as we developed this model and for all the thought-provoking questions along the way. Your input has made this a much stronger initiative that we truly believe will be a model for the rest of the country.

Regards,

John Selig
DHS Director

AAFP Congress of Delegates, October 15-17 in Philadelphia

Arkansas AFP will be represented at the AAFP Congress of Delegates in Philadelphia October 15-17 by Delegates Doctor John Alexander of Magnolia, Doctor Richard Hayes of Jacksonville, Doctor Julea Garner of Hardy, Doctor Rodney Mark Dixon of El Dorado, Dr. Lonnie Robinson of Mountain Home and Carla Coleman of the AR AFP Office.

One of the many items being considered at this Congress is a Bylaws revision that has been in process for three years with several drafts posted on the AAFP website for members comments. Several other resolutions will be proposed during the Congress. You may access the resolutions being submitted and review them on the AAFP website. (See page 23)

We are pleased to welcome Dr. James Meserow and announce the opening of the Center for Maternal-Fetal Medicine (A Baptist Health Affiliate).

Dr. Meserow graduated from Princeton University and received his medical degree from Rush Medical College in Chicago. He completed his residency at Rush University Medical Center, a fellowship in Critical Care Medicine at the University of Pittsburgh, and a fellowship in Maternal-Fetal Medicine at the University of Illinois.

He has served as the Director of Obstetrics and Maternal-Fetal Medicine at the former Michael Reese Hospital.

He is board certified in both Obstetrics and Gynecology as well as Maternal-Fetal Medicine. His practice interests include pre-conceptual counseling, pre-natal care of patients with complex medical problems, care of critically ill obstetric patients, and pre-natal ultrasounds. Dr. Meserow has more than 25 years of experience in this unique field and is excited about bringing his experience to patients and family members in Central Arkansas.

For more information or to schedule an appointment, call 501-223-2080.

Center for Maternal-Fetal Medicine

A Baptist Health Affiliate

9501 Lile Drive, Medical Towers II, Suite 800

501-223-2080

AR AFP Membership Statistics

Total membership in the Arkansas Chapter for the month ending June, 2012 was 1138 a loss of a total of 62 members since April, 2012. This is due to members being dropped from the roles for failure to report the necessary number of hours of CME for continued membership (150 each three year period) but the highest number was for non payment of 2011 membership dues.

To assist those new members from residency into practice, the Arkansas and American Academy reduced their first year Active member dues to ½ the cost. Life and Inactive members do not pay dues to the Arkansas chapter – only to the AAFP.

Looking at current statistics for the end of this year, we have 224 members who still owe 2012 dues and 146 members in need of continuing medical education hours to be re-elected at year end.

If you are in need of CME hours please be reminded that you can access the AAFP online and obtain many CME hours at no charge. The AAFP Journal quiz can be done online and you can go back one year to complete those quiz's. Teaching medical students, residents, etc. allows you to claim up to 20 Prescribed hours per year and you may claim 25 each three year period for enrichment type activities. These are classified as Elective credits. If you have taken a PALS course, an ACLS course, ATLS, please remember to record your hours. If you attended a course presented by the Arkansas AFP, we have reported your hours for you!

Those of you with dues outstanding, please remit your dues to the AAFP. If you do not know if you have paid your dues for this year, you may go online to the AAFP website and access your record with your i.d. number to see how many hours you have reported, when your re-election is and if you have paid your dues.

If you have been dropped from membership for dues payment, you can simply remit your dues to the AAFP for reinstatement. We value your membership and hope that you will contact us if we can help you in any way.

ARAFP Board Dates Set For Coming Year

Dates for Board of Directors meetings for the coming year have been scheduled as follows:

September 29 from 9 a.m. til Noon in the Academy Office

November 14 from 1 p.m. til 4 p.m. in the Academy Office

March 6 from 1 p.m. to 4 p.m. in the Academy Office

June 14 or 15 during the AR AFP Annual Scientific Assembly in Little Rock at the Doubletree Hotel

Any member of the AR AFP is cordially invited to attend any of our board meetings!!

