Happy Holidays!!

The Arkansas Family Physician

Volume 17 • Number 1

AAFP
STRONG MEDICINE FOR AMERICA

ARKANSAS LEGISLATIVE SESSION BEGINS JANUARY 14!!!

NEW ICD-10 DEADLINE: OCT 1, 2014

2014 COMPLIANCE DEADLINE FOR ICD-10

The ICD-10 transition is coming October 1, 2014. The ICD-10 transition will change every part of how you provide care, from software upgrades, to patient registration and referrals, to clinical documentation, and billing. Work with your software vendor, clearinghouse, and billing service now to ensure you are ready when the time comes. ICD-10 is closer than it seems.

CMS can help. Visit the CMS website at **www.cms.gov/ICD10** for resources to get your practice ready.

CMS ICD-10
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

The Arkansas Family Physician

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

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Dear Academy Member,

As we end another year, we focus our priorities on the upcoming legislative session beginning January 14 and on our finances which we have addressed in the 2013 budget of the AR AFP.

It is anticipated that a bill will be introduced to increase the scope of practice of nurse practitioners and advanced practice nurses. The Arkansas AFP, along with all other medical specialties in the state will do whatever is needed to defeat such a bill if presented. You are asked to join us in defeating this bill if it is introduced and be ready to speak to your legislator to say NO to this legislation.

We realize there is a shortage of primary care physicians in our state but in a survey done last year, we could not find any family doctor that could not take more patients nor did most feel that they were in an area where patients were not being taken care of due to this shortage. We support the concept of the health care TEAM available to the patient in a patient centered medical home. The team approach gives the patient access to the full range of health care services without sacrificing the medical expertise that assures the most appropriate treatments in the most timely manner. A nurse practitioner's training or an APN's training, education and clinical expertise cannot replace that of a primary care physician. Both professions have plenty of demand for their skills and when joined to provide care for patients in a team setting, those skills are best put to use.

We will monitor the session and work with the Arkansas Medical Society in making you aware of issues facing medicine during the legislative session.

Recruitment and retention of our membership is vital at this time. If you know of a colleague who is not a member of the AR AFP and is eligible to join, please encourage them to join. For those of you that have terminated your membership recently, we urge you to rethink your decision and join us in advocating for Family Medicine in Arkansas!

It is anticipated that the AR AFP will have a net loss this calendar year. Although we netted over $56,000. from the 2012 Annual Assembly, dues collections are short this year by 40% - it is not yet known if it is due to statements being mailed later than usual or an issue of larger concern so every line item in the budget has been reduced to prevent us from having to dip into our reserve funds for operations.

And last but not least, please mark your calendars to join us for our Annual Scientific Assembly in 2013 which will be held Thursday through Saturday, June 14-16 at the Doubletree Hotel in Little Rock.

It has again been a pleasure to work with and for you and best wishes to each of you for a Happy and Healthy Holiday Season!

Carla Coleman
Executive Vice President

COVER IMAGE:

Aerial view of the Arkansas State Capitol

Lonnie Robinson, M.D., President

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

There are many issues facing Arkansas Family Physicians today. The AAFP and the Arkansas Chapter are actively involved in all of these, advocating on your behalf and in your interest.

The Sustainable Growth Rate (SGR) has been an area of contention for years and must be permanently fixed. Medicare is set to enact a mandatory 27% cut in physician pay by the end of the year unless action is taken by Congress to avert these reductions. The AAFP is actively lobbying congress to address this with a permanent solution rather than a temporizing measure. Our efforts are being directed at ensuring this perennial issue is cured rather than given a band-aid treatment, as it has in the past. I would encourage your active participation in this effort by contacting your senator and member of congress. A form letter/email to send to your legislator, as well as other ways to get involved and make your opinion heard are available on the AAFP website at www.aafp.org.

We continue to fight for parity of payment to primary care physicians. Recent changes in Medicare reimbursement have seen higher rates for primary care physicians, and we continue to press the message in Congress that the cure for many of the ills that our healthcare system faces can be found in incentivizing primary care physicians to do what we do best.

Within Arkansas, the upcoming legislative session promises to be an active one. We have reviewed the issues that are expected to come forward and have made preparations to mount our own lobbying efforts in conjunction with the Arkansas Medical Society.

We also need your help. If you haven't already, please consider signing up for the AMS "Doctor of the Day" program at the State Capitol. By volunteering, you will be present at the capitol and available to any of the legislators that might need medical care, but also available to be involved in the legislative issues that we are sure to face during this session. I would also encourage you to consider a donation to ArkMedPAC, the political action committee of the Arkansas Medical Society. More information on Doctor of the Day and ArkMedPAC can be found at www.arkmed.org.

We expect to face scope of practice challenges from various parties, including a push for primary care provider status from advanced practice nurses (APN) and possibly from other provider groups. We will continue to oppose this effort, along with the Arkansas Medical Society and our national Academy, as our policy continues to assert that the patient-centered medical home is a team of many different providers, but is best led by a primary care physician.

Also at the state level, there has been increasing momentum for a constitutional amendment that would make meaningful tort reform possible. The malpractice reform package passed in 2003 has basically been whittled away by the Arkansas Supreme Court, which found the bulk of the law unconstitutional. The only way to pass effective malpractice reform that will not be subject to review by the Supreme Court would be to pass a constitutional amendment, which would have to be initiated in the legislature and then taken to the people. We expect this to be a broader tort reform act, not limited to medical malpractice, as we would be able to involve a broader group of supporters for the campaign that would be necessary to see it be successful. This effort will likely be forthcoming over the next five years or so.

This session will also consider the expansion of Arkansas Medicaid proposed under the Affordable Care Act. We were recently asked for our stance on this proposal. We have heard feedback from our membership both for and against this measure. There are many considerations that must be entertained in this politically complex and controversial subject. We are quite aware of the fiscal and political issues that are intertwined in this

continued on page 6

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Pinnacle Pointe
Behavioral HealthCare System

continued from page 4

issue. In our deliberation, we also considered the plight of the working poor, the cost of uncompensated care, the financial situation of the Arkansas Medicaid system, and the healthcare workforce shortages we already face. While we made a decision to support the expansion, we acknowledge that there really is no easy answer.

As a State Chapter, we feel that our approach should always be centered on the best interests of our membership and the patients whom we serve. While we are certain that we will never be able to formulate a position on every complex and controversial issue that will align with the stance of each individual member of such a diverse body, we strive to represent you as a whole. In order to do that, we need to hear from you. Furthermore, we encourage our individual members to contact their respective representatives to make their opinion known in the halls of the state capitol on this important healthcare issue, as well as others.

