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The Arkansas Family Physician

Volume 19 • Number 1

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The AAFP Launches National Campaign "HEALTH IS PRIMARY"
(See Page 25)

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Dear Academy Member,

With another year coming to an end, on behalf of the Officers and Board of Directors, we extend a Happy and Safe Holiday Season to all of you!

As we end this year, the AR AFP Board met recently and approved a budget for the 2015 year in the approximate amount of $330,000. which is very near last year's budget amount. As this is a legislative year coming up in 2015 we will be contacting each of you on issues of importance to Family Doctors in Arkansas.

Dues statements have been mailed and we would like to remind each of you to pay your dues as soon as possible. In addition there are more than 150 Active members that are lacking hours for re-election at the end of 2014. If you have hours you have not reported, please do so immediately - these would be hours you obtained in 2012, 2013 and 2014. You may claim up to 20 hours of Prescribed Hours each year for "teaching" – medical students, nurses, residents, etc. And, don't forget the monthly online quiz in the AFP Journal you can take for up to 2 hours a month and these are Prescribed hours. You can claim 25 elective hours for each three year period for "enrichment activitities" such as hospital staff meetings and other meetings that enriched your practice that were not formal course hours. If you need us to help you report hours or to give you ideas on how to obtain hours in a hurry, please do not hesitate to call us at 1-501-223-2272 or 1-800-592-1093.

And, please do take a look at the AFP's new campaign to transform America's Health! A preview is listed on page 25 with links to more information. There will be information for physician's to use and for use for the public.

And, please mark your calendars now for the 2015 Arkansas AFP Annual Assembly at the Doubletree Hotel in Little Rock June 11, 12 and 13. The Pre Assembly will be held on Wednesday, June 10.

Sincerely,

Carla Coleman
Executive Vice President

On the cover:
AAFP Launches "Health Care is Primary"
(see page 25)

Dr. Beth Milligan joins CMS Technical Expert Panel for ECQM

Doctor Beth Milligan of Little Rock has been selected to join the CMS Technical Expert Panel for Electronic Clinical Quality Measures Development and Maintenance for Eligible Professionals Project.

The goal of this project is to develop HER based clinical quality measures for use in CMS quality reporting programs for ambulatory care providers. The project team is led by Mathematica and includes individuals from NCQA, the AMA Physician Consortium for Performance Improvement, the American Nurses Association, Booz Allen Hamilton, Lantana Consulting Group, the Lewin Group, Telligen and the Joint Commission.

Dr. Milligan is Corporate Vice President and Chief Medical Officer at Arkansas Foundation for Medical Care, is board certified in Family Medicine and Quality Management, is a Certified Physician Executive and Certified Health Care Quality Management. She is an Active member of the Arkansas Chapter, American Academy of Family Physicians and a Fellow of the American Academy of Family Physicians.

CONGRATULATIONS ACADEMY MEMBERS!!

Matthew Nix, M.D. of Texarkana was appointed by Governor Mike Beebe to the Early Childhood Commission representing the specialty of Family Medicine.

Harold Betton, M.D. of Little Rock was appointed to represent the specialty of Family Medicine on the Contractor Advisory Committee for the Centers for Medicare and Medicaid Services.

Physicians Encouraged to Join the Society for the History of Medicine and Health Professions in Arkansas

For those who practice the art and science of healing, history becomes a close friend. We and those we deal with become a part of other people's history. The valued memory of our mentors, fellows-in-arms, students and, most importantly, the patients and their families are an important resource that is worth saving.

The Historical Research Center at the UAMS Library in Little Rock is ground zero for that effort in Arkansas. Begun thirty-six years ago through the efforts of Edwina Walls Mann, Drs. Robert Watson, Joe Bates, Tom Bruce and Richard Clark, the facility has served as a center for knowledge and research available to anyone looking to unravel the past.

The *Society for the History of Medicine and the Health Professions* (SHMHP) is an organization created to provide support for the Center. The Society supports research in the history of health sciences through an annual research award; in addition there is a lecture in the history of Arkansas health sciences each spring and fall at UAMS.

We would like to entice you into joining us in this effort. The cost is minimal ($15.00/year). What we really want from you are your stories, your memories, the things that make your town unique or outstanding.

For your efforts, your life and the people of Arkansas will be enriched.

If you are interested in joining in this adventure or would simply like more information you may contact: Sam Taggart M.D. (samtaggart@att.net), Patricia Wright (wrightpatricab@uams.edu) or the staff of the Historical Research Center by calling 501-686-6733.

ARcare IS NOW HIRING!!

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Joint Ventures Opportunity for FP Clinics in Arkansas

A Family Physician Clinic in Arkansas is looking to expand in the State of Arkansas with an interest in joint ventures with smaller Family Practice Clinics who do not wish to sell to hospitals. Partner or Purchase agreement can be arranged. Any interested Family Doctors who wish more information with a clinic with a proven track record and a solid management team in place, please contact Carla at the AR AFP office at 501-223-2272 who will provide you with the person you need to contact.

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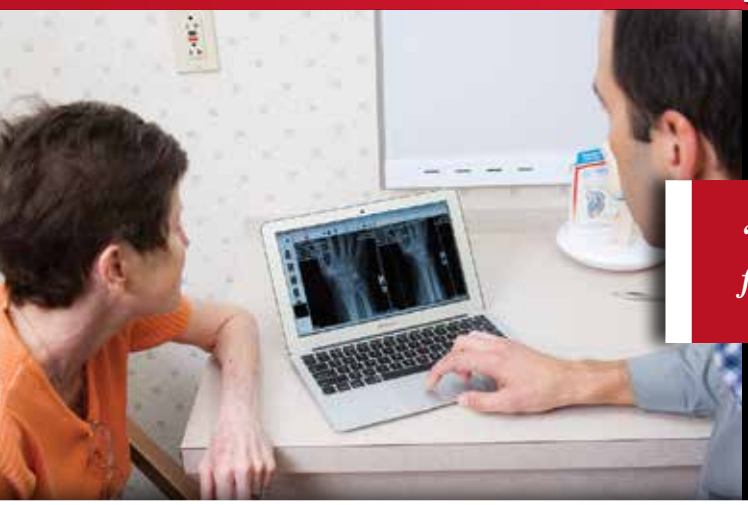

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Health Care Data Transparency in Arkansas

The recent publication of Medicare payment information from the Centers for Medicare and Medicaid Services[1] has received national media attention for many reasons. Beyond the implications of the release of raw data and the various interpretations that occurred, the release itself was historic for promoting transparency in the health care industry. The federal government has taken a significant first step to make previously guarded information open for examination. In Arkansas and many other states, there is a need for transparency not only to assess health care quality and costs, but also to examine the progress of the state's system transformation efforts. Even opponents of health care reform agree that the business of health care delivery must improve, and increased transparency is a necessary component for making that a reality. This brief focuses on the potential benefits of increased health care transparency, the status of information on the health care system in Arkansas, and initiatives that are creating opportunity and driving the need for a more transparent health care environment.

