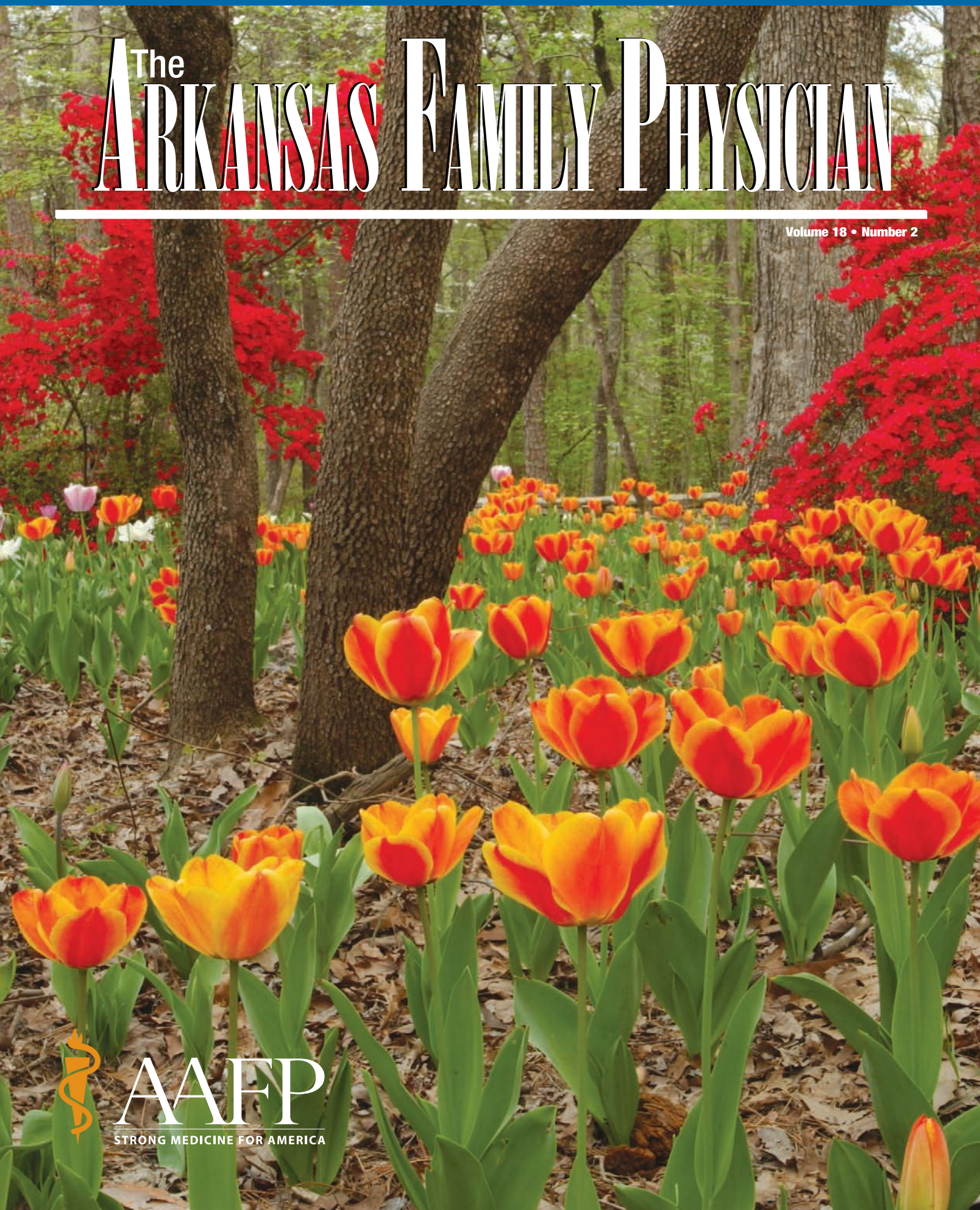
DOT COURSE SCHEDULED FOR APRIL 12: PREVIEW of 67th Annual Scientific Assembly

The Arkansas Family Physician

Volume 18 • Number 2



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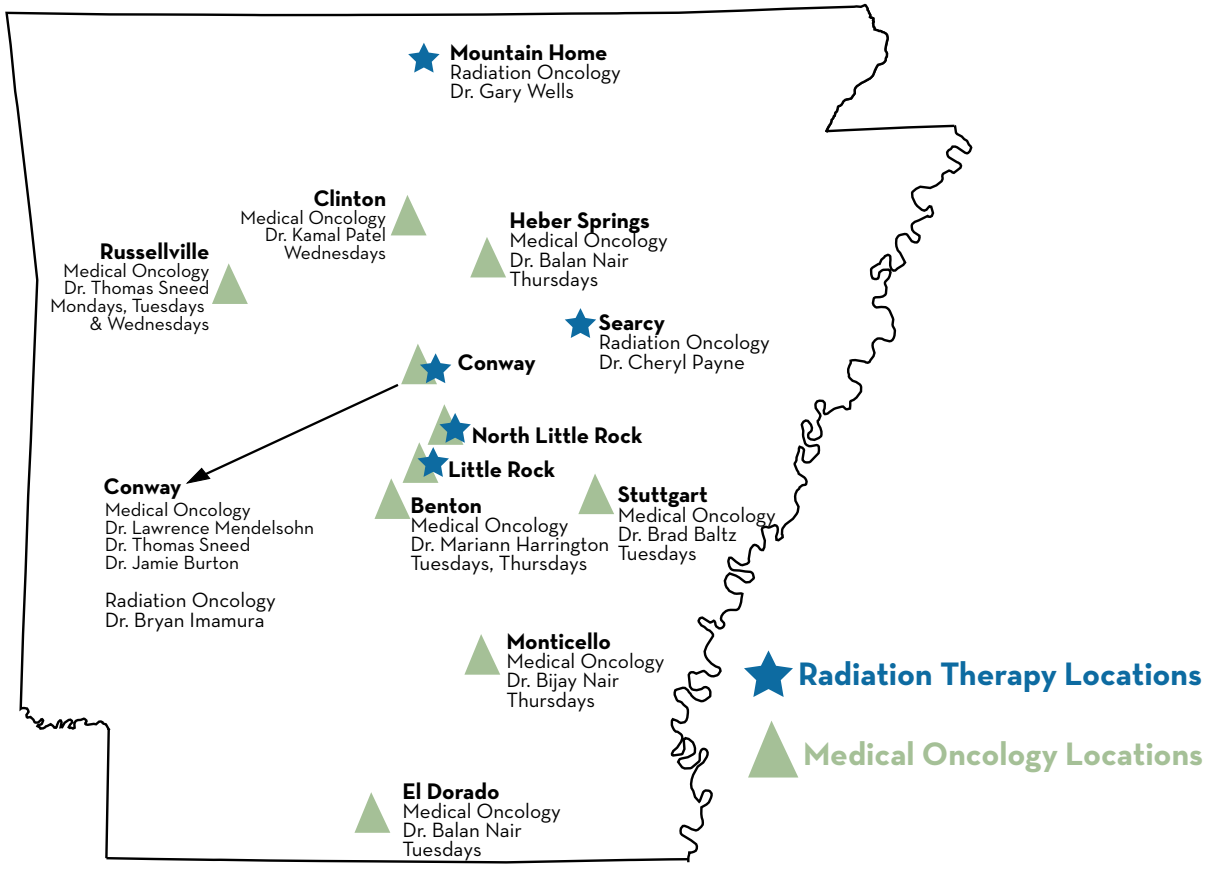

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The Arkansas Family Physician

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

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Edition 67

Dear Academy Member,

This issue of the Journal highlights not only our upcoming DOT course April 12 at Embassy Suites but a preview of our 67th Annual Scientific Assembly June 18-21 at the Doubletree in Little Rock.

The DOT course is the second we have held in Arkansas. We have identified over 234 Family Physicians who currently provide this service but only 83 have taken the course and the test to continue to offer this service. If you are interested, please contact us to register at 501 223 2272. A small block of rooms are being held at the Embassy for our group but you can probably obtain a room outside the block if you did not meet the deadline for room reservations. No walk ins are allowed for this course since the certificates are made in advance for registrants.

A **preview** of our Annual Scientific Assembly is also included which will also offer an optional Pre Assembly course for you and your staff on ICD 10. Please keep in mind our next Journal issue will highlight our speakers, events and Nominees for officers and board members. The program will be completed and mailed in the next few weeks with a code for hotel reservations.