2013 Ar AFP Annual Assembly **June 12-15, 2013** Doubletree Hotel, Little Rock

Other Important Dates:

October 15-17, 2012 AAFP Congress of Delegates Philadelphia, Pa

February 16-17, 2013 – Multi State Meeting, Dallas

April 25-27, 2013 – Annual Leadership Conference, Kansas City

September 23-28, 2013 – AAFP Congress of Delegates, San Diego

Tick-related illnesses in Arkansas:
Myths and management

By J. Gary Wheeler, MD, MPS, and Jose R. Romero, MD, FAAP

The burden of tick-borne illnesses in Arkansas is one of the highest in the United States. In 2010, Arkansas ranked first among the states for reported cases of tularemia, fourth for Rocky Mountain spotted fever (RMSF), and tenth in reported cases of *Ehrlichia chaffeensis*.[1] In association with this high level of prevalence, there continues to be much misinformation about the appropriate diagnosis and management of these diseases. This review will attempt to update providers about these subjects.

One of the most important points in managing tick-borne illnesses is realizing that they are each quite different in their presentation and should not all be lumped together for diagnostic purposes. Ehrlichiosis (caused by *E. chaffeensis*), anaplasmosis (caused by *Anaplasma phagocytophilum*), and Rocky Mountain spotted fever (caused by *Rickettsia rickettsii*) are the most similar, presenting with fever, headache, photophobia, and rash. An emerging illness is associated with the Gulf Coast tick (*Amblyomma maculatum*) and caused by *R. parkeri*, which produces similar symptoms. Not all features are present at the beginning of the illness. The rash, if present, can begin very non-specifically before becoming a classic petechial process. Other features, such as diarrhea, occur more commonly in children. The disease can progress very quickly, with most mortality occurring after five days or more of symptoms.[2]

Tularemia (caused by *Francisella tularensis*) has several different presentations depending on the route of inoculation. The most common presentations are those of glandular or ulcero-glandular disease that occur as a result of a tick bite or other cutaneous inoculation event. While both syndromes are associated with regional lymphadenopathy, the latter is also associated with an ulcer at the site of inoculation. Uncommonly, conjunctival inoculation can result in conjunctivitis and pre-auricular node involvement (Parinaud's syndrome). With oral inoculation from consumption of infected rabbit or deer meat, a typhoidal syndrome can result. Inhalation of tularemia leads to the development of pneumonia and can be seen in laboratory workers, bioterroristic exposure or the aerosolization of infected rabbits by lawn mowers, or systemic forms such as meningitis and sepsis.

Lyme disease is not acquired in Arkansas. It mainly presents with a circular skin lesion called erythema migrans that radiates outward over time from the tick bite. Meningitis and carditis can occur three to 10 weeks after a tick bite, and arthritis two to 12 months after. Lyme disease is often mistakenly attributed to tick granulomas or other hypersensitivity reactions to bites that are very common in Arkansas. Southern Tick Associated Rash Illness (STARI) may also be confused with erythema migrans. It is a poorly defined entity with no definite pathogen identified as of yet. To date, no long term complications of STARI have been described, nor has the requirement for treatment been determined.

The epidemiology of tick-borne illness is important in a correct diagnosis. The different illnesses above are transmitted by different types of ticks. The vectors of ehrlichiosis, RMSF, and tularemia are the Lone Star and American dog ticks (*Amblyomma americanum* and *Dermacentor variabilis*, respectively), and the vectors of Lyme disease and anaplasmosis are the black legged ticks (*Ixodes scapularis* and *I. pacificus*).[3] The latter ticks are uncommon in Arkansas and the infected nymphal forms, required for transmission, are rarely recovered. Patients who have traveled to the upper Midwest, New England and the Atlantic Coast, where Lyme disease is endemic, are the main suspects for this disease. The Gulf Coast tick is not found in Arkansas to date, but a history of travel to the Gulf Coast should prompt questions of tick exposure. The Lone Star and American dog ticks are extremely prevalent in Arkansas. Patients are typically unable to identify the ticks correctly, and more importantly, the absence of a history of tick bite is found in about half of proven cases of tick-associated illnesses. The period of tick feeding can be brief

continued on page 24

continued from page 22

and not noted by the host.