WHY TRANSPARENCY?

Health care is unlike most other major industries in the U.S. As the Institute of Medicine documented in its report, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,*[2] most industries provide readily available information about the price of their services and the quality a consumer can expect in the delivery of those services. In the health care industry, quality and price information is limited. At a time when consumerism is at the forefront of health care, and patients are increasingly asked to make better choices and have greater exposure to costs at point of service through deductibles, coinsurance, and copayments, consumers are unable to find answers to the most basic questions about what they are purchasing.

The health care industry and its consumers, however, are often apprehensive about accelerating health care quality and price transparency. Cited risks include exposure of personal health information, poor data quality, administrative burden, and untested metrics for quality measurement. The benefits of health care transparency must be weighed against the risks of disclosing certain information. Too often, though, the systematic barriers that serve to protect from such risks—contractually restrictive clauses between carriers and providers, statutory protections from disclosure of data for proprietary interests, and privacy protections for patients—eliminate pathways to greater transparency and make less attainable the goals of system transparency that would support individuals, families, and businesses from making informed choices. These barriers must be overcome to improve quality of care, contain costs, and make consumers more informed and active in managing their own health care.

Value

Our current health care system consumes more of our gross domestic product per citizen than any other nation, yet our health statistics lag and too often individuals receiving care experience gaps in quality, inappropriate therapies, and a fragmented health care system.[3] Many increasingly question the health care system's value, or the experience and outcomes of patient care compared to the cost of the services provided. Demands are growing for the evaluation of quality—the outcomes and efficiency of a health care service—relative to the cost of the service. If a service is of high quality and affordable costs, it has good value; if a service has low or minimal benefit and high cost, it has relatively poorer value. Especially in health care, the ratios will change depending on the product or service being evaluated, but being able to identify the levels of both quality and cost are essential to assessing the relative value of alternative therapeutic options.

Quality Care

Enhanced ability to identify high quality clinical performers and those that enhance successful outcomes is key to health care consumers and providers being able to choose more wisely. In addition, informed clinicians could utilize quality and outcomes data to better determine where to refer their patients or drive hospital improvements where quality gaps exist. Likewise, private businesses could identify opportunities to improve their employees' health by tailoring their offered health plans to best fit their employees' needs. Additionally, insurance companies could identify the best providers available to their members, thus improving outcomes and patient experiences and reducing inefficiencies. Evidence suggests that transparency can increase health care quality. For example, in 2005 British heart surgeons began publishing outcome data through national media.[4] Since then, mortality rates for related heart surgeries have continued to fall. The Secretary of State for Health from the United Kingdom estimates that around 1,500 lives are saved each year, just with the published expected mortality rates of heart surgeries. The *New England Journal of Medicine* [5] suggests that data transparency is as effective as financial incentives to encourage providers to improve clinical performance.

Cost Control

There is limited research showing a direct link between health care price transparency and cost reduction.[6] This is mainly due to the limited scope of available price information, including only cost averages and medians. However, increasing the availability of price information for specific services and frequently combined therapies will highlight the price variations between various providers, and enable consumers to identify their best choices. Studies of private

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Sister Judy Raley, SCN
Board Member

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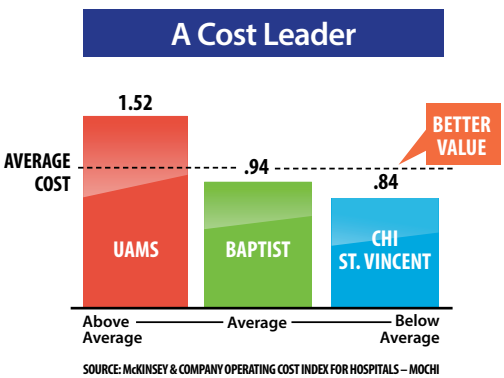

That's how we're continuing to make health care better for Arkansans.

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businesses participating in transparent business practices outline three different value points:

- matching appropriate buyers with appropriate sellers;
- creating relationship-specific information flows between trusted partners; and
- providing comprehensive information on suppliers, the products and services they offer, and their products' availability.[7]

Price transparency alone, although important, is limited in helping consumers identify high value products and providers. Price information must be linked with quality to enable informed consumer choice. Price data in isolation might make consumers assume that a higher price tag will result in a higher quality product. Experienced consumers know the latter is not always true; pricing information alone does not tell the whole story. Studies show that in the pharmaceutical industry, a better-advertised and more recognizable brand-named drug is perceived by consumers as being a better product than a clinically-equal but lower-priced alternative. Because consumers do not readily see the quality information between the two products, they often presume a quality difference exists and choose the brand-named drug based on this faulty assumption.

The New White Coat

The White Coat Ceremony is a significant event for medical students normally held as they transition out of preclinical requirements and into a role with more responsibility. The coat symbolizes purity and conveys trust. A clean, white coat proves a physician has done no harm to any other before the patient, and clearly identifies the physician as the one in charge of caring for a patient.

Data transparency is the new white coat. By publicly sharing information concerning quality and cost outcomes, doctors, hospitals, and insurance companies alike are identifying themselves as trustworthy and accessible. Currently, legislation and business practices inhibit consumers from being able to identify their best options in terms of their health care. Yet the state's desire to move individuals both in the private sector and on public assistance to more consumer-directed purchasing programs necessitates the availability of this information.