And although each of you are aware that the Private Option for Medicaid finally passed the House of Representatives March 4 (allowing Arkansas to accept federal Medicaid funds and use them to pay for private insurance), it was such big news we could not overlook mentioning it. The Governor has signed this bill into law.

And, finally, our Board approved partnering with the Arkansas Department of Human Services in : assisting and enrolling Academy members eligible for the Patient Centered Medical Home who were not enrolled as of January 1: to promote PCMH in all sponsored events and activities and provide peer to peer outreach to generate interest and enrollment in PCMH through contact with unenrolled members participating in the CPCI or the Medicaid PCMH Advisory Committee ; communicate information on PCMH or the Arkansas Payment Improvement Initiative with members as needed. We have already linked the Arkansas DHS to our website and will continue to add information as needed along with emails to you. At our annual meeting program a booth will be set up with information on the PCMH along with a breakfast meeting to educate you on what this means for your practice! Volunteer members of our Board have agreed to schedule programs across the state and serve as a source of information to those of you that have questions. More information will be forthcoming on this partnership.

We hope to see you at our DOT course coming up soon and hope that you will join us for another great educational program – our Annual Scientific Assembly, on June 19-21 at the Doubletree Hotel in Little Rock!

Sincerely,

Carla Coleman

On the cover:

Garvin Gardens, Hot Springs, Arkansas

Photo by Don Fry

National Physician Panel Case Review Opportunity

C2C Solutions, is actively recruiting qualified physicians that are licensed in Arkansas for its national physician panel for medical case reviews. This opportunity extends to physicians that have prior experience of case review work or those that may want to be trained by C2C in doing medical cases reviews.

C2C is a longtime federal contractor for the Centers for Medicare and Medicaid Services (CMS) and adjudicates second level Medicare Part B appeals for 35 states. Their website, www.C2Cinc.com can also provide additional insight about their company.

If you are interested, please contact Maria Lagoutaris@C2Cinc.com.

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- **Cancellations prior to April 4 will be refunded less $100. No refunds after April 4!!!**

Suites are available at Embassy Suites for $109.00 per night. Please call them prior to 4/02 and mention you are with the Ar Academy of Family Physicians to reserve your room by calling 501-312-9000.

More information can be found at: http://nrcme.fmcsa.dot.gov/index.aspx Once you have passed this course and obtained an NRCME number, you can schedule to sit for the exam. Training organizations such as this are prohibited by DOT from administering the exam. To find a testing center near you: NRCME testing centers. And http://nrcme.psiexams.com/

IF YOU WOULD LIKE TO REGISTER, PLEASE CONTACT US AT: 501-223-2272 OR 800-592 1093 OR EMAIL ARAFP@SBCGLOBAL.NET

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Improved Quality of Life but no change in Resident Education or Time for Academic Enhancement.

Accreditation Council for Graduate Medical Education (ACGME) Duty Hour Change: 1 Year Later. How Do Family Medicine Residents feel?

Jasmine Brathwaite, MD, [1]Appathurai Balamurugan, MD, MPH [2]

[1] University of Arkansas for Medical Sciences, College of Medicine, Department of Geriatrics, Little Rock, Arkansas
[2] University of Arkansas for Medical Sciences, College of Medicine, Department of Family and Preventive Medicine & Arkansas Department of Health, Little Rock, Arkansas. Email: abalamurugan@uams.edu

Objective:
To examine the views of family medicine residents about how the 2011 Accreditation Council for Graduate Medical Education (ACGME) duty hour change has impacted their professional and personal well-being in addition to residency training.

Design:
Survey

Setting:
The survey was emailed to Family Medicine residents whose department is affiliated with the Association of Family Medicine Residency Directors (AFMRD) in spring 2013.

Participants:
There were 342 respondents to the survey and these included postgraduate years 1, 2 and 3 residents.

Results:
According to the residents who completed the survey, the 2011 ACGME duty hour change had a positive effect on the personal quality of life for the 1st and 2nd year family medicine residents however they felt the quality of resident education and time for academic enhancement have not improved.

Conclusion:
Many questions remain unanswered about how the 2011 duty hour change has affected resident education, experience, personal and professional life. Additionally, future studies should assess how patient safety has been affected by the duty hour change.

Introduction

Residency is a life-changing experience. It is the time when medical students are molded into hard working medical professionals filled with knowledge. Work hours are long and the entire experience can be mentally and physically exhausting. [1, 2] Sleep-deprived and fatigued doctors pose a safety risk to themselves and their patients[3, 4] whether driving home from work or completing a 20-item medication reconciliation. The fear of burn out and resultant mistakes in medical management led the Association of Graduate Medical Education (ACGME) to implement duty hour restrictions.

Since 2003 all residents were eligible to work a maximum of 30 consecutive hours. The most recent changes occurred in July 2011 when postgraduate year 1 (PGY1) residents could only work a maximum of 16 consecutive hours with mandatory supervision, while PGY – 2 or greater residents are eligible to work a 24-hour on-call period with a maximum of 4 additional hours for the transition of care (a total of 28 hours). [5]

Methods and Results

Three hundred and forty two (N=342) family medicine residents responded to the electronic survey sent to all Family Medicine residents whose department is affiliated with the Association of Family Medicine Residency Directors (AFMRD) in spring 2013. Of these, there were 119 postgraduate year 1 residents (PGY1), 107 postgraduate year 2 residents (PGY2) and 116 postgraduate year 3 (PGY3) residents.

62% of PGY 1 residents reported feeling moderately well rested, and 57% of PGY 2 residents reported improvement in the amount of rest they got (Table 1 and 2). Conversely, 51% of 3rd year residents reported no change in the amount of rest they got (Table 2). 50% of PGY3 residents saw no change in their personal quality of life while the majority of lower level residents (46% PGY1 and 61% PGY 2 residents) reported a positive effect on their personal life. This difference in results is likely because PGY3 residents had no significant change in their duty hours from 2nd to 3rd year, and also possibly from having a greater workload and therefore additional responsibilities as interns have less duty time.

Discussion

Despite a reduction in the total number of consecutive work hours, more than half (57%) of 1st year residents reported not having enough time for academic enhancement. Additionally, numerous comments collected during the survey expressed that despite a reduced number of consecutive work hours there was a greater frequency of days worked, with fewer days off as was previously allowed on post call days (Table 3). This ultimately leads to less time for reading/studying. Some residents even reported that the duty hour change was counterproductive to their residency education and experience. 61 % of PGY3 residents reported a decrease in the preparation of junior staff for senior roles. A survey from 2011 of 549 program directors showed similar results where 73% of respondents thought junior residents were ill prepared for senior roles. [7] Although our survey was sent to all family medicine residents whose department was affiliated with AFMRD, we were unable to track the response rate. This is a major limitation of the study.

Further studies on the 2011 duty hour change are needed to assess its impact on

continued on page 10

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continued from page 8

residents' academic performance, personal and professional life. Additionally, future studies should assess how patient care and safety has been affected by the duty hour change.

References

1. Accreditation Council for Graduate Medical Education. Comparison Table 2003 v 2011. Dh_ComparisionTable2003v2011.pdf. Accessed at http://www.acgme.org/acgmeweb/GraduateMedicalEducation/DutyHours.aspx on December 15, 2012

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4. Sugden C, Housden CR, Aggarwal R, Sahakian BJ, Darzi A. Effect of Pharmacological Enhancement on the Cognitive and Clinical Psychomotor Performance of Sleep-Deprived Doctors: A Randomized Controlled Trial. Ann Surg. 2012 Feb; 255(2):222-7.