Similarly, our national Academy, the AAFP, occasionally makes decisions that don't necessarily reflect the opinions or values of our Chapter. Despite this, I continue to hold a strong belief that our national and state organizations are the best overall representative of our interests as Family Physicians. I have always been of the opinion that if you identify a problem within an organization, you have a clear choice to make. You can either choose to withdraw and become uninvolved, and thereby actually contribute to and perpetuate the problem. Or alternatively, you can become more involved and seek to be a force for positive change. Having stated this, I invite you to become more, not less engaged.

Our attention is focused on all these issues and we strive to be your voice for Family Medicine, both throughout the state of Arkansas and in Washington, D.C. We speak loudest when we speak with one voice, and our strength is in our numbers.

Let's all get involved!

Lonnie Robinson

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501-955-5519

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Benton, AR 72019
501-847-0158

Heber Springs
301 Southridge Blvd, Ste. A,
Heber Springs, AR 72543
501-206-0176

Stuttgart
North Buerkle Road,
Stuttgart, AR 72160
870-673-2511

CMS Releases Final Regulation On Affordable Care Act Provision

The Centers for Medicare and Medicaid Services released the final regulation containing important details regarding how CMS is implementing the Affordable Care Act provision that increases Medicaid payments for specified primary care services to Medicare levels for certain primary care physicians in 2013 and 2014.

Section 1202 of the Affordable Care Act specifies that physicians with a specialty designation of "family medicine, general internal medicine and pediatric medicine" qualify for purposes of this increased payment. The increased payment also applies to services paid through Medicaid managed care plans. Payments to non physician providers are not affected by this though primary care services performed by a non physician practitioner would be paid at the higher rates if properly billed under the provider number of a qualified physician, whether the services were furnished by the physician directly, or under the physician's personal supervision.

In total states would receive more than $11 billion in new funds over two years to bolster their Medicaid primary care delivery systems. The federal agency will fully reimburse states for these increased payments. Further details regarding the proposed version can be accessed in a May 2012 summary (http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/background/medicaid052412.Par.ooo1.File.tmp/Medicaid050912.pdf)

In the proposed version of this rule, CMS proposed to also allow sub specialists to qualify for this increased payment. In a formal regulatory comment letter submitted to CMS June 6, 2012, the AAFP disagreed with the agency's proposal to allow sub-specialists to qualify since the inclusion of sub specialty physicians is not the intent of Section 1202 and would only serve to perpetuate existing disparities in physician reimbursement policies. CMS largely finalized policies as proposed. AAFP staff is now reviewing the final regulation and will quickly prepare a comprehensive summary of the final rule. The summary will be published as soon as possible.

The final rule is on display in the Federal Register: http://www.ofr.gov/(X(1)S(inzp4wxrutgayxne1ogtegeqq))/OFRUpload/OFRData/2012-26507_PI.pdf.

MagMutual Welcomes Ed Lynch as Senior Vice President of Business Development

Atlanta (November 5) – MagMutual Insurance Company, the Southeast's foremost medical malpractice insurance company, recently added Ed Lynch to the senior management team. Appointed Senior Vice President of Business Development, Lynch will lead the sales, service and marketing divisions for the physician-owned mutual.

"With more than 17,500 insured physician-owners across the Southeast, it's important that we serve and defend them while continuing to build a true partnership with them," says Neil Morrell, President and Chief Operating Officer of MagMutual. "Ed's extensive healthcare industry and liability insurance experience will enable us to continually improve our focus on creating strategic alliances, retaining and developing client relationships and leveraging the company's leading malpractice coverage and additional product offerings to the benefit of our owners."

Lynch brings more than 20 years of professional liability insurance experience in both the intermediary and company side of the insurance industry, almost exclusively working in the healthcare market. Most recently he was the Area Senior Vice President and Director for the national healthcare practice of Arthur J. Gallagher Risk Management Services, Inc. in Princeton, NJ. Gallagher is one of the world's largest insurance brokerage and risk management firms.

He holds a master's degree from the University of Pennsylvania, attended the Weatherhood School of Management at Case Western Reserve University and has a bachelor's degree from Hiram College. Lynch is a member of several insurance and reinsurance societies and a frequent speaker on risk management topics for practitioners and their professional associations.

About MagMutual

MagMutual provides medical professional liability (malpractice) insurance in Alabama, Arkansas, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee and Virginia. Founded in 1982 by physicians and led by a physician Board of Directors, MagMutual is one of the largest medical liability insurers in the U.S., with offices throughout the Southeast. The company is rated A (Excellent) by A.M. Best. Visit MagMutual.com for more information. Insurance products and services are issued and underwritten by MAG Mutual Insurance Company and its affiliates.

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Have you met your CME Requirements for 2012??

Members due for re-election this year have until December 31, 2012 to earn your CME!

CME Requirements for Membership

ACTIVE and SUPPORTING (FP) MEMBERS must accrue at least 150 hours of approved continuing education within each three-year reporting period to retain membership. These credits must include at least 75 Prescribed credits and at least 25 group activity hours.

Reporting Your CME

The Academy offers four easy and convenient ways to report CME credit:

- Online at www.aafp.org/cme
- Complete quizzes for AAFP programs such as American Family Physician, Family Practice Management, Home Study Self Assessment, Video CME, and Proficiency Testing.
- Call a CME representative 1-800-274-2237 between the hours of 8:30 a.m. – 5:00 p.m. Central Time.
- Complete and fax the AAFP reporting form to 913-906-6087 or mail to:
  AAFP, CME Records
  11400 Tomahawk Creek Parkway
  Leawood, Kansas 66211-2672

The AAFP offers members over 200 credits of free online CME. For a complete listing, log-on to www.aafp.org/onlinecme.xml.

Questions About CME

If you have questions about your reelection or need a current copy of your CME record, please call 1-501-223-2272 or 1-800-592-1093.

Revised Obstetric Data Definitions Are Open for Comment

The American College of Obstetricians & Gynecologists (ACOG) has posted revised obstetric data definitions for public comment, and the AAFP is encouraging its members to participate.

The more than 60 obstetric definitions were revised at and after the reVITALize Obstetric Data Definitions Conference in August. The goal is to standardize clinical obstetric data terms used in registries, electronic health record systems and vital statistics. Valerie King, M.D., a member of the AAFP's Commission on Health of the Public and Science, and Steven Waldren, director of the AAFP Center on Health IT, both served as the Academy's representatives to the team.

ACOG has separated the definitions into five categories, with issues and rationale for changes listed:

- delivery
- gestational age and term
- labor
- maternal indicators: current comorbidities and complications and
- maternal indicators: historical diagnoses

Physicians are permitted to comment on any number of categories.