Basic Principles

The Healthcare Financial Management Association recently published guiding principles for price transparency.[8] Two of the five principles are based on data composition: (1) pricing data should be easy to understand and communicate, and (2) price data should be paired with quality data. The other three principles regard

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patient interaction: (1) pricing data should empower the patient to make decisions before receiving care, (2) transparency should be comprehensive, including the total and itemized cost, and (3) comprehensive transparency should involve all stakeholders, including insurers and providers. Compliance with these principles can make changes in transparency successful while not ignoring risk.

WHERE WE ARE NOW

Health care price transparency in Arkansas is currently limited. In 2013, Catalyst for Payment Reform (CPR) and the Health Care Incentives Improvement Institute (HCI3) worked together to release a report card evaluating each state's transparency laws.[9] In this first report card, Arkansas was given a "D" grade for having only one statute in place concerning cost transparency, which had limited applicability. The newest report card, released in March 2014, expanded its scope to look at state regulations and public accessibility of price information.[10] The 2014 report incorporated state efforts nationwide unfortunately resulting in Arkansas receiving an "F." Many surrounding states received equally poor grades. Consequently, Arkansas again has the opportunity to step ahead and be a leader in yet another area of health care management transformation. States that received higher grades from CPR-HCI3's 2014 report card were commended for having a web-accessible all-payer claims database (APCD) which provides consumer access to information on claims charges and payment amounts.

Existing Legislation

Several states have accomplished increased transparency via legislative initiatives. For example, Colorado has a statutorily authorized APCD[11] with a publicly available website that features information on payment amounts for both practitioners and facilities. The CPR-HCI3 reports may prompt other states to pursue similar legislation more aggressively. In Arkansas, legislation regarding the collection of health care data is limited and characterized by restricted use when collected. Table 1 below outlines the provisions and limitations that currently exist in legislation in Arkansas.

STATEWIDE INITIATIVES

Over the last two years, Arkansas has drawn national attention by making purposeful and innovative changes to the way health care is delivered and managed across the state. The early results of these innovative designs have made Arkansas a recognized leader in whole health system

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Table 1: Data Collection Related Statutes in Arkansas

Related Agency/Organization	Arkansas Statute	Collection Authority	Limitation
Arkansas Department of Health (ADH)	A.C.A. § 20-7-301	Authorized to collect data, claims information to establish a base of health care information for patients, providers, and hospitals	Prohibited from releasing data that could identify providers, institutions, or health plans*
Health Services Permit Agency	A.C.A. § 20-8-110	Authorized to collect utilization statistics, claims data, and other health data to review applications for new or expanding health care facilities	Prohibits the release of information that can identify individual patients or be linked with any third-party payer
Office of Health Information Technology	A.C.A. § 25-42-106	Houses and shares patient-specific protected health information with participating health care providers	Requires patient authorization, information exchange is limited to participating or subscribing providers non-disclosable
Arkansas Insurance Department	A.C.A. § 23-61-108	Insurance Commissioner can issue rules necessary for the regulation of insurance or as required to be in compliance with federal laws	Limited uses, not inclusive of systems research
Arkansas Center for Health Improvement (ACHI) and the Health Data Initiative	A.C.A. § 20-8-401 *et seq.*	Authorizes ACHI to have access to any data the state owns or contracts for that could inform health policy	Needs permission of the agency responsible for the data, data use is limited to research and to inform health policy decisions

*ADH must provide data to the AR Hospital Association for its price transparency and consumer-driven health care project that will make price and quality information about Arkansas hospitals available to the general public.

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transformation. Alongside these new initiatives, there are ongoing efforts aimed at improving population health outcomes, such as reducing tobacco use, obesity, and the prevalence of chronic diseases. Together these initiatives are generating a desire and driving a need for the greater availability of data.

Arkansas Health Care Payment Improvement Initiative (AHCPII)

The Arkansas Health Care Payment Improvement Initiative (AHCPII) is designed to transition Arkansas to a "patient-centered" health care system that embraces the triple aim of (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care.

Two key components of the AHCPII are Patient-Centered Medical Homes (PCMH) and Episodes of Care. Both of these elements include incentives for providers that make referrals that are more informed and to higher performing physicians. The ability to make these educated referrals will be hindered without making performance and payment data available, and PCMH providers in Arkansas are beginning to demand this information.

Arkansas Health Care Independence Act

The Arkansas Health Care Independence Act of 2013,[12] often referred to as the "Private Option," is expected to provide health care coverage to an estimated 250,000 low-income citizens via private insurance plans on the Health Insurance Marketplace (HIM). It is designed to benefit Arkansans who have previously been without insurance or access to affordable care to take a more active and responsible role in their own health, which can only be improved by making data concerning quality and price variations available. Importantly, the act incorporates a requirement that HIM carriers participate in the AHCPII. As part of that requirement, carriers must (1) assign a primary care physician, (2) support a patient-centered medical home model, and (3) provide clinical performance data to providers.

All-Payer Claims Database

As mentioned in the CPR-HCI3 reports, an all-payer claims database (APCD) is an extremely useful piece of statewide data transparency. Recently, the Arkansas Insurance Department-Health Insurance Rate Review Division awarded ACHI a contract to build an APCD to promote price quality and transparency. ACHI is in the first stages of the project, which includes stakeholder engagement, database design and build, establishment of data submission guides and data use agreements, and the development of a sustainability plan.

CONCLUSION

With the nation's largest health care payer making a very decisive move towards transparency, it is a sign for other stakeholders to take note. There will be many lessons learned from the Centers

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for Medicare and Medicaid Services' data release, and the nation will be able to analyze its spending of health care dollars with great insight because of it.

The need for system change is evident, and the responsibility falls largely on providers, insurance companies, and state programs. Nevertheless, change is inhibited by a lack of available data. It is unreasonable to expect consumers to feel trust and find value in what they purchase when the prices, products offered, and outcomes are hidden. Policymakers should work to remove barriers to data access and enable the creation of meaningful consumer information to ensure that Arkansans are empowered to improve their health.