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6. Drolet BC, Christopher DA, Fischer SA.. Residents' Response to Duty-Hour Regulations – A Follow-up National Survey. N Engl J Med 2012; 366:e35. June 14, 2012

7. Drolet DB, Khokhar MT, Fischer SA. The 2011 Duty-Hour Requirements — A Survey of Residency Program Directors. N Engl J Med 2013; 368:694-697. February 21, 2013

Table 1. PGY-1 Family Medicine residents' responses to the survey questions

Question	PGY-1		
During the first few months of residency	Well-rested	Moderately rested	Not well rested
How well rested do you generally feel?	13%	62%	25%
	Positive	Neutral	Negative
What effect do the duty hour requirements have on your: Personal life: Professional life:	 46% 32%	 37% 52%	 16% 16%
	Yes	No	
Do you think you get adequate patient experience with your current duty hours?	82%	18%	
Do you have enough time to read (academic enhancement)?	43%	57%	

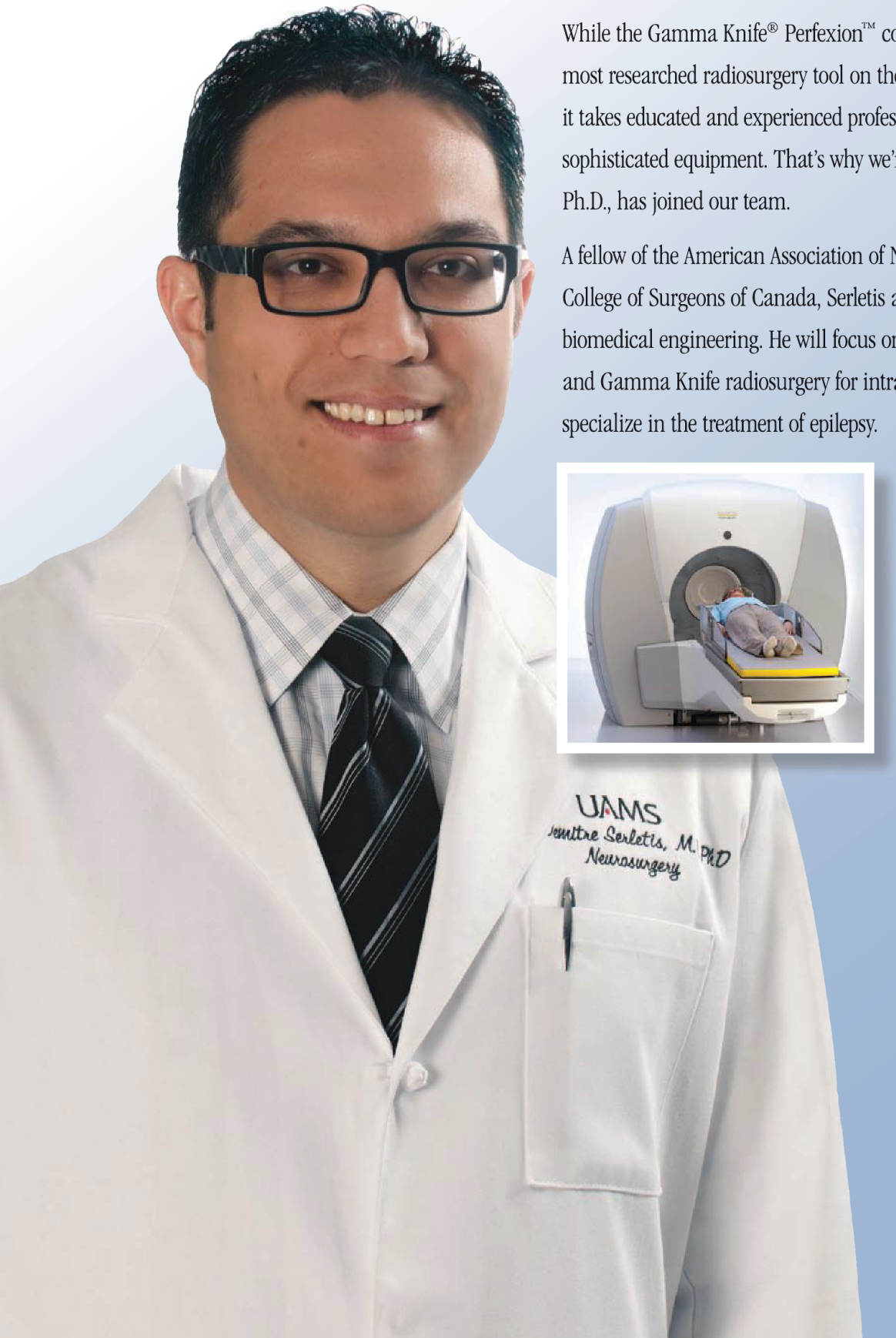
Table 2. PGY-2 and PGY-3 Family Medicine residents' responses to the survey questions

Question	PGY-2			PGY-3		
How have the following been affected by the new ACGME regulations on duty hours	Improved	Unchanged	Decreased	Improved	Unchanged	Decreased
Quality of resident education	22%	54%	23%	12%	45%	43%
How much rest you get	57%	33%	10%	36%	51%	13%
Time for academic enhancement	38%	49%	13%	25%	60%	15%
Prep of your junior residents for senior roles	20%	50%	30%	10%	28%	61%
Your personal quality of life	61%	24%	15%	33%	50%	17%
Your professional quality of life	47%	40%	13%	28%	49%	23%

Table 3. Verbatim responses of the family medicine residents who completed the survey

Comments
"The duty hours currently in place are a great way to provide time for activities such as reading, family time and extracurricular activates."
"I think the focus should be on quality instead of quantity of time spent at work."
"Lack of continuity – too many signs outs."
"More continuous work days with fewer days off, is questionably more difficult than having 30- hour shifts with post-call days."
"Patient safety first- a sleepy resident is not a safe resident. It is too bad that upper years are still allowed to work 30- hours – that is too long"
"Big change in duty hours between 1st and 2nd year made the transition very difficult"

UAMS Welcomes Demitre Serletis, M.D., to our Gamma Knife® Team



While the Gamma Knife® Perfexion™ continues to be the 'gold standard' and most researched radiosurgery tool on the market today for brain diseases, it takes educated and experienced professionals to properly utilize this sophisticated equipment. That's why we're excited that Demitre Serletis, M.D., Ph.D., has joined our team.

A fellow of the American Association of Neurological Surgeons and the Royal College of Surgeons of Canada, Serletis also holds a Ph.D. in physiology and biomedical engineering. He will focus on adult neurosurgery, neuro-oncology and Gamma Knife radiosurgery for intracranial diseases and will also specialize in the treatment of epilepsy.

For more information or to make a referral to the gamma knife team, call (501) 603-1800. For more information on Dr. Serletis, visit **uamshealth.com/md**.

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Arkansas AFP Represented at AAFP Multi State Meeting

The Arkansas Chapter was represented at the AAFP Multi State Meeting February 22-23 in Dallas by President Barry Pierce of Mountain View, Past President Lonnie Robinson of Mountain Home and EVP Carla Coleman.

Participating chapters of Multi State were California who was the host this year: Arizona Colorado, Illinois, Iowa, Kansas, Missouri, Nebraska, New Mexico Oklahoma and Texas. Topics presented in this Saturday-Sunday format were: "The Medical Home and Payment Reform": "Anticipating the Outcome and Impact of the Fall Elections and Legislative Update by the AAFP": "Challenges and Best Practices in Rural Family Medicine": "Play the Non MD Expansion of Scope of Practice Game" with presentations by each chapter in attendance on "Best Practices" and "Legislative Updates." AAFP President Dr. Reid Blackwelder was in attendance to speak on and Update from the AAFP which was insightful.

This informal meeting held annually is a great information exchange with participating states in addition to timely presentations.

Dr. Lonnie Robinson Appointed To AAFP Commission

Congratulations to Dr. Lonnie Robinson, immediate Past President of the Arkansas AFP and a practicing Family Physician in Mountain Home has been appointed by the AAFP Board of Directors to the AAFP Commission on Continuing Professional Development

for a term of service beginning January 14 and ending December 14, 2015.

The Commission on Continuing Professional Development works directly to support the AAFP's Strategic Objective on Education by supporting the lifelong learning of family physicians and other health care professionals. The goals of the commission are to guide the AAFP's accreditation and provision of continuing medical education that helps learners demonstrate continuous improvement in knowledge, competence, practice transformation and patient outcomes as well as fulfill the educational requirement for licensure and certification.

Communication Sent to ARAFP Members with Insufficient CME

Arkansas AFP Active members due for re-election at the end of 2013 who had not reported sufficient CME received a fax reminder to report CME no later than March 31 to maintain AAFP membership. Membership cancellation for those with insufficient CME occurs May 1.