Diagnosis of tick-borne illness is clinical. In addition to the findings on history and physical exam noted above, RMSF and ehrlichiosis are associated with thrombocytopenia, very high numbers of immature neutrophils and hyponatremia as the illness progresses. In tularemia, pleural effusions and meningitis are often noted to have lymphocytic cell differentials. Commonly available diagnostic tests are often negative in the first one to two weeks of the illness. As such, treatment should begin before laboratory confirmation of disease. Testing should be syndrome specific and "tick panels" should be discouraged. Confirmation of RMSF, ehrlichiosis or tularemia is done by antibody measurement: Determination of acute and convalescent titers are desirable, demonstrating a four-fold increase for a solid diagnosis. It is important to note that in endemic areas, many people have had tick-borne infections that have resulted in subclinical illness and recovery. These patients will have low positive titers that will not rise when convalescent serology is performed. PCR testing for ehrlichiosis is available and helps with diagnosis in the acute phase but can become negative quickly with antibiotic treatment. It is important to note that a negative PCR assay does not exclude ehrlichiosis. Testing for Lyme disease is generally futile as a screen because the false positive rate (IgG and IgM even with Western blot studies) far exceeds the true positive rate due to the extremely low incidence of disease. *F. tularensis* is the one agent that can be routinely cultured from infected lymph nodes, blood and spinal fluid. It is critical to warn the laboratory if this illness is suspected since growth on agar plates can be highly infectious to the laboratory personnel and specific protective practices need to be put in place.

Treatment of tick-borne illness depends on the specific pathogen/syndrome. Empiric doxycycline is recommended for suspected ehrlichiosis or RMSF with a minimal course of one week or until fever has stopped for several days. Long-held prohibitions of use of this drug in children under 8 years of age, due to concerns of tooth staining, persist and have led to deaths in this state due to a delay in treatment. Several reports have shown that the risk of tooth staining occurs from cumulative doses of tetracycline. If the cumulative dose prior to age 8 is fewer than three to four weeks of therapy, there is no risk of tooth staining.[4,5] More importantly, the risk of death from RMSF has been estimated at 30 percent in the pre-antibiotic era, and far outweighs the morbidity of tooth staining. Tularemia is treated with gentamicin, usually for seven to 10 days. Doxycycline is an alternative but approximately one-third of patients will relapse and require re-treatment. For patients with a typical rash who have just returned from endemic areas, acute Lyme disease is treated with amoxicillin for 14 days. Suspected early localized and late onset disease should be referred to an infectious disease specialist.

J. Gary Wheeler, MD, MPS, is branch chief of infectious diseases for the Arkansas Department of Health and a professor of pediatrics at the University of Arkansas for Medical Sciences. Jose R. Romero, MD, FAAP, is Horace C. Cabe Professor of Pediatrics and chief of pediatric infectious diseases at UAMS and director of clinical trials research at the Arkansas Children's Hospital Research Institute.

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Key points

1. Tick-borne illnesses have specific recognizable syndromes
2. Lyme disease in Arkansas is limited to travelers returning from endemic areas and screening for Arkansas-acquired disease is associated with false positive results
3. Treatment should begin before laboratory confirmation of disease
4. Doxycycline is acceptable therapy for all children with RMSF or ehrlichiosis

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ARAFP Committee Chairs Named

At the Organizational Meeting of the AR AFP Board, the following Board members were named as Committee chairs for the coming year: Dr. Lonnie Robinson, Chair of the Executive Committee: Dr. Tommy Wagner, Chair of the Finance Committee: Dr. James Bryan, Chair of Membership, Member Services, Public Relations and Publications: Dr. Jeff Mayfield, Chair of the Scientific Program: Dr. Dan Knight, Chair of Education: Dr. Drew Dawson, Chair of Health Care Sevices/Quality and Practice: Dr. Danny Proffitt, Chair of Planning: Dr. Tommy Wagner, Chair of Legislative: Dr. Julea Garner, Chair of Bylaws.

From AAFP NEWS NOW:

New Vaccine Protects Infants as Young as Age 6 Weeks Against Meningococcal, Hib Disease

Family physicians now have a new weapon in their immunization armamentarium, thanks to the FDA's recent approval of GlaxoSmithKline Biologicals' application to market its meningococcal groups C and Y and *Haemophilus* b tetanus toxoid conjugate vaccine, MenHibrix, in the United States. The vaccine is indicated for the prevention of invasive disease caused by *Neisseria meningitidis* serogroups C and Y and *Haemophilus influenzae* type b (Hib) and is approved for use in children ages 6 weeks through 18 months.