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Networking with our medical counterparts

Lindy Bollen, Jr., DDS
Director, Office of Oral Health
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As I begin my third career in dentistry I am excited to be part of changes here in Arkansas that seeks to address the issue of "access to care". Thanks to the tireless efforts of many oral health partners, the Arkansas legislature signed into law three acts to ensure better oral health care for our citizens. While Act 197 of 2011 has been underway to guarantee the benefits of fluoridated water for communities with 5,000 or more citizens served, we have yet to fully enact the extended benefits afforded to us in Acts 89 90 of 2011.

Act 89 of 2011, the Collaborative Care Act, will be topics for future journals. For now, I would like to address the benefits provided to our citizens by Act 90 of 2011. This act will allow family practice physicians, pediatricians, nurses and other qualified health professionals to apply topical fluoride varnish on the newly erupted teeth of infants and children. I know many out there may have the knee jerk reaction of, "Hold on a minute! Why would we want to let the medical field into our area of expertise?" Good question and I am glad you asked.

This will serve as a win-win proposal in the long run for all participants. First of all, for any medical personnel to become eligible to receive payment they must take the time to learn about the whole process. This is readily done with a well created online video. This course shows the medical team several examples of the "3 D's": decalcification, demineralization and decay. Getting our brethren in the medical field to take the time to look at the dentition may not seem like a big deal to us, but it will be a different scope of practice for them.

This is not intended to catch all decay. Instead, it will open a conversation about dental care with the patient's guardian. Over 90% of infants will see a physician in the first two years of life while less than 5% of the same age children will have a visit to a dental office. By looking and finding early childhood caries (ECC), these children can be referred to a dental home well before the child begins to experience pain. By seeking care early, children are less likely to develop the fear associated with toothache pain, or the perceived pain from a dental visit.

This leads to the second aspect of the win-win approach, the connection of the young patient

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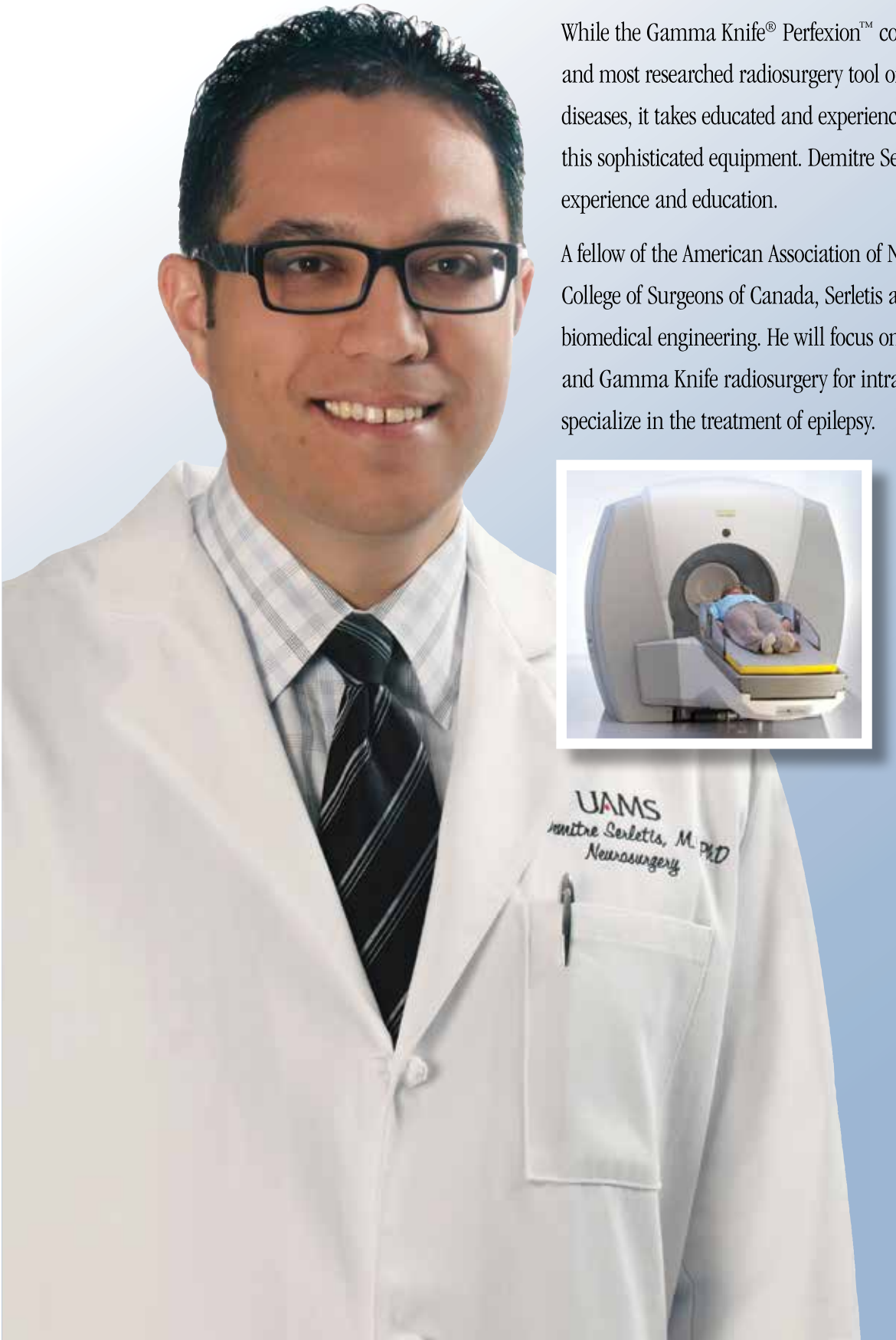
to a dental home. We all talk to our patients with children and encourage frequent visits to establish the habit of good oral health care. But what about those less fortunate due to no insurance or low income that makes dentistry sound more like an option than a necessity? When the parents are clueless about dental issues, they don't even think about it until their child is in pain and complains about a bad tooth. An established dental home will allow the dental team to provide the necessary education and training for good oral hygiene. After all, the ultimate responsibility does belong with our patients to take care of themselves. We just need to show them how!

Last, but certainly not least, is the addition of fluoride varnish on the teeth of high risk children. Studies have shown that fluoride varnish can reduce the occurrence of caries by as much as 30%. Fluoride varnish applied to early demineralized tooth surfaces encourages reminerilzation. Once that has happened, the newly strengthened area is more resistant to the effects of acid producing bacteria in the oral cavity.