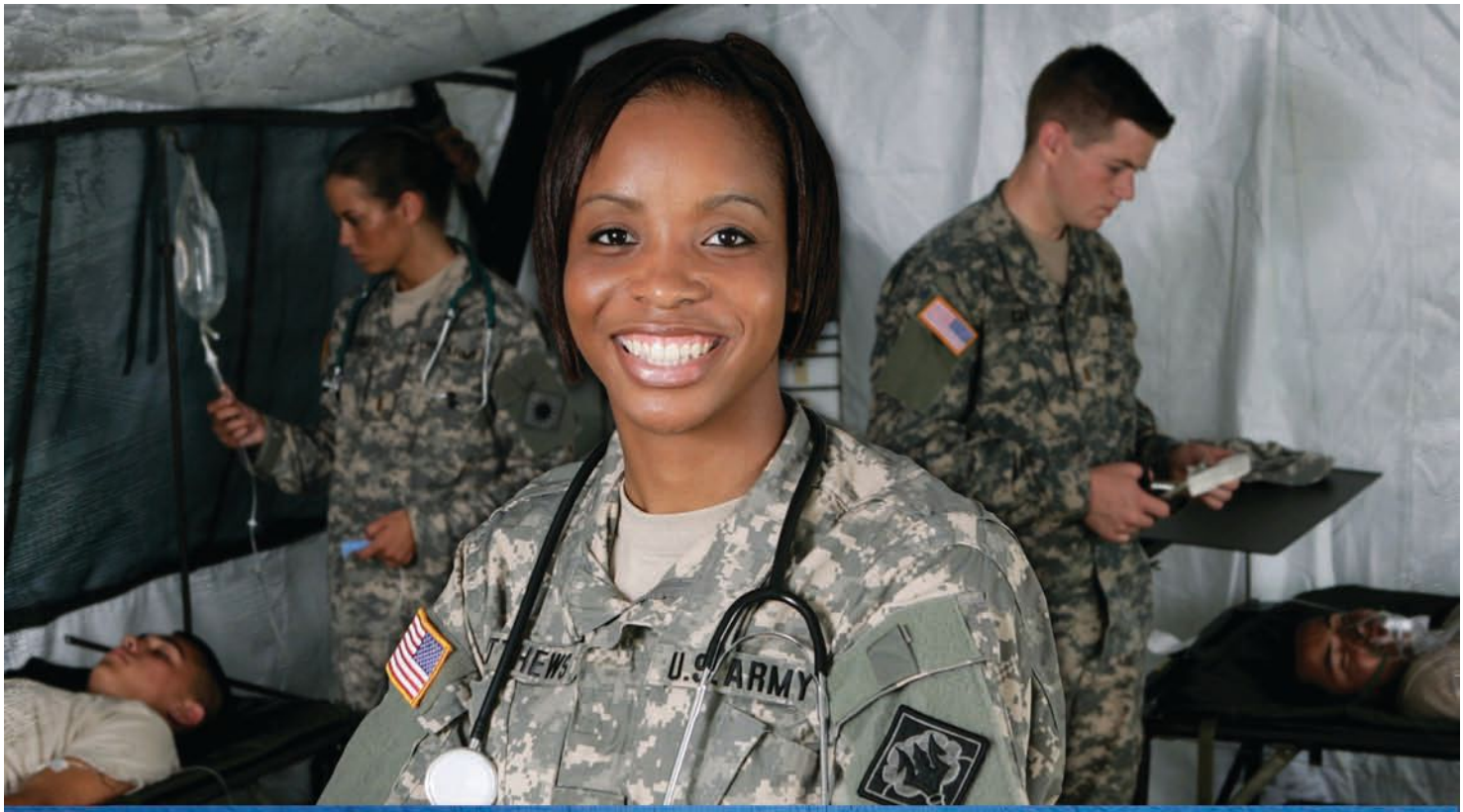
Members reporting CME can:

*Self Report on AAFP.org (https://nf.aafp.org/Cme/Accreditation/)

*Report through the AAFP Contact Center via mail, phone, fax or email:

AAFP Contact Center
11400 Tomahawk Creek Parkway
Leadwood, Kansas 66211-2680
Phone: 800-274-2237
Fax: 913-906-6075
Or email: contactcenter@aafp.org

If the Arkansas Chapter can assist you, please contact us at 501-223-2272 or email us at arafp@sbcglobal.net



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PREVIEW

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

2014 Arkansas 67th Annual Scientific Assembly

Wednesday June 18 - Pre Assembly - ICD 10 for the Family Physician

June 19-21, 2014

DOUBLETREE HOTEL , LITTLE ROCK

2014 Arkansas 67th Annual Scientific Assembly
June 19-21, 2014
Doubletree Hotel, Little Rock, Arkansas
PREVIEW

Wednesday, June 18

1:00 p.m. til 4:00 p.m. **PRE ASSEMBLY CME**
(separate fee and registration)
" ICD 10 for the Family Physician and the Family Physician's Office Staff"

Thursday, June 19

7:00 a.m.	**Registration**-Ballroom Foyer *Visit Exhibits-Palisades, Riverside East, & Riverside West*
8:15 a.m.	**Opening ceremony**
8:30 a.m.	***"The Future of Family Medicine in Arkansas"*** G. Richard Smith, M.D., Dean, UAMS College of Medicine
9:00 a.m.	***"Health Care Reform in Arkansas"*** Joseph W. Thompson, M.D., MPH, Arkansas Surgeon General
9:45 a.m.	**Break – visit exhibits**
10:15 a.m.	***"State Health Alliance for Records Exchange" (SHARE)*** Shirley Tyson, Chief Operations and Technical Officer, Ar. Office of Health Information Technology, DHHS
10:45 a.m.	***"Dermatology Tips for the Family Doctor"*** Scott Dinehart, M.D., Arkansas Skin Cancer and Dermatology Center, Little Rock, Ar
11:30 a.m.	**Physician/Registrant Lunch** – compliments of State Volunteer Mutual Insurance ***" Gems of Management"*** – Tom Stearns, FACMPE, SVMI, Brentwood, Tennessee
1:15 p.m.	***" ER/LA Opioid REMS: Achieving Safe Use while Improving Patient Care"*** Carol Havens, M.D., Family Practice Physician & Addiction Medicine, Sacramento, California
3:15 p.m.	**Break – Visit Exhibits**
3:45 p.m.	***"Spinal Pain – Methods of Treatment, Management of Pain"*** Michael Calhoun, Neurosurgeon, Central Arkansas Neurosurgery Clinic, North Little Rock, Ar
4:30 p.m.	***"Prescribing of Pain Medications"*** Juan Carlos Roman, M.D., Anesthesiologist, Little Rock Anesthesia, Little Rock, Ar.

Friday, June 20

7:00 a.m. **Buffet Breakfast Meeting for Physician Registrants**
AFMC's Involvement in Health Care Reform"
Ray Hanley, Chief Executive Officer, AFMC
Peggy Starling, Vice President, Medicaid Operations, AFMC
Michael Moody, M.D., Chief Medical Officer, AFMC
Compliments of Arkansas Foundation for Medical Care

8:30 a.m. ***" Foot Management"***
Jesse Burks, DPM, Foot and Ankle Surgery, Ortho Surgeons, PA, Little Rock , Ar

9:15 a.m. ***" Diabetes – New Targets, New Therapies, New Approach to Patient Management"***
Niyaz Goxmanov, M.D., CDE, Endocrinologist, Oklahoma City, Oklahoma

10:15 a.m. **Break - Visit Exhibits**

10:45 a.m. ***"The ABC's of Pediatric ENT"***
Charles Bower, M.D., Professor and Vice Chairman of Pediatric Services, Otolaryngology, Arkansas Children's Hospital, UAMS, Little Rock, Ar

11:40 a.m. **Installation of Officers Luncheon** – Courtesy of Baptist Health

1:00 p.m. **Final exhibit visitation**

1:30 P.M. ***"Keeping Current with COPD Management"***
Barbara Yawn, M.D., MSC, FAAFP, Olmstead Medical Center, Minnesota

3:00 p.m. **Break**

3:15 p.m. ***" ACS - Transitioning Patients from Hospital to Home"***
Tomas Villanueva, D.O., MBS, FACPE, SFHM, Medical Director, Hospital Medicine, Miami, Florida

Saturday, June 21

7:15 a.m. **Breakfast Meeting -** ***"The Medicaid Patient Centered Medical Home"***
Lonnie Robinson, M.D., FAAFP, Family Physician, Mountain Home, Ar
Beth Milligan, M.D., FAAFP, Family Physician, Little Rock, Ar
Sheena Olson, JP, MPA, Assistant Director, Medicaid Programs, Arkansas DHS, Little Rock, Ar
Courtesy of Creative Educational Concepts

8:45 a.m. ***"An Update from the American Academy of Family Physicians"***
Robert Wergin, M.D., FAAFP,Family Physician, Private Practice, Milford, Nebraska
President Elect, American Academy of Family Physicians

9:30 a.m. ***"Acne Vulgaris"***
Mark T. Jansen , M.D., FAAFP, Family Physician, Assistant Professor, UAMS Department of Preventive Medicine, Little Rock, Ar.