According to ACOG, all comments received during the open period will be reviewed and logged for consideration by leadership teams composed of both clinical and operational members. Should comments require further clarification, commenters may be contacted during the review period to obtain clarifying information needed to make an informed and appropriate decision regarding a potential revision.

The list will be open for public comment through Jan. 15, 2013. Any comments posted after this period may not be considered in the final summary, reporting or decision-making process that will commence after the open comment period ends.

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Demographic Characteristics By Membership Type
Chapter: Arkansas AFP

Demographic	Active		Inactive		Life		Resident		Student		Supporting (FP)		Totals	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Gender														
Male	615	73.13	3	60.00	91	94.79	94	56.29	48	50.00	2	66.67	853	70.61
Female	226	26.87	2	40.00	5	5.21	72	43.11	47	48.96	1	33.33	353	29.22
No response	0	0.00	0	0.00	0	0.00	1	0.60	1	1.04	0	0.00	2	0.17
Gender Totals	841	100.00	5	100.00	96	100.00	167	100.00	96	100.00	3	100.00	1208	100.00
AAFP Fellow														
Yes	153	18.19	2	40.00	71	73.96	0	0.00	0	0.00	0	0.00	226	18.71
No	688	81.81	3	60.00	25	26.04	167	100.00	96	100.00	3	100.00	982	81.29
AAFP Fellow Totals	841	100.00	5	100.00	96	100.00	167	100.00	96	100.00	3	100.00	1208	100.00
Med. School Grad														
US Med. Sch.	718	85.37	5	100.00	92	95.83	67	40.12	96	100.00	2	66.67	980	81.13
Int. Med. Sch.	122	14.51	0	0.00	4	4.17	92	55.09	0	0.00	1	33.33	219	18.13
No response	1	0.12	0	0.00	0	0.00	8	4.79	0	0.00	0	0.00	9	0.75
Med. School Grad Totals	841	100.00	5	100.00	96	100.00	167	100.00	96	100.00	3	100.00	1208	100.00
FP Residency Grad														
Yes	789	93.82	5	100.00	12	12.50	167	100.00	0	0.00	1	33.33	974	80.63
No	52	6.18	0	0.00	84	87.50	0	0.00	96	100.00	2	66.67	234	19.37
FP Residency Grad Totals	841	100.00	5	100.00	96	100.00	167	100.00	96	100.00	3	100.00	1208	100.00
Ages														

AMERICAN ACADEMY OF FAMILY PHYSICIANS
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Demographic Characteristics By Membership Type
Chapter: Arkansas AFP

Demographic	Active		Inactive		Life		Resident		Student		Supporting (FP)		Totals	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
0-20	0	0.00	0	0.00	0	0.00	0	0.00	1	1.04	0	0.00	1	0.08
20-24	0	0.00	0	0.00	0	0.00	0	0.00	21	21.88	0	0.00	21	1.74
25-29	8	0.95	0	0.00	0	0.00	54	32.34	56	58.33	0	0.00	118	9.77
30-34	76	9.04	0	0.00	0	0.00	67	40.12	7	7.29	0	0.00	150	12.42
35-39	106	12.60	0	0.00	0	0.00	25	14.97	1	1.04	0	0.00	132	10.93
40-44	146	17.36	0	0.00	0	0.00	13	7.78	3	3.13	0	0.00	162	13.41
45-49	105	12.49	2	40.00	0	0.00	8	4.79	0	0.00	0	0.00	115	9.52
50-54	113	13.44	1	20.00	0	0.00	0	0.00	0	0.00	1	33.33	115	9.52
55-59	130	15.46	0	0.00	1	1.04	0	0.00	0	0.00	2	66.67	133	11.01
60-64	86	10.23	0	0.00	6	6.25	0	0.00	0	0.00	0	0.00	92	7.62
65-69	46	5.47	2	40.00	9	9.38	0	0.00	0	0.00	0	0.00	57	4.72
70-74	4	0.48	0	0.00	22	22.92	0	0.00	0	0.00	0	0.00	26	2.15
75->	1	0.12	0	0.00	58	60.42	0	0.00	0	0.00	0	0.00	59	4.88
Unknown	20	2.38	0	0.00	0	0.00	0	0.00	7	7.29	0	0.00	27	2.24
Ages Totals	841	100.00	5	100.00	96	100.00	167	100.00	96	100.00	3	100.00	1208	100.00
Average Ages		48.30		56.40		76.48		32.81		26.27		57.33		46.80
Urbanization Code														

AMERICAN ACADEMY OF FAMILY PHYSICIANS
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Demographic Characteristics By Membership Type
Chapter: Arkansas AFP

Demographic	Active		Inactive		Life		Resident		Student		Supporting (FP)		Totals	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
1	7	0.83	1	20.00	4	4.17	1	0.60	0	0.00	0	0.00	13	1.08
2	427	50.77	2	40.00	41	42.71	85	50.90	92	95.83	2	66.67	649	53.73
3	127	15.10	1	20.00	13	13.54	62	37.13	2	2.08	0	0.00	205	16.97
4	26	3.09	0	0.00	5	5.21	0	0.00	1	1.04	0	0.00	32	2.65
5	34	4.04	0	0.00	6	6.25	14	8.38	0	0.00	0	0.00	54	4.47
6	93	11.06	1	20.00	8	8.33	2	1.20	0	0.00	1	33.33	105	8.69
7	102	12.13	0	0.00	13	13.54	0	0.00	0	0.00	0	0.00	115	9.52
9	17	2.02	0	0.00	4	4.17	0	0.00	0	0.00	0	0.00	21	1.74
Unknown	4	0.48	0	0.00	2	2.08	3	1.80	1	1.04	0	0.00	10	0.83
8	4	0.48	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	4	0.33
Urbanization Code Totals	841	100.00	5	100.00	96	100.00	167	100.00	96	100.00	3	100.00	1208	100.00

Arkansas AFP Board Of Directors Votes to Support Medicaid Expansion

At a recent meeting of the Arkansas AFP Board of Directors, unanimous approval was given to support Medicaid expansion in our State.

There was considerable discussion regarding misgivings about the Medicaid expansion and particularly concerns about the state budgetary and fiscal obligations that would logically follow. Understanding that our state ranks as one of the poorest states in the nation, the Arkansas AFP Board was of the opinion that the Medicaid expansion could ultimately benefit our State's economy as well as provide needed health benefits to the working poor. It has been reported that Federal funds will be used to pay for the increased costs in the first three years. Afterwards, the state's share will rise to 10% of the costs. This increase will begin in the year 2020. The expansion will be gradual with a portion of the federal dollars offset by the elimination of current Medicare payments made for uncompensated care paid to hospitals and to some other providers. It is noted that these reductions will take place even if Arkansas chooses not to participate in the Medicaid expansion. It has further been indicated that if Arkansas does not participate in the Medicaid expansion, these tax dollars will be spent in other states choosing to participate.