The Office of Oral Health (OOH) at the Arkansas Department of Health has assembled a team of dental hygienists to go out across the state to help promote the application of fluoride varnish in medical practices. In the beginning our target areas will be those counties that are deemed lowest in relation to access to care. We also have plans to exhibit at the state medical meetings of family practice physicians and pediatricians as well as nursing organizations. We have a lot of ground to cover before this initiative can truly yield the intended results. You can do your part by explaining the program to your medical friends. Drop off your business cards and encourage them to refer patients to you when they suspect dental decay. Isn't this one way to have a collaborative network in your town?

One thing I have learned in my brief tenure as your state oral health officer is that changes of this magnitude take time to execute. I have faith that our diligent efforts to canvas the state, exhibit at medical meetings and publish news articles in the medical association journals will begin to enlighten our medical peers about dentistry's preventive services which provides better oral care for the young citizens of Arkansas.

Demitre Serletis, M.D. is a Gamma Knife® Expert



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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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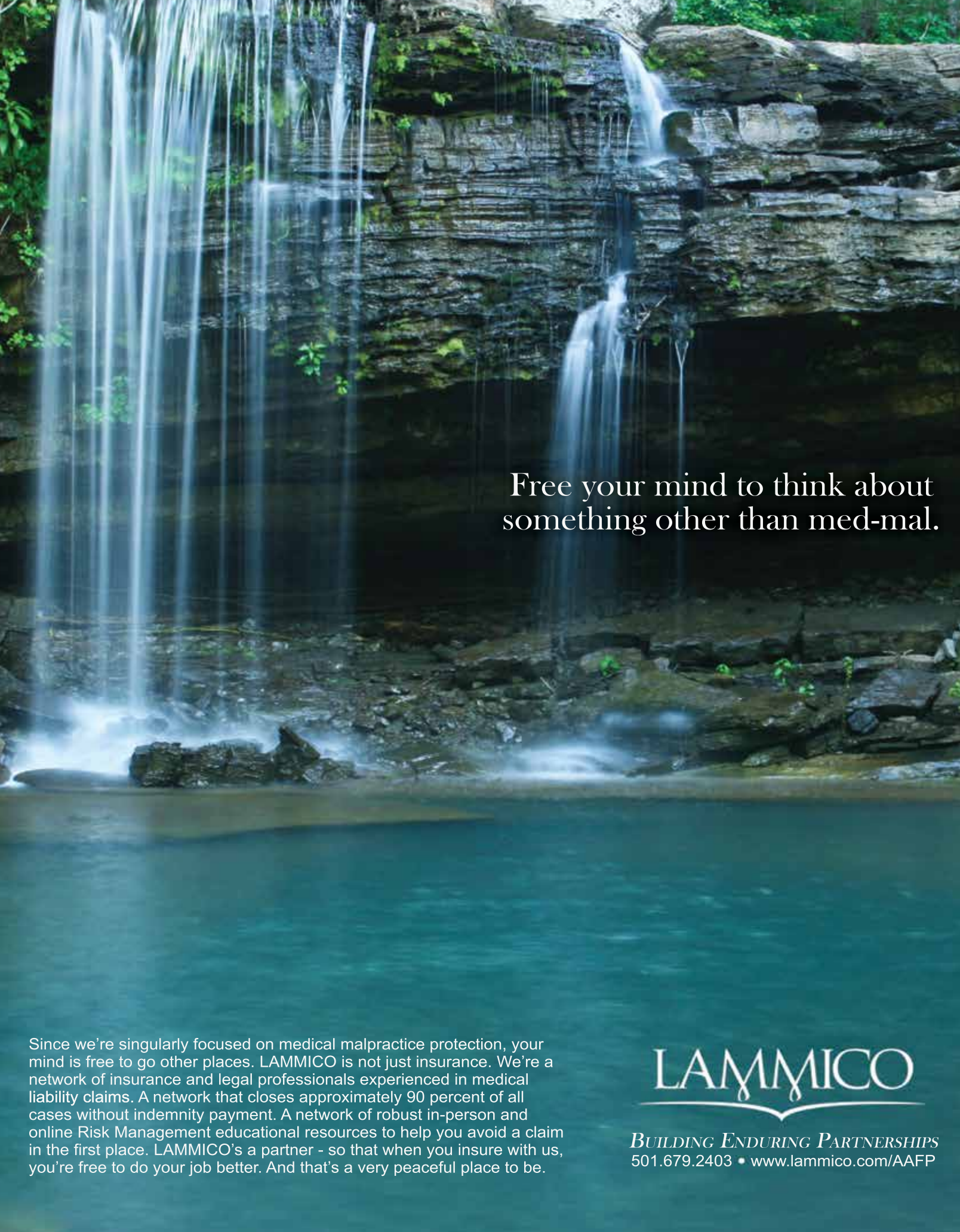

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Radiation Safety Concerns and Clinical Decision Support in Computed Tomography

By James E. McDonald, MD and David A. Nelsen, Jr., MD, MS

The use of X-rays, multi-row detector computed tomography (CT) and nuclear medicine has improved the lives of patients and revolutionized the practice of medicine. However, the increasing use of these modalities has resulted in a significant increase in the population's exposure to ionizing radiation. The United States per-capita annual effective radiation dose from all sources almost doubled between 1980 and 2006, from ~3.0 mSv to ~5.6 mSv. More than one-half of this increase is due to medical imaging.

Since 1990, as utilization of CT in the emergency department (ED) setting has increased, the potential biologic effects of medical radiation to induce cancer has become a concern to the profession and the public.[1]

Specialty societies have developed evidence-based criteria to guide appropriate use. Incorporation of evidence-based clinical support tools can decrease utilization and radiation exposure while increasing diagnostic yield.