10:15 a.m. ***"When the Pressure Is On"***
Angela Driskill, M.D., FAAFP, PWCC, Family Physician,
Baptist Health Wound & Hyperbaric Center, North Little Rock, Ar

11:00 a.m. ***"Diseases Transmitted Animals to Humans"***
Elton Cleveland, M.D., FAAFP, Family Physician, Associate Professor, UAMS Department of Adolescent Medicine, Little Rock, Ar

11:45 a.m. **Adjournment**

A block of rooms are available at the Doubletree Hotel, 501 372 4371 for a rate of $133.
Our group code is AFP or specify Arkansas Academy of Family Physicians.

REGISTRATION FORM

AR AFP – 67th ANNUAL SCIENTIFIC ASSEMBLY

June 18-21, 2014

NAME:_____

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SCIENTIFIC ASSEMBLY FEES:

Pre-Assembly-ICD-10 **$125.00 all registrants**

Academy Members -	$400.00	Resident Members -	No Charge
Non Members -	$475.00	Student Members -	No Charge
Inactive\Life -	$125.00	Spouse\Guest -	$40.00

To Obtain Free Registration, Students and Residents must Pre-Register!

ASSEMBLY CME:_____

Pre-Assembly "ICD-10" Wednesday, June 18……..$_____

Scientific Assembly Fee (includes all meal functions) .....$_____

Spouse\Guest Fee .....$_____

ArAFP Foundation Fund – Optional Contribution .....$_____

*TOTAL ENCLOSED .....$_____

The following functions are included in assembly registration fees:

Please indicate how many people will be attending-

Registrant Lunch – Thursday ..... _____

Registrant Breakfast – Friday..... _____

Installation of Officers/Registrant Lunch – Friday..... _____

Registrant Breakfast – Saturday ..... _____

*REGISTRATION AFTER MAY 30th & ONSITE- ADD $100.00

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AAFP Supports SGR Repeal and Medicare Provider Payment Modernization Act of 2014

A letter has been mailed to John Boehner, Speaker, U.S. House of Representatives, Eric Cantor, Majority Leader, U.S. House of Representatives, Nancy Pelosi, Minority Leader, U.S. House of Representatives: Harry Reid, Majority Leader, U.S. Senate and Mitch McConnell, Minority Leader, U.S. Senate supporting the bipartisan, bicameral SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (HR 4015/S.2000), calling for its immediate passage.

Every state chapter of the AAFP representing 110,600 members signed on to this letter which expressed strong support for this proposal and urged passage of this measure before March 31 when the current extension of the Medicare payment formula that includes the SGR formula expires.

HR 4015/S.2000 repeals the Medicare SGR with the AAFP letter stating the troublesome history of this payment formula since Congress has had to override the reductions in physician payment rate mandated by the current formula. These reductions threatened the stability of the Medicare program and the access to seniors to Medicare benefits. The looming threat of frequent reductions also stifles innovation in care delivery and hinders transformation of primary care practices. This bill makes several changes in Medicare that family medicine supports – the legislation shifts emphasis away from fee for service toward new advanced delivery models that demonstrate innovation in care delivery and higher quality care. Those include the Patient Centered Medical Home which the AAFP has promoted for many years and agrees with the legislation's automatic inclusion of the PCMH as an Advanced Alternative Payment Model designed to improve delivery of health care.

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Quality Colonoscopies Save Lives

Arkansas has the sixth highest rate of death due to colorectal cancer (CRC) in the nation. CRC is the second biggest cancer killer in the Natural State. To improve the quality of colonoscopies and increase the number of people using this screening tool, the Arkansas Foundation for Medical Care (AFMC) has implemented the "Do It Right" campaign (afmc.org/doitright).

"Do it Right" works with patients and doctors to ensure everybody who needs a colonoscopy is getting a high-quality procedure. AFMC's mission is to make sure colonoscopies are done at the right time, with the right physician and in the right way. Adopting evidence-based best practices for screening procedures and increasing the reporting of quality indicators are key to this effort.

The Right Time. More than 90 percent of people who develop CRC are over age 50. The majority of patients and those at normal risk of CRC should get a colonoscopy at age 50 and repeat it every 10 years. Screenings should begin before age 50 and occur more frequently if CRC risk factors are present.

The Right Physician. At least 20 percent of patients have polyps. Physicians performing screening colonoscopies should know his or her rate of polyp detection. When it is higher than 20 percent (15% for women; 25% for men), the physician is doing an adequate job finding polyps. Clinical guidelines now recommend a withdrawal time of at least six minutes. Going slowly and carefully checking all areas of the colon is what the right physician does.

The Right Way. Both patients and physicians contribute to a quality colonoscopy.

- Emphasize with patients that they must carefully follow directions in preparing for a colonoscopy. Adequate bowel prep is the first evidence-based quality indicator of this project.
- Physicians need to take enough time to find all polyps in the colon. A colonoscope withdrawal time of at least six minutes is the second evidence-based quality indicator.
- Physicians should document adenoma detection rates, including number, location and size. This is the third quality indicator.
- Achieve a cecal intubation rate of at least 95 percent.

Ways to Improve Colonoscopies

Endoscopists should:

- Monitor performance using recommended quality indicators.
- Adopt evidence-based screening guidelines; specifically record and report adequate bowel prep and colonoscopy withdrawal time; and adenoma detection rates, including number, location and size.
- Document prep quality as "good," "fair" or "poor" in procedure notes. This enhances appropriate scheduling of screening intervals. The recommendation is one year if prep quality was less than "good."
- Document cecal intubation rate by photo in at least 95 percent of procedures.

Referring providers should:

- Increase patient awareness of the importance of quality endoscopies, especially with Medicare or high-risk patients.
- Increase patient knowledge of the significance of early identification of polyps and adenomas. Explain the value of a high-sensitivity FOBT for appropriate patient populations, and that it must be done annually. Use either a high-sensitivity guaiac-based FOBT (Hemacult Sensa has better sensitivity) or an immunochemical FIT test. The later has higher sensitivity and specificity and is not influenced by food or medication. Positive screening results should be followed up with a colonoscopy.
- Refer patients to endoscopists who provide a high-quality procedure and meet ASGE quality guidelines.

Increase Patient Compliance

The number one reason given for not getting a colonoscopy is that the doctor never talked to them about it. Patients also cited fear, embarrassment, discomfort, time and cost as specific reasons for not getting a CRC screening.

Patients were not aware of the

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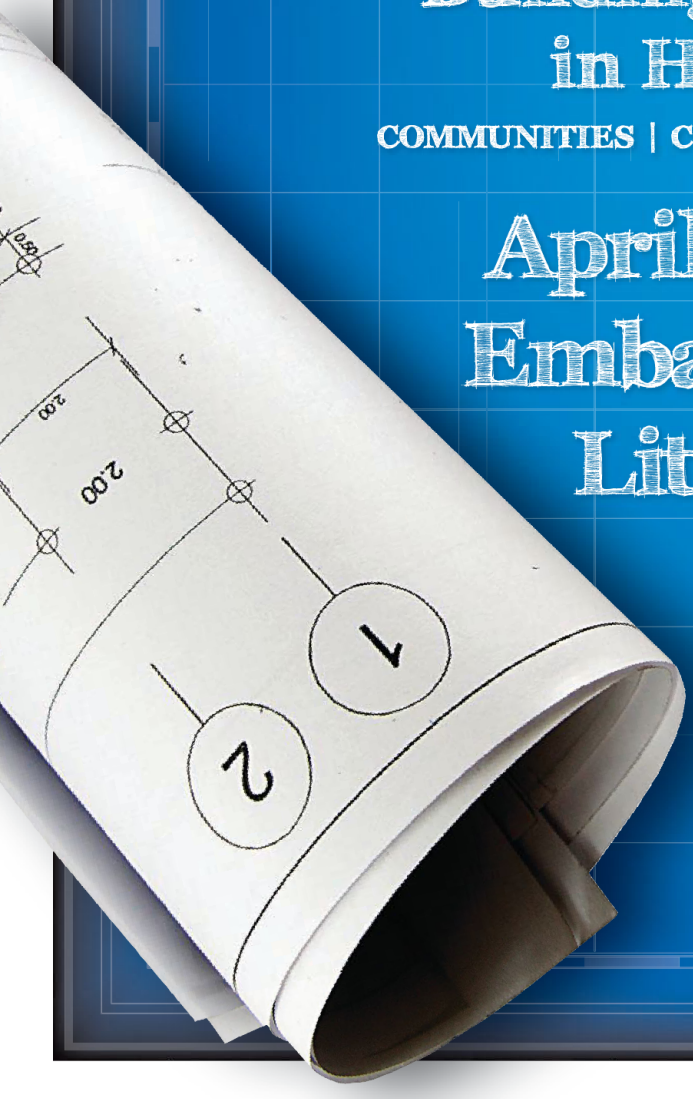