Dr. Andy Allison, Director of the Medicaid Program stated that it is estimated the State of Arkansas could save roughly $372 million in SGR spending if expansion happens. These savings are based upon the federal government's coverage of 100% of the costs for an estimated 250,000 newly eligible recipients under Medicaid Expansion for State Fiscal Years 2014-2016. After that the federal match decreases by steps to 90% in 2020 and beyond.

The expansion of Medicaid in Arkansas is expected to provide health care coverage to an estimated 250,000 of Arkansas's poorest. Included primarily in this number are those working families that cannot currently afford health insurance. These families forego preventative as well as basic health care which leads to more expensive medical care, procedures and treatment in the future. In addition, studies have shown that lack of insurance coverage at lower income levels leads to a much shorter life expectancy.

As you know, Family Physicians now routinely care for patients with no expectation of reimbursement. Medicaid expansion can assist in supporting the ability of Family Physicians to treat these Arkansans. Local hospitals, particularly those that are considered critical-access facilities, would also realize payment for previously uncompensated care. Ultimately, this will improve the health of previously uninsured Arkansans through the provision of basic, preventative and emergent care, and ensuring that the large rural areas of the state continue to have access to emergency hospital care, thus improving the overall health of Arkansas citizens.

Although Medicaid is prompt in its payment of providers for covered services, it is well known that its reimbursement levels are significantly lower than private insurance for primary care services. However, enhanced Medicaid coverage would provide a source of reimbursement not currently available to our Family Physicians currently treating the uninsured.

In arriving at the final decision, it was our opinion that the expansion would be beneficial not only to the public, but to our physician members as well, to the extent that it would be expected to attract more Primary Care Physicians to the under-insured and under-served areas of our state. It is primarily because of this expectation that both the Arkansas Academy and Family Physicians in general should support this expansion.

What Members Need to Know about Reporting CME

The AAFP sent letters to members who are due for re-election on December 31, 2012 who sstill hve insufficient CME . Target members were: Members with a 2013 Board recertification date in their record who still need to reach 150 CME hours: Members with a 2013 Board recertification date in their record who have reported more than 150 hours of CME but still need to report CME in a specific category: New Physicians who need hours: and all other members who have not reported sufficient hours for re-election to membership at year end.

AAFP CME (American Family Physician, Family Practice Management, FP Essentials and FP Audio require the successful completion of an assessment of quiz in order for the credit to be earned and must have the completed assessment/quiz online by December 31 for credit!!!!

Arkansas AFP to Participate in AMS Day at the Capitol

The Arkansas AFP will again be a co-sponsor with the Arkansas Medical Society for the DAY AT THE CAPITOL, Wednesday, January 30, 2013.

The schedule of events follows:
11:30 a.m. - Lunch Program and Legislative Briefing (optional)
Victory Building Conference Center, 1401 West Capitol Avenue, Little Rock

1:15 p.m. – State Capitol Visits, State Capitol Building, 3rd Floor

5 – 7 p.m. - Legislative Reception, Argenta Community Theater, 405 Main Street Little Rock, Arkansas This event cohosted by the Arkansas AFP, the Arkansas Medical Society and the Arkansas Ophthalmological Society

Cost of the Lunch is $20. ; Reception $30. Or Lunch and Reception for $45. Per person. Pre Registration necessary!!!!!

If you are interested in participating, you MUST REGISTER FOR ANY OF THE ABOVE LISTED EVENTS BY CONTACTING THE ARKANSAS MEDICAL SOCIETY AT 501-224-6489. There is a fee for the lunch and reception and must be made in advance!!!!

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2013 ANNUAL SCIENTIFIC ASSEMBLY PREVIEW

Please mark your calendars to be with us June 13-16 for an all new Assembly format!

The assembly will kick off on Thursday morning, June 13 and will conclude at approximately 2 pm. on Saturday, June 15 at the Doubletree Hotel in Little Rock.

We are GOING GREEN THIS YEAR!! There will be no printed syllabus; instead the speaker handouts will be on our website for you to download and print. For those that do not have access to a computer and wish for a printed copy, there will be a charge and orders must be made in advance.

In addition, instead of the formal program we have had in past years with speakers photos and bios, the program this year will be simple on one sheet of paper front and back with speakers topics and names. In addition to saving on the many reams of paper that are used for the syllabus and printed program, several thousands of dollars will be saved for the meeting costs.

The Installation of Officers event will also be a change from past years. The installation of President Elect Barry Pierce and other officers and directors will be held on Friday at Noon in the lecture hall. An informal reception honoring our newly installed President, officers and directors will be held Friday evening.

Exhibitors will be set up in the Palisades and Riverside Rooms this year which will allow us to have lunch CME meetings and breakfast CME meetings all in one room which will be the ballroom adjacent to the lecture hall. Exhibits will be open on Thursday, June 14 and Friday June 15.

On Saturday, special events are planned for the student and resident members including a Medical Jeopardy contest for the resident and student members! We are now booking speakers and plans are to also have a SAMS course. If you have any topics to suggest, please forward them to us as soon as possible. We look forward to having you with us at another quality CME event for Family Physicians!

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- **The DGA recommends** low-fat or fat-free milk and milk products daily
  - 3 cups for 9 years or older
  - 2 1/2 cups for 4-8 year olds
  - 2 cups for 2-3 year olds

By the age of 4 *children do not consume the recommended number of servings from the Dairy Group*

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Visit **thedairyreport.com** and join The Dairy Report blog for nutrition discussion and dairy research.

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Arkansas Legislative Session Begins January 14!!!

On January 14 the Arkansas Legislative Session begins!! We anticipate many bills of interest to Family Physicians and urge you to become active in the legislative process. As bills are presented that require our action, we will alert you through emails and urge you to contact your elected representatives and senators as the need arises.

As we have done the past three years, we have joined with the Arkansas Medical Society to represent our interests in the session. With seasoned lobbyists and legislative staff at the AMS we feel very comfortable in their representation and feel certain there are no bills foreseen that we will not agree upon.

Please note that to find your state senators you may go online to www.arkansas.gov/senate: to find your state representatives, go to www.arkansashousse.org. The capital switchboard number for the Senate is 501-682-2902 and the House number is 501-682-6211. There are 35 Senators in the Arkansas Senate and 100 representatives in the House of Representatives.