Epidemiologic studies of atomic bomb survivors in Japan, the most comprehensive data available, show a statistically significant increase in cancer at dose estimates in excess of 50 mSv.[2] These projections rely on linear extrapolations from higher doses and assume no threshold below which small doses have no effect (linear non-threshold theory).[1]

No large-scale epidemiologic studies of cancer risks associated with CT scans have been reported. However, projected cancer risks associated with the radiation exposure from any given CT scan have been done by estimating the organ doses involved and applying data derived from studies of atomic bomb survivors. The organ doses for a typical CT study involving two or three scans appear to be in the range at which there is evidence of a statistically significant increased risk of carcinogenesis.[3]

A 2009 study in the Archives of Internal Medicine estimated that, although individual risks are small, approximately 29,000 future cancers could be related to the 72 million CT scans performed in the United States in 2007. Organ-specific radiation doses were used to estimate age-specific cancer risks for each scan type. These models were combined with age- and sex-specific scan frequencies for the United States obtained from survey and insurance claims data.[4] Additionally, estimates of radiation risk to children are significantly increased relative to adults.[5]

There is a clear trend of increased CT use in EDs, although only a small percentage of scans yield clinically significant findings. From 1998 to 2007, use of imaging during injury-related ED visits increased approximately three-fold, without an equal increase in the diagnosis of significant injuries or associated hospital admission rates.[6]

Emergency department CT utilization in adolescents has increased at rates significantly exceeding the growth in ED patient volume. From 2000 to 2006, pediatric ED patient volume increased by 2 percent, while acuity remained stable. During this same period, head CT increased by 23 percent, cervical spine CT by 366 percent, chest CT by 435 percent, abdominal CT by 49 percent and miscellaneous CT by 96 percent. Increases in CT utilization were most pronounced between ages 13 and 17 years, and met or exceeded increases seen in the adult population.[7]

The American College of Radiology (ACR) published the first volume of Appropriateness Criteria (AC) in 1995. They are the most comprehensive evidence-based guidelines for diagnostic imaging selection, including the relative radiation burden associated with the various examinations.[7]

Thirteen specialty societies created the Alliance for Radiation Safety in Pediatric Imaging in 2008 to "educate radiologists and radiology technologists on the need to 'child-size' CT scan technique."[8] CT protocols appropriate for children are maintained on the "Image Gently" website (**www.imagegently.org**). The ACR has developed a similar education program for patients and physicians regarding adult imaging, "Image Wisely" (**www.imagewisely.org**).

An initiative of the ABIM Foundation focuses on encouraging physicians, patients and others to think and talk about medical tests and procedures that may be unnecessary, and in some instances, may cause harm (**www.choosingwisely.org**).

Policymakers, including the Centers for Medicare and Medicaid Services, are developing reporting metrics for imaging efficiency to assess physician adherence to such evidence. These may eventually be incorporated into reimbursement.[9]

Formally developed consensus of

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continued from page 22

informed experts is an efficient way to estimate the appropriateness of specific types of medical care. An emerging use for appropriateness criteria is in clinical decision support, especially in concert with computerized order entry (CPOE) in electronic health records (EHRs).[10]

Clinical decision support (CDS), integrated with CPOE, has been shown to decrease utilization and improve the diagnostic yield of CT imaging in the ED.9 Mild traumatic brain injury accounts for more than 1.2 million visits annually to EDs in the United States; 63 percent of these visits result in head CT. In 2008, the American College of Emergency Physicians published a clinical policy on neuroimaging and decision-making for adult head trauma in the ED.10 In a recent study, implementation of CDS was associated with a 56 percent increase in adherence to evidence-based guidelines for imaging in ED patients with head trauma.[9] In another large study of the effect of CDS using CPOE in the ED, utilization of CT for diagnosis of pulmonary embolism decreased 20 percent with a 70 percent increase in diagnostic yield.[11]

The ACR's Appropriateness Criteria are available online and a CPOE set, called "ACR Select" (**www.acrselect.org**), has been developed. Using these tools, criteria can be embedded directly into EHR CPOE systems or be deployed as a web window within that system. These tools will provide point-of-care scoring of appropriateness for a given clinical situation. Targeted use of the ACR Select tool is associated with decreases in the inappropriate utilization of advanced imaging tests.[12] The University of Arkansas for Medical Sciences is adopting ACR Select as part of the implementation of its Epic UConnect EHR.

Dr. McDonald *is director, Division of Nuclear Medicine and vice-chair, Department of Radiology at the University of Arkansas for Medical Sciences. He is also an assistant professor and chairs the Radiation Safety Committee at UAMS.*

Dr. Nelsen *is associate medical director for quality, Arkansas Foundation for Medical Care and an associate chief medical officer and associate professor at the University of Arkansas for Medical Sciences.*

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AAFP Launches Family Medicine for America's Health

On October 23, during the AAFP's Annual Scientific Assembly in Washington, D.C., the American Academy of Family Physicians announced family physicians in a campaign to transform America's health care system into one based on strong primary care and patient engagement.

This multi-year campaign, created and driven by America's family physicians will focus on transforming American's health care to make the United States a place where *Health is Primary*.

This initiative includes two integrated elements: a communications program aimed at consumers, policymakers, payers and the medical community and a strategic plan that will focus on addressing key issues facing the family medicine specialty.

Family Medicine's strategic direction is composed of seven statements. Working together with its healthcare colleagues and other engaged stakeholders, Family Medicine aims to achieve the following:

1. Show the value and benefits of Primary Care
2. Ensue every person will have a personal relationship with a trusted family physician or other primary care professional, in the context of a medical home
3. Increase the value of primary care
4. Reduce health care disparities
5. Lead the continued evolution of the Patient Centered Medical Home
6. Ensure a well trained primary care workforce
7. Improvement payment for primary care by moving away from fee for service and toward comprehensive primary care payment

The strategic plan is focused on six key implementation areas: Practice, Payment, Workforce Education and Development, Technology, Research and Engagement.

During the October 23 launch of *Health is Primary*, Chairman of the Family Medicine for America's Health Board of Directors Glen Stream, MD, FAAFP, said, "We believe that the values of family medicine can be our road map for putting the 'health' back in health care. By shining a light on our definition and vision for true primary care, we can get to a place where the system works for everyone and delivers better patient experiences, better health, and lower costs."

Health is Primary is part of a five-year strategic effort led by Family Medicine for America's Health. Learn more about the campaign. For more information, go to http://www.annfammed.org/content/12/Suppl1/S1.full.pdf. The website www.healthisprimary.org contains the public facing communications campaign.