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benefits of screening or of their individual risk for CRC (smoking, obesity, being sedentary, family history of cancer, age 60+ and high-fat-low-fiber diet). For example, there are no signs or symptoms of polyps or early colon cancer. The only way to know if you have polyps is to have a quality colonoscopy. Colon cancer can be prevented with a colonoscopy and polyp removal. The five-year survival rate is over 90 percent if cancer is in situ when identified, but only 10 percent if distant metastases. Polyp removal confers a 53 percent lower risk of CRC death than the general population.

PCPs should explain that colonoscopy prep is now easier, gentler and causes less discomfort. It no longer requires suppositories, enemas or harsh laxatives. The recommended prep is PEG with electrolyte replacement (MOVIprep or Miralax with Gatorade). The patient is responsible for completing the entire prep the day before.

The cost of over-the-counter prep medications is less than $10. Medicare requires a $50 co-pay for prescription prep medications. Private insurance does not cover prep medications.

The quality of the patient's prep determines success in cecal intubation and the adenoma detection rate. It also strongly influences the complication rate. PCPs must emphasize the importance of carefully following prep directions.

A physician's recommendation is the most consistently influential factor in CRC screening. And while screening has increased from 39 percent in 2000 to 59 percent in 2010, there is still enormous progress to be made.

High-Risk Individuals

Patients at higher risk for colorectal cancer include those who:

- Smoke tobacco
- Eat a high-fat, low-fiber diet
- Drink alcohol
- Are obese (BMI >30 = 1.5 times higher risk of CRC)
- Are > 60
- Are sedentary
- Are African-American, Native American, Alaskan native, Ashkenazi Jew or Eastern European
- Have a history of CRC; cancer of the ovary, endometrium or breast; inflammatory bowel disease; family history of polyps; or CRC
- Have hereditary cancer syndromes (familial adenomatous polyposis or hereditary non-polyposis colon cancer).

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2014 Recommended Immunization Schedules Serve as Reminder to Vaccinate

Adults, Especially, Lag in Receiving Appropriate Vaccines

Among the changes affecting the newly released 2014 recommended immunizations schedules, perhaps one of the biggest is what family physicians won't see this year. For the first time, the familiar figures, footnotes and tables have not been publish in full in the CDC's *Morbidity and Mortality Weekly Report*. Instead, electronic versions of the schedules (http://www.cdc.gov/vaccines/schedules/hcp/index.html) have been posted to the Vaccines and Immunizations section of the CDC website so they can be swiftly revised of errors or omissions are discovered.

In conjunction with this innovation, the agency also has introduced a content syndication feature that allows external websites to link directly to the CDC-hosted schedules so users always have the most up-to-date information.

The combined schedule for individuals ages O through 18 years and catch-up schedule (http://www.aafp.org/content/dam/AAFP/documents/patient_care/immunizations/child-immunization-schedule.pdf) and the adult schedule (http://www.aafp.org/content/dam/AAFP/documents/patient_care/immunizations/adult-immunization-schedule.pdf) also are available on the AAFP website as PDF files.

What's New or Improved?

As for changes to the actual content of the schedules, most involve clarification of existing recommendations, with just a few exceptions. Where appropriate, brand names are included for each vaccine because they are more familiar to most clinicians and staff.

For example, in the child and adolescent schedule (http://www.cdc.gov/vaccines/schedules/hcp/child-adolscent.html#chgs), the legend and footnote for the meningococcal conjugate vaccine row have been updated to ref ect a recent recommendation to use quadriv6tent meningococcal congeal (MenACWY-CRM) vaccine (Menveo) in infants as young as age 2 months. Previously, only bivalent meningococcal conjugate vaccine and Haemophilus inf uenza type b conjugate (Hib-MenCY) vaccine (MenHibrix) was recommended for infants this young.

Other changes include:

Inf uenza vaccine footnotes have been updated to guide dosing tor children ages 6 months through 8 years during the 2013-14 and 2014-15 seasons, pneumococcal vaccine footnotes have been updated to guide vaccination of people with high risk conditions, and hepatitis A vaccine footnotes have been updated to provide guidance for unvaccinated people who are at increased risk.

The catch-up schedules for Hib conjugate vaccine, pneumococcal conjugate vaccine, and tetanus, diphtheria and acelluiar pertussis (Tdap) vaccine also have been clarified.

The adult schedule (http://www.cdc.gov/vaccines/schedules/hcp/adult.html#chgs) contains a number of changes pertaining to Hib vaccine. Specifically, a single dose of the vaccine now is recommended for people with functional or anatomic asplenia and those who have sickle cell disease if they have not been vaccinated previously. For patients scheduled to undergo elective splenectomy, the dose should be given at least 14 days before the procedure.

In addition, hematopoietic stem cell transplant recipients should receive a three-dose regimen six to 12 months after successful transplantation, regardless of vaccination history. Doses should be given at least four weeks apart.

Also new this year, physicians no longer need to consider Hib vaccine for individuals with HIV infection, because the likelihood of Hib infection is low in this population.

Other changes to the adult schedule include:

- moving the row for the pneumococcal conjugate 13-valent vaccine (Pcv13) on top of that for the pneumococcal polysaccharide (ppsv23) vaccine as a visual reminder that Pcv13 should be administered before PPSV23 in patients for whom both vaccines are recommended (i.e., those with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal f uid leaks, or cochlear implants);
- reordering the respective footnotes for the pneumococcal vaccines to mirror row sequence, as well as adding language to remind clinicians of the appropriate order of administration when both are injected;
- modifying the meningococcal vaccine footnote to clarify which patients need either one or two doses of vaccine, as well as to clarify which patients should receive the meningococcal conjugate (MenACWY-D) vaccine (Menactra) versus MenACWY-CFM vaccine;
- adding information about the recombinant inf uenza vaccine (RIV) and use of RIV and inactivated inf uenza vaccine (IIV) among egg-allergic patients to that RIV or IIV can be used in patients with hives-only allergy to eggs;
- editing the tetanus and diphtheria toxoids Od)/Tdap vaccine footnote to harmonize with the language used in the pediatric immunization schedule; and
- simplifying both the human papillomavirus (HPVI vaccine footnote and the herpes zoster vaccine footnote, including removal of the bullet regarding health care personnel.

Low Vaccination Rates, Barriers Persist

Coincidentally, a brace of recently released research reports highlight key issues related to adult immunization: continuing low administration rates and barriers to overcoming them.

According to "Noninf uenza Vaccination Coverage Among Adults — United Slates, 2012," (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6305a4.htm) published Feb.7 in *MMWR* the CDC analyzed data for selected vaccines from the 2012 National Health Interview Survey to assess

vaccination coverage among adults ages 19 and older. Included in that analysis were pneumococcal, tetanus toxoid-containing (Td or Tdap), hepatitis A, hepatitis B, herpes zoster, and HPV vaccines.

Compared with 2011, only modest increases were seen in Tdap vaccination among adults ages i9-64 (from an overall .12.4 percent to 15_6 percent), herpes zoster vaccination among those 60 or older (from 1 5.7 percent to 20.1 percent) and HPV vaccination among women ages from 9-26 (from 29_S percent to 34.5 percent); coverage for the other vaccines did not improve.

A study report (http://annals.org/article.aspx?articleid=1819120) published Feb. 4 in the Annals of Internal Medicine may shed some light on barriers to achieving higher rates of adult immunization.