According to Karen Midthun, M.D., director of the FDA's Center for Biologics Evaluation and Research, approval of the new product "means there is now a combination vaccine that can be used to prevent potentially life-threatening Hib disease and two types of meningococcal disease in children." "It is the first meningococcal vaccine that can be given starting as young as 6 weeks of age," she said in a June 14 FDA news release. The vaccine's package insert calls for MenHibrix to be given as a four-dose series at ages 2, 4, 6 and 12 through 15 months. The first dose may be given as early as age 6 weeks, and the fourth dose may be given as late as age 18 months. In its approval letter, the FDA directs vaccine manufacturer GlaxoSmithKline to conduct a Phase III controlled, multicenter study to evaluate concomitant administration of MenHibrix with rotavirus, 13-valent pneumococcal conjugate and hepatitis A vaccines administered according to the CDC-recommended vaccine schedule. The study is to begin no later than Oct. 31, 2013, with a final study report to be submitted by Dec. 15, 2016.

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Arkansas Becomes First State to Receive Federal Approval to Begin Phase II of Health Information Exchange Implementation (HIE)

- Arkansas successfully completed the first-phase of implementation of SHARE, the State Health Alliance for Records Exchange, Arkansas's statewide HIE. Phase I entailed using Direct standards for Secure Messaging to enable participating physicians, authorized health services professionals, and hospital facilities to exchange patients' clinical information from point to point.
- In Phase II, providers who participate in SHARE will utilize the Optum HIE solution to exchange and query clinical data to inform care processes and decisions.

LITTLE ROCK, ARK. Jul. 18, 2012 - Arkansas has become the first state in the nation to receive federal approval to begin Phase II of its statewide health information exchange (HIE). SHARE the Arkansas HIE, will eventually enable participating health care providers to securely share patient information.

The Office of the National Coordinator for Health Information Technology (ONC) granted its approval to the Arkansas Office of Health Information Technology (OHIT) to move forward with its Phase II as outlined in its strategic and operational plans. OHIT is the entity responsible for establishing the State Health Alliance for Records Exchange (SHARE), and for coordinating the use and deployment of health information technology throughout the state.

Through the use of federal and state funding, OHIT's and SHARE's mission is to improve the quality of health for Arkansans by making the delivery of health care services more efficient and affordable, while improving patient safety. The state received $7.9 million in funding as part of the State Health Information Exchange Cooperative Agreement Program made available through ONC.

"We're delighted for Arkansas to be the first state to enter Phase II of its statewide plan for HIE implementation," said Rebecca Lee, Presidential Management Fellow, U.S. Department of Health and Human Services. "The state has demonstrated exceptional implementation progress in Phase I, and we look forward to continued momentum of HIE adoption in Arkansas and across the nation."

"All of this progress is a positive sign that the health care provider community in Arkansas understands how important better use of health information can be in improving patient care," said Ray Scott, the State Coordinator for Health Information Technology and Director of OHIT. "The work of our outstanding subcontractor partners, Oleen Pinnacle Health Solutions, and our Regional Extension Center - HIT Arkansas, is the primary reason for our success in getting such a large number of health care providers signed up so quickly," Scott added.

SHARE operates the statewide HIE with the Optum Health Information Exchange platform. During Phase I, SHARE provided secure messaging using the NwHIN Direct messaging protocols and standards to facilitate and expand the secure, electronic movement and use of health information between unaffiliated health care providers.

To date, 34 hospitals, 199 practices, 7 laboratories, and 44 other health care entities have agreed to participate with SHARE in Phase I, Phase II or a combination of both. Currently, 1112 users are registered to begin exchanging information through SHARE, with 3,000 others in the process of completing their registration.

About the Arkansas Office of Health Information Technology

The Arkansas Office of Health Information Technology (OHIT) is responsible for establishing the State Health Alliance for Records Exchange (SHARE), the statewide interoperable health information exchange, and for coordinating health information technology activities throughout the state. Through the use of federal and state resources, OHIT and SHARE will improve the quality of health for Arkansans by enabling the more effective use of electronic health information technology to improve the delivery of healthcare services. For more information about OHIT, visit www.ohit.arkansas.gov; for further information on SHARE, visit http://sharearkansas.com.

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