New AAFP Leaders Elected at the AAFP Congress of Delegates

The AAFP Congress of Delegates elected officers and directors October 23 in Washington, D. C. They are as follows:

President Elect – Wanda Filer, M.D., M.B.A. of York Pennsylvania
Speaker of the Congress – John Meigs, Jr., M.D. of Brent, Alabama
Vice Speaker – Javette Orgain, M.D., M.P.H. of Chicago
Directors – Mott Blair, M.D., of Wallace, North Carolina; John Cullen, M.D., of Valdez, Alaska, Lynne Lillie, M.D., of Woodbury, Minnesota and Carl Olden, Jr., M.D., of Yakima, Washington
New Physician Board Member – Emily Briggs, M.D., of New Braunfels, Texas
Resident Board Member – Andrew Lutzkanin, M.D., of Reading, Pa.
Student Board Member – Kristina Zimmerman of Scranton, Pa.

The Arkansas Chapter was represented in the Congress of Delegates by Delegates: Doctor Richard Hayes of Jacksonville, Doctor Julea Garner of Hardy: Alternate Delegates: Doctor Dennis Yelvington of Stuttgart and Doctor Lonnie Robinson of Mountain Home and President Daniel Knight of Little Rock.

Prepare Now for Ebola in Your Office

The first steps in preparing your office for a possible case of Ebola virus infection are to make sure you have all referral contact information ready to go and that your staff is educated on his/her role if a case presents.

The critical starting point with any patient during the current Ebola outbreak is gathering a travel history. If a patient comes to the office with nonspecific symptoms and has a positive travel history to the affected countries, he/she should be isolated immediately and standard, contact and droplet precautions should be implemented.

The Centers for Disease Control has directed that all suspected Ebola cases be reported to local/state health departments (501-661-2136) who in turn will notify the CDC's Emergency Operations Center.

If physician's offices do not currently have an established relationship with their health department, they should ensure they reach out and have appropriate business and after hours phone numbers available. Physician offices should also reach out to any hospital systems they might potentially transfer patients to and ensure they have appropriate contact numbers for those organizations as well.

After contact for local health departments and hospital systems is disseminated to medical and office staff, the next step is the critical starting point with any patient who has symptoms suspicious for the disease during the current Ebola outbreak: gathering a travel history at any opportunity.

Appointment clerks and front desk personnel taking calls for appointments should inquire about African travel history in patients calling for appointments for fever, headache, weakness, diarrhea, vomiting, muscle aches or bleeding. Anyone with a positive travel history should be contacted by a provider to gather additional information and determine if public health authorities need to be involved before a patient even presents to the physician's office.

The Arkansas Department of Health provides general information stating that there is a low risk to Arkansas but the ADH continues to work with hospitals, emergency medical service providers, laboratories, waste water management facilities, faith based organizations, the State Chamber of Commerce and the Department of Education and Higher Education to provide guidance and training to ensure they can appropriately screen, monitor and care for individuals who may be affected with Ebola. Only those individuals who have traveled to Arkansas from the affected West African countries (Sierra Leone, Guinea or Liberia) cared for an Ebola patient in a health care facility within the last 21 days or have been told by a public health authority that they are considered at risk for Ebola. Currently travel to and from Dallas and New York does not pose a risk for contracting Ebola. (http://www.healthy.arkansas.gov/programs/Services/communications/features/Pages/Ebola)

If a patient in Arkansas is confirmed with Ebola, the CDC will deploy a team to the state to provide guidance and assistance. **Any suspected cases should be reported to the Arkansas Department of Health immediately at 501-661-2136. Emergency assistance call 1-800-633-1735: CDC Info – 800-232-4636 : 24 hours a day.**

For more information: go to the CDC guidance (http://www.cdc.gov/vhf/ebola/hcp/index.tml). Or you may call the CDC at 770-488-7100 or ecoreport@cdc.gov. Other sources for information on Ebola are from the AAFP at http://www.aafp.org/news/health-of-the-public/20140806ebola.html or http://www.ama-assn.org/ama/pub/physician-resources/publichealth/ebola-resource-center-page)

Human Papillomavirus (HPV) Vaccination Report: Arkansas

Working Together to Reach National Goals for HPV Vaccination

Oct 2014

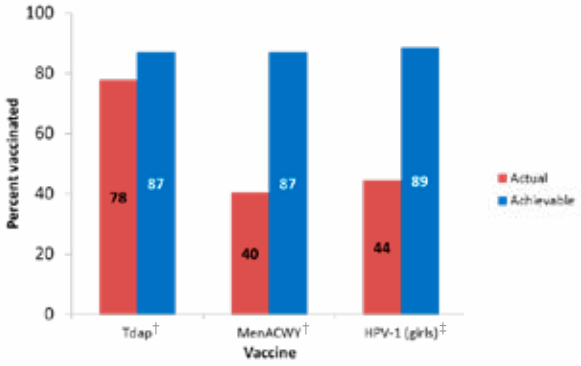
Data Spotlight: Missed HPV Vaccination Opportunities in Arkansas

A missed opportunity is a healthcare encounter where a person does not receive a vaccination for which he or she is eligible. In this analysis, encounters where at least one vaccination was administered were evaluated. Achievable coverage may be higher if all healthcare visits were included. Missed opportunities for the three adolescent vaccinations are displayed on the right.

In 2013, 79% of Arkansas girls who were unvaccinated against HPV had a missed opportunity for HPV vaccination.

89% of Arkansas girls could have started the HPV vaccine series if missed opportunities were eliminated.

Actual and Achievable* Vaccination Coverage if Missed Opportunities Were Eliminated: Teens 13-17 Years of Age, Arkansas, NIS-Teen 2013



*Achievable: vaccination coverage that could have been achieved if all recommended vaccines were administered during the same healthcare encounter
† Tdap and MenACWY calculations include both boys and girls
‡HPV-1: Receipt of at least one dose of HPV among girls only. Due to data limitations, boys were not included in this analysis.

Call to Action!