Study authors noted that the AClP currently recommends 12 vaccines for adults, including vaccines recommended universally, catch up vaccines and vaccines for high-risk patients. In addition, the context for adult immunization has shifted in recent years, with some vaccines now being covered by Medicare Part D and many patients moving away from primary care settings as the site of vaccination.

Based on survey responses from members of a primary care network comprising family physicians and general internists, the CDC-funded study found:

• Almost all physicians reported assessing patients' vaccination status during annual visits or new-patient visits, but less than one-third of respondents reported doing so at every visit. The most common means of assessment was a review of the patient's medical record; only a minority used tools such as immunization information systems (IISs).

• Nearly all physicians assessed vaccination status for seasonal inf uenza, pneumococcal, Td, Tdap, and zoster vaccines. Fewer reported assessing status tor the remaining recommended vaccines.

• Most physicians reported stocking seasonal inf uenza, pneumococcal, Td and Tdap vaccines; they were less likely stock hepatitis vaccines; catch-up vaccines (HPV; mumps, measles and rubella; varicella; and meningococcal): and zoster vaccine.

• Characteristics associated with reporting greater financial barriers included private practice setting, fewer than five health care professionals in the practice, southern region west region (for FPs only), and Midwest region and having a higher proportion of patients with Medicare Part D (for internists only).

• Most respondents reported referring Patients elsewhere for vaccines they did not stock. Patients also were referred to alternative vaccinators because of insurance coverage issues. Typically, patients were referred to a local pharmacy/ retail store or the public health department,

Overwhelmingly, the physicians surveyed reported that they considered it their responsibility to see that their patients received all recommended vaccines, even if they themselves did not administer the vaccines. Although most said their patients preferred to be immunized in the physician's office rather than at a pharmacy or retail store, many respondents did see a role for pharmacists in providing immunizations.

The same could not be said for subspecialists, however, with most survey respondents noting that subspecialists who administered vaccines rarely notified the primary care physician.

"Although primary care physicians appear motivated to ensure that patients are up to dale on vaccinations, many barriers exist," the authors concluded.

"Implementation of system changes, including adopting practices that improve communication between primary care physicians and alternate vaccinators, more widespread use of effective tools (IISs and clinic decision support systems) and removing policy-related barriers, could improve adult vaccination in the United States."

HPV - Arkansas Ranks Next to Last Immunization

According to the Arkansas Department of Health, Arkansas ranks next to last nationwide in the percentage of HPV vaccines given todate at 18.3% for the year 2012. Despite availability of safe and effective vaccines and ample opportunities for vaccine delivery in the health care setting, HPV vaccination coverage among adolescent girls failed to increase nationwide from 2011 to 2012.

In a survey by the CDC reasons given by parents who did not intend to vaccinate their daughters, the top five responses were: vaccine not needed: vaccine not recommended by their physician: vaccine safety concerns; lack of knowledge about the vaccine or the disease and daughter not sexually active.

The CDC states that missed vaccination opportunities remain high. Every health care visit whether for back to school evaluations or acute problems, should be used to assess teenagers immunization status and provide recommended vaccines if indicated.

Genital human papillomavirus (HPV) is the most common sexually transmitted virus in the United States. More than half of sexually active men and women are infected with HPV at some time in their lives. About 20 million Americans are currently infected and about 6 million more get infected each year. It is usually spread among sexual contact.

Most HPV infections do not cause any symptoms and go away on their own. But HPV can cause cervical cancer in women which is the second leading cause of cancer deaths among women in the world. It is also associated with several less common cancers and there is no cure for HPV infection but some of the problems it causes can be treated.

The HPV vaccine is one of two vaccines that can be given to prevent HPV. It may be given to both males and females. This vaccine can prevent most cases of cervical cancer in females if it is given before exposure to the virus. In additiona it can prevent vaginal and

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vulvar cancer in females and genital warts and anal cancer in both males and females. Protection from HPV vaccine is expected to be long lasting but vaccination is not a substitute for cervical cancer screening.

HPV vaccine is given as a three dose series: *1st Dose – Now: * 2nd dose – 1 to 2 months after Dose 1: and *3rd Dose – 6 months after Doses 1. Additional booster does are not recommended. This HPV vaccine is recommended for girls and boys 11 or 12 years of age and may be given starting at age 9.

Two HPV vaccines are licensed by the FDA and recommended by CDC. These vaccines are *Cervarix* made by GlaxoSmithKline and *Gardasil* made by Merck.

According to the CDC, both vaccines are very effective against diseases caused by HPV types 16 and 18 which cause most cervical cancers as well as other HPV associated cancers and both are very safe. Only one of the vaccines (*Gardisil*) protects against HPV types 6 and 11, the types that cause most genital warts and tested and licensed for use in males.

For more information on HPV and the HPV vaccine, contact the Arkansas Department of Health or the Centers for Disease Control and Prevention (vaccines website).

From AAFP NEWS NOW:

Yari Broussard, 2, holds on to Dr. Najeeba Bootwala's hand as Bootwala conducts a health check at Oakhurst Medical Center in Stone Mountain on April 11, 2012. The health center provides primary care to around 40,000 patients.
(Photo: File photo by Mikki K Harris for USA TODAY)

Obama budget will seek record funding for new doctors

WASHINGTON — President Obama will propose boosting the National Health Services Corps from 8,900 a year to 15,000 a year over the next five years, as well as spending $5.23 billion to train 13,000 primary care residents over the next 10 years, in his budget next week, administration officials told USA TODAY.

The budget, which Obama will reveal Tuesday, marks the first time Medicare funds will be used to increase the number of medical residents, and it's the largest-ever proposed increase of the corps, officials said.

The administration hopes to boost both team-based care, as well as send residents out to rural areas and areas with lower access to care, officials said.

The president's budget proposal:

- Adds $5.23 billion over 10 years to train 13,000 primary care residents in high-need communities, and in team-based care, such as an accountable care organization.
- Extends higher payments to Medicaid providers, including physician assistants and nurse practitioners, by one year at a cost of about $5.44 billion.
- Adds $3.95 billion over the next six years in the National Health Services Corps to support growing the program from 8,900 primary care providers in 2013 to at least 15,000 annually starting in the 2015 fiscal year.

"This is a booster shot unlike any other before now," said Mary Wakefield, administrator of the Health Resources and Services Administration.

The proposal also addresses a shortage of mental health providers by offering residencies for psychiatrists, psychiatric nurse practitioners and other mental health providers as part of the team-based approach.

The Affordable Care Act opened up health insurance to potentially millions of previously uninsured people — so far, 4 million people have signed up for private plans through the state and federal health exchanges. That means there will be a demand for more doctors. At the same time, Medicare pilot programs as well as hundreds of new Accountable Care Organizations offered by physicians' groups, hospitals and insurers have pushed health care toward a team-oriented approach.

The administration officials said there should be no problem recruiting primary care physicians, although medical students have been drawn to medical fields that pay higher salaries, often to pay off their student loans.

Recruiting primary care practitioners for the residencies makes sense because young people are interested in working with teams of providers, the officials said.

A medical home or ACO means a doctor can quickly get a patient exactly what he or she needs. For example, a heart-disease patient is likely to be more at-risk for depression and may also need physical therapy and nutrition counseling. The team-based approach makes the resources necessary, as well ensuring everyone on the team thinks about a patient's entire health, rather than just the area in which he or she specializes.

Priority for the residents will be given to hospitals and other community-based health groups, such as ACOs or medical homes, that emphasize team-based care in underserved areas, including rural areas, though residencies in other settings will also be awarded. The budget also proposes bringing payments to teaching hospitals in line with the cost of providing care.

The National Health Services Corps now has 8,900 health care providers but would increase to 15,000 people in the service every year for the next five years. The corps provides scholarships and student loan repayments for people who practice in high-need areas. This comes in addition to increases that have more than doubled the number of corps members from 3,600 in 2008.

From AAFP NEWS NOW:

■ 2014 HYPERTENSION GUIDELINE STANDS TO SIMPLIFY TREATMENT: AAFP TO BEGIN RIGOROUS PROCESS OF REVIEWING FOR POSSIBLE ENDORSEMENT

The 2014 Evidence Based Guidelines for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee by JAMA: outlines nine specific recommendations for initiating and modifying pharmacotherapy for patients with elevated blood pressure.