Resident Physician Asks For Input From Fellow Family Medicine Residents

As Resident Representative to the AR AFP Board of Directors, Doctor Appathural Balamurugan, Chief Resident of the Department of Family and Preventive Medicine at UAMS has been contacting all family medicine residency programs in the state to obtain thoughts, ideas and suggestions for Resident members to become committed to their specialty organization.

As of this date, half of the residency programs have replied to his requests and we hope that the remaining residency programs who have not answered will do so as soon as possible.

He has asked that at least two residents from each program be in attendance at the AR AFP's Annual Scientific Assembly in June. Plans are to have a Resident Quiz Bowl at the Assembly between the AHECs and the UAMS program with the winning team receiving a trophy with prizes to increase enthusiasm and a friendly competition among residents and the residency programs. Any ideas are appreciated.

Articles from residents and residency program directors are always welcome for the *Arkansas Family Physician Journal*. This is a great venue to display the great work the residents and residency programs are doing. This opportunity can be used to showcase case studies, case reports or any scientific articles or perspectives of interest to family medicine. Contact Carla at the AR AFP office for more information on deadlines and space for the articles. You may contact Doctor Balamurugan at ABalamurugan@uams.edu or the AR AFP office at arafp@sbcglobal.net with your suggestions!

Ameridose Issues Recall Of All Products

The Arkansas Department of Health is working with the FDA and the CDC to identify Ameridose products that may have been sent to Arkansas facilities in order to assure that the products are removed from the shelves. The ADH will be contacting affected facilities and encouraging them to take action.

This is as a consequence of the recent multi state outbreak of fungal meningitis associated with products manufactured by New England Compounding Center in Massachusetts and other affiliated pharmaceutical compounding companies.

According to the Arkansas Department of Health, there are no reported human illnesses associated with Ameridose products in Arkansas todate.

E-Prescribing Hardship Exemption Deadline Extended

CMS has announced that the Quality Reporting Communications Support Page will re-open November 1 through January 31, 2013 to offer an additional opportunity for providers to apply for a hardship exemption to avoid the 2012 e-prescribing 1.5 percent payment adjustment on Medicare claims.

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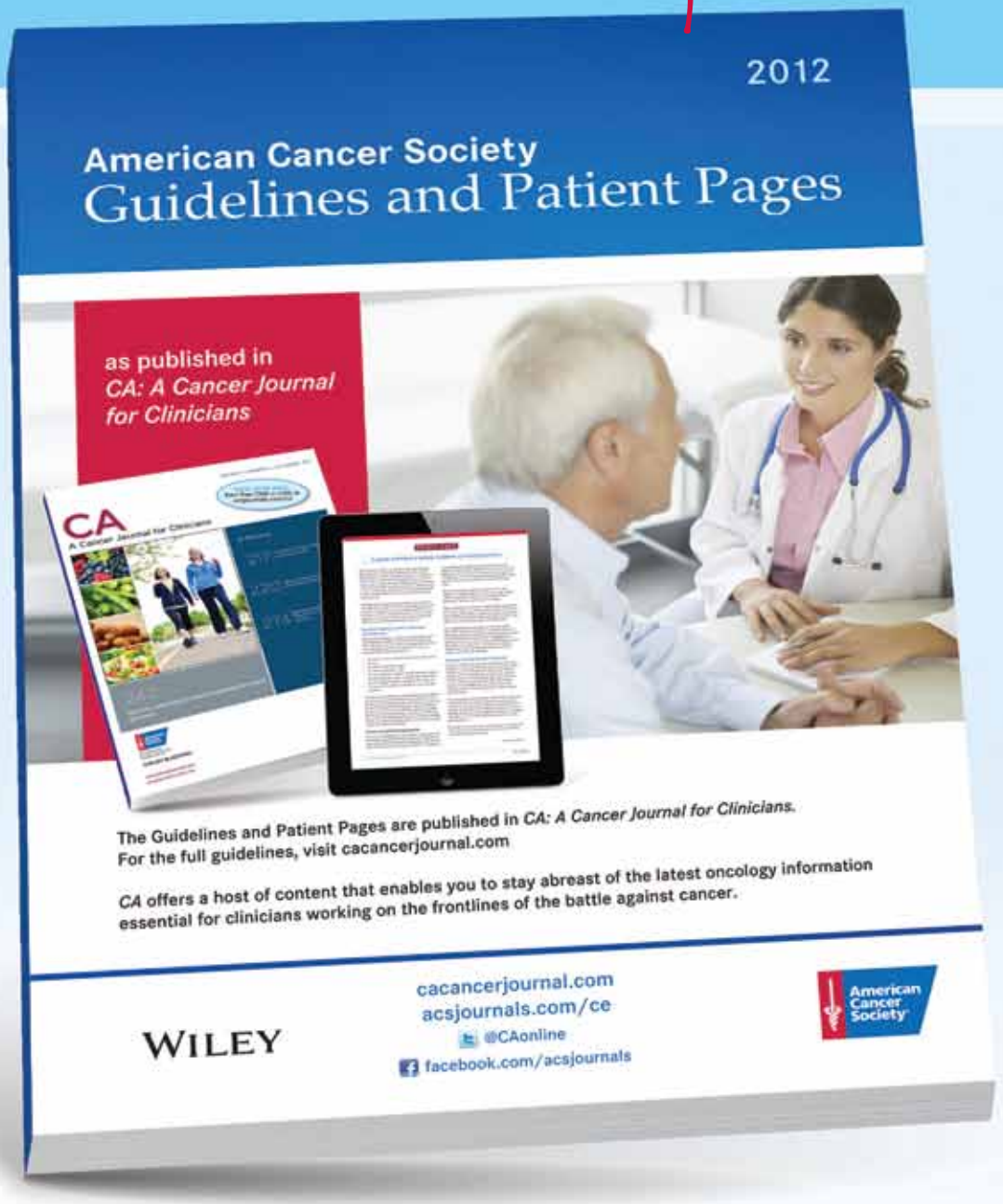

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Gluten Sensitivity:
Fad and Fact

By David A. Nelsen Jr., MD, MS

When Miley Cyrus tweets, "Everyone should try no gluten…" or Gwyneth Paltrow gushes over a gluten-free donut, it is hard to escape the latest dietary fad, which was barely a blip on the nutritional radar 20 years ago. This and other dietary fads have propagated across the Internet at a dizzying pace. For which patient is a gluten-free diet (GFD) nothing more than a fad, and for whom is the GFD a specific medical nutritional therapy for a very serious disease process?