Key Recommendations for Preventing Missed HPV Vaccination Opportunities

Below are suggested strategies for engaging clinicians, parents, and partners to prevent missed opportunities for HPV vaccination in your jurisdiction:

- **Educate clinicians about the importance of making a strong and timely HPV vaccination recommendation, focused on cancer prevention.** The best recommendation for HPV vaccination is one that bundles all indicated adolescent vaccinations. HPV vaccination should be recommended in the same way and during the same visit that other adolescent vaccinations are recommended. View CDC's "Tips and Timesavers" for making a strong recommendation here: http://www.cdc.gov/vaccines/who/teens/for-hcp-tipsheet-hpv.pdf.
- **Encourage clinicians to partner with practice managers to implement standards of practice to:**
  - ✓ **Check the vaccination status of each teen patient and offer all indicated vaccines at every visit**. Every healthcare visit is an opportunity to review teens' immunization histories and ensure every teen is fully vaccinated.
  - ✓ **Schedule the next HPV vaccination dose appointment before the family leaves the office.**
  - ✓ **Utilize reminder/recall strategies to ensure teens return for remaining doses.**
- **Partner with local stakeholders to implement these and other strategies to minimize missed HPV vaccination opportunities**. For additional strategies to reduce missed opportunities, visit http://go.usa.gov/wa9F.

Visit the clinician-specific web portal for more resources and materials: www.cdc.gov/vaccines/YouAreTheKey

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Wed	Belize	8:00 AM	5:00 PM
Thu	Mahogany Bay, Isla Roatan	9:00 AM	5:00 PM
Fri	Fun Day At Sea		
Sat	Fun Day At Sea		
Sun	New Orleans, LA	8:00 AM	

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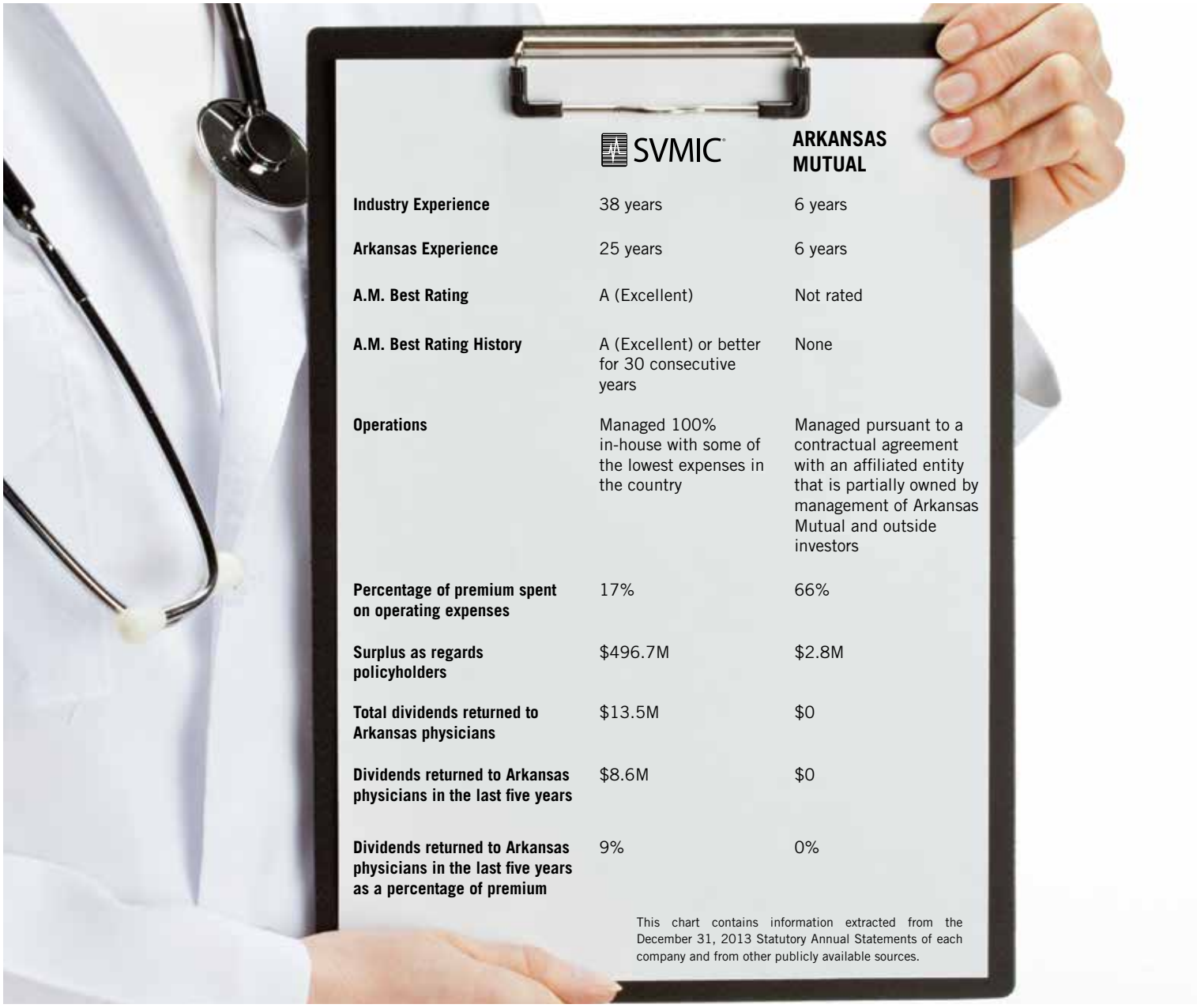

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Industry Experience	38 years	6 years
Arkansas Experience	25 years	6 years
A.M. Best Rating	A (Excellent)	Not rated
A.M. Best Rating History	A (Excellent) or better for 30 consecutive years	None
Operations	Managed 100% in-house with some of the lowest 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	17%	66%
Surplus as regards policyholders	$496.7M	$2.8M
Total dividends returned to Arkansas physicians	$13.5M	$0
Dividends returned to Arkansas physicians in the last five years	$8.6M	$0
Dividends returned to Arkansas physicians in the last five years as a percentage of premium	9%	0%

This chart contains information extracted from the December 31, 2013 Statutory Annual Statements of each company and from other publicly available sources.

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