According to lead author and Family Physician Paul James, M.D. of Iowa City, Iowa, rather than tackle the entire panoply of what is known or assumed about diagnosing and treating hypertension the diverse group of members appointed to the guideline panel by the National Heart, Lung and Blood Institute focused on answering three key questions:

In adults with hypertension, does initiating antihypertensive pharmacologic therapy at specific BP thresholds improve health outcomes?

In adults with hypertension, does treatment with antihypertensive drugs or drug classes differ in comparative benefits and harms on specific health outcomes?

At what time do you start medication? At what BP do you maintain medication? And What are the medications that doctors should use to get to goal?

A condensed version of the guidelines nine recommendations follows. Details of the strength of evidence grading system the panel used are discussed in an online supplement (http:jama.jamanetwork.com/data/Journals/JAMS/O/JSC130010supp1_prod.pdf) to the guideline.

*In the general population 60 and older, pharmacologic treatment to lower BP should be initiated at a systolic blood pressure of 150 mmHg or higher or a diastolic DBP of 90 mmHg or higher. Patients should be treated to a goal SBP lower than 150 mmHg and a goal DBP lower than 90 mmHg. If treatment results in lower achieved SBP and is not associated with adverse effects, treatment does not to be adjusted.

*In the general population younger than age 60, initiate pharmacologic treatment at a DBP of 90 mmHg or higher or an SBP of 140 mmHg or higher and treat to goals below these respective thresholds.

*In the population ages 18 or older with diabetes or CKD, initiate pharmacologic treatment at an SBP of 140 mmHg or higher or a DBP of 90 mmHg or higher and treat to goals below these respective thresholds.

*In the general black population, including those with diabetes, initial treatment should include a thiazide type diuretic, calcium channel blocker, angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB).

*In the general black population, including those with diabetes, initial treatment should include a thiazide type diuretic or a CCB.

*In the population ages 18 or older with CKD and hypertension, initial (or add on) treatment should include an ACE inhibitor or an ARB to improve kidney function outcomes. This applies to all patients in this population regardless of race or diabetes status.

*Finally, the main objective of hypertension treatment is to attain and maintain goal BP. If goal BP is not received within a month of initiating treatment, increase the dose of the initial drug or add a second drug from one of these four classes. The clinician should continue to assess BP and adjust the treatment regimen until goal BP is reached. If goal BP cannot be reached with two drugs, add and titrate a third drug from the list provided.

This final recommendation includes a caveat that ACE inhibitors and ARBs should not be used concomitantly. If goal BP cannot be reached using the above named drugs because of a contraindication or the need to use more than three such drugs to reach goal BP, antihypertensive drugs from other classes may be used.

Referral may be indicated for patients in whom goal BP cannot be reached using the above strategy or to manage complicated patients for whom additional clinical consultation is needed.

FAMILY MEDICINE COMES OUT ON TOP IN OSTEOPATHIC MATCH

More Osteopathic physicians matched to family medicine than any other medical specialty in the recently completed American Osteopathic Association (AOA) Intern/Resident Registration Program, which matches graduating osteopathic physicians with residency programs nationwide.

When the results were tabulated, family medicine filled 519 of 880 open positions in the 2014 Osteopathic Match. According to an AOS press release, the 2014 family medicine fill number represented a ten percent increase compared to the 472 family medicine positions filled in 2013. Furthermore, primary care as a whole – defined by the AOA as family medicine, internal medicine, pediatrics and OB/GYN – accounted for 53 percent of all matches for a total of 1096 placements.

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Pictured Left to Right - **Derek S. Buck, M.D.** – PM&R / Interventional Pain Management; **Jason E. Tullis, M.D.** – NeuroSurgery; **Anthony L. Capocelli, M.D.** – NeuroSurgery **Pranitha R. Nallu, M.D.** – PM&R / Interventional Pain Management; **Audie Partain, P.A.** – NeuroSurgery
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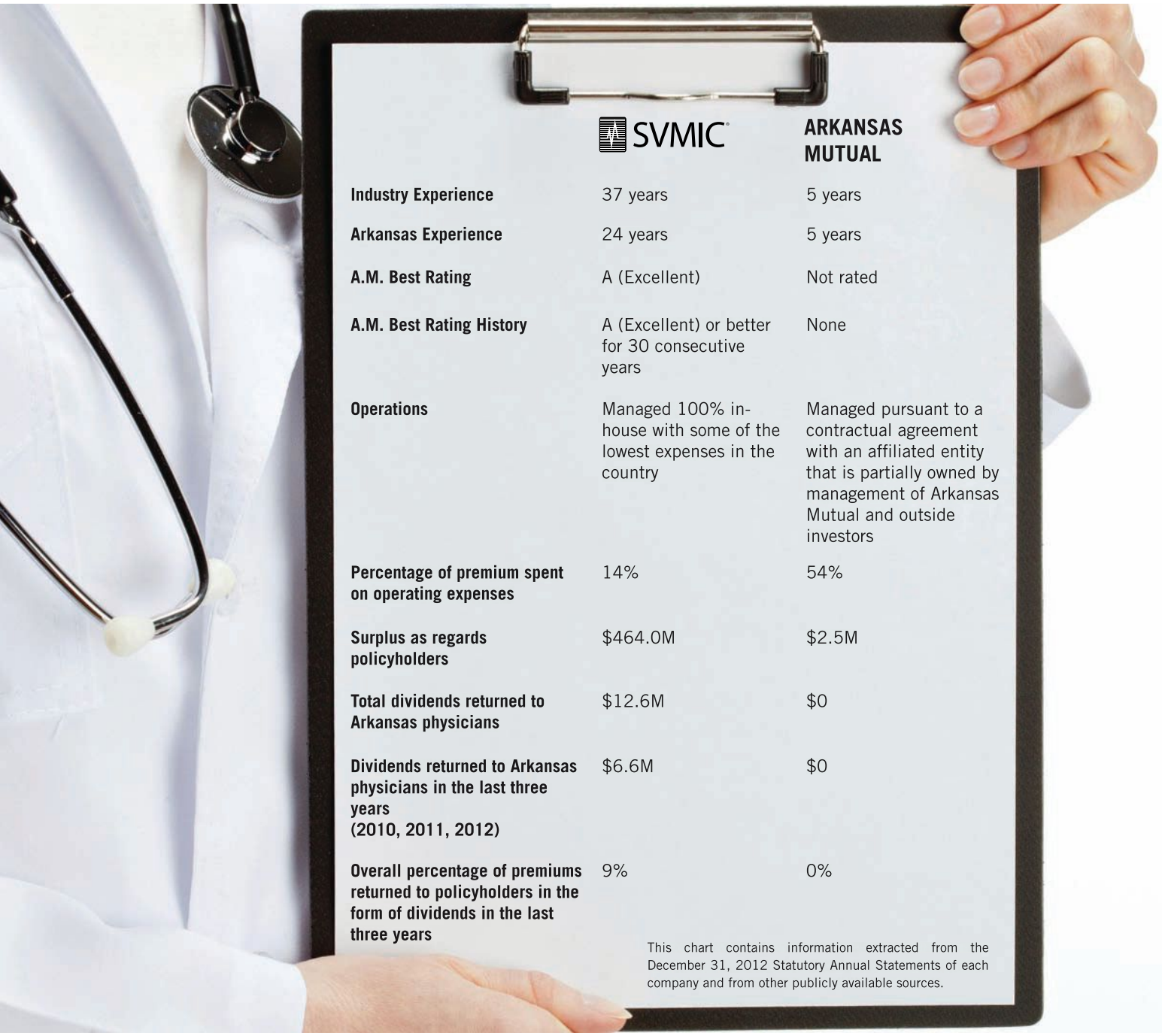

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A.M. Best Rating History	A (Excellent) or better for 30 consecutive years	None
Operations	Managed 100% in-house with some of the lowest expenses in the country	Managed pursuant to a contractual agreement with an affiliated entity that is partially owned by management of Arkansas Mutual and outside investors
Percentage of premium spent on operating expenses	14%	54%
Surplus as regards policyholders	$464.0M	$2.5M
Total dividends returned to Arkansas physicians	$12.6M	$0
Dividends returned to Arkansas physicians in the last three years (2010, 2011, 2012)	$6.6M	$0
Overall percentage of premiums returned to policyholders in the form of dividends in the last three years	9%	0%

This chart contains information extracted from the December 31, 2012 Statutory Annual Statements of each company and from other publicly available sources.

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