Many primary care physicians are now aware that celiac disease (CD), also known as gluten sensitive enteropathy, is significantly more common than was previously known, affecting somewhat less than 1 percent of Americans.[1] CD is an acquired autoimmune enteropathy that occurs in genetically predisposed individuals. It is associated with other autoimmune disorders, including type I diabetes, autoimmune thyroid disorders, and Sjögren's syndrome, to name a few. Patients with CD who ingest proteins from wheat, barley, or rye will develop an inflammatory enteritis that culminates with the destruction of the villous structures and malabsorption of micro-and macro-nutrients. Patients with untreated CD are at significant risk of complications of malabsorption as well as increased risk of certain lymphoid neoplasms, such as non-Hodgkin's lymphoma. Extraintestinal manifestations may include dermatitis herpetiformis, epilepsy, and neuropathy.

Patients with active CD produce IgA (auto) antibodies against tissue transglutaminase and generally express seropositivity. Most experts recommend that the IgA antitransglutaminase (sensitivity 90 percent to 99 percent, specificity 95 percent to 99 percent) be used instead of the outdated anti-gliadin studies for the diagnosis of CD. A new IgA test for anti-deamidated gliadin peptide is receiving a lot of attention.[2] Many experts recommend that both tests be performed to increase sensitivity. Duodenal biopsy remains the gold standard for diagnosis and should be recommended for most patients. It is important that both serologic testing as well as duodenal biopsy be performed on patients who are continuing to include gluten proteins in their diet. Genetic testing that demonstrates the absence of specific disease-associated genetic markers may rule out CD but should not be used to make the diagnosis.

HLA-DQ2 and DQ8 are present in more than 95% of patients with CD but also occur in up to one-third of the general population.

The GFD represents a specific medical nutrition therapy that mitigates most if not all of the manifestations of CD. Patients on a GFD for the treatment of CD must permanently exclude wheat, barley, and rye from their diets. Similarly, wheat protein allergy ("Baker's asthma") is an IgE-mediated type 1 allergy that may benefit from a GFD. A detailed discussion of the pathophysiology of CD or wheat protein allergy is beyond the scope of this article; there are numerous recent evidence-based publications.[3,4]

As with most of medicine, there are gray areas. A recently described entity, "non-celiac gluten sensitivity," is making its way through the medical literature[5] (as well as the lay Internet). This is a clinically defined entity that includes patients who have symptomatic improvement on a GFD but do not meet the diagnostic criteria for CD. These patients are seronegative and do not manifest enteropathy or malabsorption. The symptoms that patients describe are similar to those of irritable bowel syndrome (IBS), fibromyalgia and/or chronic fatigue syndrome. At least one small randomized clinical trial has suggested the existence of this entity, although no pathophysiologic mechanism has been described in the medical literature. Anecdotally, these patients may be seropositive for the less specific anti-gliadin antibody tests but not for anti-transglutaminase. There is at least one Internet site that offers stool autoantibody testing for anti-gliadins and antitransglutaminase; formal scientific evidence is lacking in this area.

Autism, schizophrenia, and postpartum psychosis have purportedly been "cured" with a gluten-free, casein-free (GFCF) diet.[6] The theory underlying this is based on the assumption that partially hydrolyzed gliadin and casein fragments—gliadorphins and casomorphins—bind to endogenous opioid receptors and exert psychoactive effects. Formal evidence for this hypothesis is scant. Two Cochrane reviews have been published relative to GFCF diet in the treatment of autism. The reviewers suggest that current evidence is poor and that additional large scale studies are needed.[7]

Patients with IBS may benefit from a GFD as well. Some studies have shown that patients who meet criteria for IBS may actually have latent CD or a CD variant. A study of patients with diarrhea-predominant IBS showed that one-third of these patients had an IgG autoantibody (as opposed to the IgA autoantibody in CD) without evidence of villous damage. Most of these patients improved on a GFD.[8]

Given this information, why not just recommend a GFD for all of these patients? This has become a very popular approach, particularly in the "complementary and alternative

continued on page 24

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As a health care provider, you understand that no two patients are alike. That's why the Centers for Disease Control and Prevention recommends specific flu vaccines based on a patient's age and health status.

Most seniors and others with long-term health conditions need an annual flu vaccination.

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Prevention and Control of Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), *U.S. 2012-13 Influenza Season*

MANUFACTURER	TRADE NAME/ VACCINE	PRESENTATION	AGE GROUP	NUMBER OF DOSES
Sanofi Pasteur, Inc.	Fluzone® TIV	0.25 mL prefilled syringe	6-35 months	1 or 2(1)
		0.5 mL prefilled syringe	≥36 months	1 or 2(1)
		0.5 mL vial	≥36 months	1 or 2(1)
		5.0 mL multidose vial	≥6 months	1 or 2(1)
	Fluzone® High Dose/ TIV High Dose(3)	0.5 mL prefilled syringe	≥65 years	1
	Fluzone Intradermal	0.1 mL prefilled microinjection system	18-64 years	1
Novartis Vaccine	Fluvirin™ TIV	5.0 mL multidose vial	≥4 years	1 or 2(1)
		0.5 mL prefilled syringe		
GlaxoSmithKline	Fluarix™ TIV	0.5 mL prefilled syringe	≥3 years	1 or 2(1)
	FluLaval™ TIV	5.0 mL multidose vial	≥18 years	1
CSL Biotherapies	Afluria	0.5 mL prefilled syringe	≥9 years	1
		5.0 mL multidose vial		
MedImmune LAIV	FluMist™(2)(4)	0.2 mL prefilled intranasal sprayer	2-49 years	1 or 2(1)

TIV: Trivalent Inactivated Vaccine • LAIV: Live Attenuated Influenza Vaccine

(1) Children aged 6 months through 8 years who did not receive seasonal influenza vaccine during the 2010–11 influenza season should receive 2 doses at least 4 weeks apart for the 2011–12 season. Those children aged 6 months through 8 years who received ≥1 dose of the 2010–11 seasonal vaccine require 1 dose for the 2011–12 season.

(2) A new quadrivalent formulation of FluMist was approved by the Food and Drug Administration in February 2012. It is anticipated that this formulation will replace the currently available seasonal trivalent LAIV formulation for the 2013–14 season. FluMist is shipped refrigerated and stored in the refrigerator at 36°F–46°F (2°C–8°C) after arrival in the vaccination clinic. The dose is 0.2 mL divided equally between each nostril. Health-care providers should consult the medical record, when available, to identify children aged 2–4 years with asthma or recurrent wheezing that might indicate asthma. In addition, to identify children who might be at greater risk for asthma and possibly at increased risk for wheezing after receiving LAIV, parents or caregivers of children aged 2–4 years should be asked: "In the past 12 months, has a health-care provider ever told you that your child had wheezing or asthma?" Children whose parents or caregivers answer "yes" to this question and children who have asthma or who had a wheezing episode noted in the medical record within the past 12 months should not receive FluMist.

(3) Trivalent inactivated vaccine high dose. A 0.5-mL dose contains 60 mcg each of A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like antigens.

(4) Age indication per package insert is ≥5 years; however, the Advisory Committee on Immunization Practices recommends Afluria not be used in children aged 6 months through 8 years because of increased reports of febrile reactions in this age group. If no other age-appropriate, licensed inactivated seasonal influenza vaccine is available for a child aged 5--8 years who has a medical condition that increases the child's risk for influenza complications, Afluria can be used; however, providers should discuss with the parents or caregivers the benefits and risks of influenza vaccination with Afluria before administering this vaccine. Afluria may be used in persons aged ≥9 years.

SOURCE: 2012 RECOMMENDATIONS OF THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES, CENTERS FOR DISEASE CONTROL AND PREVENTION

continued from page 22

medicine" domains. A wise clinician should strive to make a diagnosis when one can be made. A formal diagnosis of CD is of great benefit to the patient and should include both serologic testing and a small intestinal biopsy to evaluate for enteropathy. It is vitally important to correct nutritional deficiencies in these patients. The GFD is a critical therapy to prevent lymphoma and other complications of untreated CD. Additionally, CD is common (10 percent to 15 percent) in first-degree relatives of patients with CD. Serologic screening should be offered to first-degree relatives of patients with CD and to other high-risk groups, such as patients with type I diabetes or Down syndrome.

For patients in whom a diagnosis of CD remains unclear after study, it may still be advisable to discuss and recommend a GFD. The non-celiac gluten sensitivity syndrome is a clinical diagnosis and may benefit from a GFD. Not infrequently a patient will decide on his or her own to follow a GFD and will have already instituted such before seeking medical care. It may be impossible to rule in or out CD in this situation. If the patient is unwilling to undergo testing after a period of four to six weeks of "gluten loading," it may be appropriate to evaluate for nutritional deficiencies and counsel the patient appropriately for a GFD. In any case where a GFD is recommended, the role of a trained dietitian or clinical nutritionist should not be underestimated.

Is the GFD more or less healthy than a "regular" diet? Of course, this depends on the viewpoint that one takes. Gluten-free flours such as rice flour and cornstarch typically have a higher glycemic index compared to wheat-based flours. This may exacerbate insulin resistance, weight gain, and glucose intolerance. If the patient pursues all of the wonderful gluten free cakes, breads, rolls, pastas, and so on, then a weight gain would typically be expected. If the patient eschews the typical packaged gluten-free products and instead steers towards fresh fruit, vegetables, nuts, meat, and dairy, then a GFD could in fact be the healthiest diet of all.

David A. Nelsen Jr., MD, MS, is associate professor of family and preventive medicine and associate chief medical officer for clinical informatics at the University of Arkansas for Medical Sciences, and a physician consultant for the Arkansas Foundation for Medical Care.

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Pulaski County Judge Ruling Could Allow Doctors to Dispense Prescriptions from their Offices

As a result of a recent motion for summary judgement by Pulaski County Circuit Judge Chris Piazza, doctors will not have to "show a need" to obtain the permit to sell medications. The ruling is very likely to be appealed.

For nearly thirty years, in order for a doctor to obtain a permit to dispense medication, he or she had to apply to the Arkansas State Medical Board and show a need. In nearly all cases, the board denied appliations.

Dr. Dana Abraham of Little Rock challenged the Arkansas Medical Board's policy of limiting dispensing of prescription drugs at doctors offices. Abraham who specializes in breast oncology surgery appealed the decision of the State Medical Board to the Pulaski County Circuit Court and won. She stated her sole reason for wanting to dispense was for the convenience of her patients, a large number which are on Medicaid and had to not only find transportation to her office but one to the pharmacy for the prescription.

As a result of the circuit court ruling, doctors won't have to "show a need" to obtain the permit to sell medications. The attorney for the Medical Board said he would wait before the ruling is entered before deciding his next move.

The Arkansas Pharmacists Association has called the ruling "dangerous" stating there was not a need nor a public outcry for physicians to dispense. Mark Riley, Executive Director of the Arkansas Pharmacists Association stated that while it is the doctors job to diagnose and identify treatments, pharmacists are the ones trained to best use the drugs.

We'll keep you posted!

In Memory

Doctor Robert Hunt Langston of Harrison died November 23 with friends heading to a Razorback football game. He was 81 years old, a Life time member of the Arkansas Chapter, American Academy of Family Physicians since 1961. He graduated from UAMS in 1956 and served an internship at Baptist Hospital in Little Rock before opening his Family Medicine Clinic in 1963 where he practiced until his retirement in 1996.

He is survived by his wife, Frances, three sons, William Robert Langston, James David Langston and Thomas Langston all of Harrison, 5 grandchildren and one sister.

A memorial has been sent from the AR AFP to First Baptist Church in his memory. His funeral was held November 27. Our sincere sympathy is extended to his family.

The 2013 membership dues invoices were mailed in October! If you have not already done so, please renew your AAFP membership now. You can pay in one of three ways:

- Return your invoice and payment in the envelope provided
- Call the AAFP and set up monthly installment payments, 1-800-274-2237
- Online at http://www.aafp.org/checkmydues

Thank you for maintaining your membership in the AAFP!

From AAFP NEWS NOW:

USPSTF Widens HIV Screening Net to Cover All Patients 15-65 Years, Pregnant Women

■ *By Matt Brown*

Posted: 11/21/2012, 3:40 p.m. -- New draft recommendations from the U.S. Preventive Services Task Force (USPSTF) encourage clinicians to screen all adolescents and adults, as well as all pregnant women, for HIV infection regardless of risk.

According to USPSTF Co-vice Chair Michael LeFevre, M.D., M.S.P.H., a family physician from Columbia, Mo., the update, which will be open for public comment until Dec. 17, 2012, expands the task force's 2005 recommendations for HIV screening for patients aged 15-65 years, as well as for all pregnant women. The expanded recommendation are so physicians "don't have to go through the screening process of asking questions about the in-depth sexual history and so forth before making the decision that everyone should be screened," said LeFevre. "It simplifies the screening process because physicians can now say that the USPSTF recommends that everybody be screened irrespective of their perceived risk for having HIV. You can make decisions later about whether it needs to be repeated, but for people who have not been screened, we recommend that they get screened." LeFevre said that although the update is part of the USPSTF's normal routine, it also is based on studies that have filled in the evidentiary gaps since 2005. The task force found that expanding HIV screening identifies a substantial number of persons with previously undiagnosed HIV infection, many of whom could benefit from early treatment. "The motivation for (the expansion) came from new evidence that showed there really was substantial benefit to screening -- and then early treatment -- for HIV infection in all of these patients," he said. "I think that's the key right now -- that antiretroviral therapy has been demonstrated to be quite effective at earlier stages of infection and also reduces transmission at early stages of infection." The task force also encourages physicians to screen younger adolescents and older adults who are at increased risk for HIV, as well as pregnant patients with an unknown HIV status who are in labor. According to the recommendation, an estimated 1.2 million people in the United States currently live with HIV, a number that increases annually by about 50,000 cases. Approximately 20-25 percent of individuals living with HIV infection are unaware of their positive status.

CMS Releases Final Rule on Medicaid/ Medicare Payment Parity

■ Academy Urges States to Immediately Take Action on Implementing Provision

The AAFP is praising the release of a final CMS rule that implements a provision in the health care reform law that brings Medicaid payment for certain primary care services up to Medicare levels for the next two years.

In a prepared statement, the Academy said the rule is a "step in the right direction." The AAFP is urging states to act quickly to implement the payment provision so low-income, working families and the elderly in nursing homes can immediately benefit from the provision. "We know from research that when Medicaid beneficiaries cannot find a physician who accepts new Medicaid patients, they face the same access problems as those who have no insurance," said AAFP President Jeffrey Cain, M.D., of Denver, in the statement. He noted that these patients are less likely to have a usual source of care, and they tend to skip needed preventive and acute care. Because of this, they often develop complications that require intensive and costly medical intervention and generally have poorer health. Although current law limits the payment parity rule to only two years, "bringing Medicaid payments up to Medicare levels will do much to enable physicians to care for Medicaid patients," said Cain. The final CMS rule implements Section 1202 of the Patient Protection and Affordable Care Act, and requires state governments to take further action before 2013 to implement the provision, prompting the AAFP's call for states to take immediate action. Cain pointed out that states will receive an estimated $11 billion in new funds during 2013-2014 to bolster their Medicaid primary care delivery systems. He stressed, however, that the funding is only temporary. "Unless Congress acts to permanently extend and fund this provision, a sudden return to disparate and inadequate payment for primary services needed by Medicaid patients after only two years will again threaten to restrict their access to such needed services," said Cain. "It would once again shut out people who have come to know and depend on their primary care physicians. Only by extending Medicaid parity with Medicare can we ensure that these Americans continue to have uninterrupted medical care in the future." Cain noted that more than six in 10, or 64 percent, of family physicians accept new Medicaid patients and that Medicaid

beneficiaries make up 15 percent of the average family physician's patient panel. "Family physicians commit themselves to a long-term relationship with all their patients, including Medicaid beneficiaries," said Cain. "However, increasingly inadequate Medicaid payment has forced nearly two in 10 family physicians to stop accepting new Medicaid patients."

AAFP Recruiting Family Medicine Practices for Adolescent Immunization Project

Family physicians play a critical role in increasing adolescent immunization rates, which is why the AAFP is recruiting 20 family medicine practices to participate in a new CDC-sponsored Adolescent Immunization Office Champions project.

According to Bellinda Schoof, M.H.A., the AAFP's clinical policies manager, immunization survey coverage levels show that national vaccination rates in adolescents have improved for tetanus-diphtheria-pertussis and meningococcal conjugate vaccines, but a wide variation remains at state and local levels. Immunization coverage for the human papillomavirus vaccine also remains below national goals for both girls and boys. A three-year cooperative agreement with the CDC will allow the Academy to work on increasing adolescent immunization rates in family physician practices using its Office Champions Tobacco Cessation National Dissemination Project as a template. The selected practices will work to improve immunization rates in their adolescent patient population, and in doing so, will develop a culture that promotes the importance of vaccines and integrating effective strategies to reach vaccination goals. Schoof said the adolescent program is focusing on improving practice-level performance using the Academy's METRIC (Measuring, Evaluating and Translating Research Into Care) Adolescent Immunization module, as well as by facilitating support for each practice's office champion to meet the program's ends. METRIC is approved by the American Board of Family Medicine as an alternative program to fulfill Maintenance of Certification for Family Physicians (MC-FP) Part IV (performance-in-practice) requirements and uses family physicians› own practice data to help develop an action plan to keep adolescent patients on schedule with their immunizations. The module also offers tips, templates and resources and allows FPs to track and evaluate their performance. "Practices will be recruited from the Academy's active category membership," Schoof said. "A family physician in each practice will be required to complete the METRIC module, and each practice will be required to designate an 'office champion' to spearhead this effort." To qualify as a participant in the project, at least one FP in the practice must be an active AAFP member and complete

- an AAFP conflict-of-interest form and a memorandum of understanding,
- the AAFP METRIC Adolescent Immunization performance improvement module,
- two chart reviews of 50 random adolescent patient charts,
- two practice surveys at the pre and post-intervention phase,
- a mid-project interview with AAFP project staff,
- an action plan to implement office system changes, and
- monthly teleconferences and training webinars.

Participating practices will receive $3,000 to cover administrative costs, and the deadline to apply is Jan. 7. Schoof said implementation is tentatively set to begin in February 2013 and is expected to take approximately 17 months. Qualified applicants can contact Schoof via e-mail for more information.

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Tue	Key West, FL	10:00 AM	6:00 PM
Wed	Freeport, The Bahamas	8:00 AM	5:00 PM
Thu	Nassau, The Bahamas	7:00 AM	5:00 PM
Fri	Fun Day At Sea		
Sat	Fun Day At Sea		
Sun	Galveston, TX	8:00 AM	

Who says Continuing Education can't be fun?

Join ThinkNurse and Poe Travel for our 8th Annual CE Cruise. Cruise the Caribbean on Carnival's Magic while you earn your annual CE credits and write the trip off on your taxes! Prices for this cruise and conference are based on double occupancy (bring your spouse, significant other, or friend) and start at only $1088 per person (not including airfare to Galveston) A $250 non-refundable per-person deposit is required to secure your reservations. Please ask about our Cruise LayAway Plan!

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For more information about the cruise and the curriculum, please log on to our Web site at ThinkNurse.com or call Teresa Grace at Poe Travel Toll-free at 800.727.1960.

POE TRAVEL

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