Arkansas Legislative Session In Full Swing!!

The Arkansas Family Physician

Volume 19 • Number 2

2015 Arkansas 68th Annual Scientific Assembly, June 10-13 Doubletree Hotel, Little Rock, Arkansas

AAFP
STRONG MEDICINE FOR AMERICA

THE RESULTS WE PROVIDE USUALLY GO UNNOTICED.

Less operative time and a quicker recovery. These are the major benefits that we bring our patients through the use of minimally invasive surgical treatments. At Legacy Neurosurgery, we offer some of the most innovative treatments and techniques in our field. Learn more about our expertise and advanced services at **legacyneuro.com**.

LEGACY
NEUROSURGERY
SPINE & BRAIN SPECIALISTS

Scott Schlesinger, MD, FACS | Kelli Schlesinger, MD | David Rubin, MD | **501-661-0077**

The Arkansas Family Physician

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

Managing Editor
Carla Coleman

Correspondence, articles, or inquiries should be directed to:
ArAFP, 500 Pleasant Valley Drive,
Building D, Suite 102
Little Rock, Arkansas 72227
Phone: 501-223-2272
Instate Toll-Free: 1-800-592-1093
Fax: 501-223-2280
E-mail: arafp@sbcglobal.net

Edition 71

pcipublishing.com
Created by Publishing Concepts, Inc.
David Brown, President • dbrown@pcipublishing.com
For Advertising info contact
Tom Kennedy • 1-800-561-4686
tkennedy@pcipublishing.com

Dear Academy Member,

As this publication goes to press, House Bill 1160 is scheduled for a special order of business Thursday, February 26 before the House Public Health Committee. So the outcome of that bill will be known before this Journal reaches you. We strongly oppose this bill which would open the entire Schedule II prescribing to APNs allowing them to practice independent of physician supervision in all but two counties in Arkansas and provide for reimbursement equivalent to physicians. Contact has been made with members whose legislators on the Public Health Committee reside in their areas. Should this bill get out of the Public Health Committee, we will be making contact with the entire membership to contact your legislators to oppose this bill.

Included in this issue is a preview of the Academy's 68th Annual Scientific Assembly which will be held Thursday, June 11 through Noon on Saturday, June 13. As soon as all of the information is received from speakers, we will go to press and hopefully have the program with hotel and registration information to you in late March. There will be a Pre Assembly program on Wednesday, June 10 on "Team Based Care and What you Need to Know about ICD 10". This will provide additional CME hours and will be at a separate registration fee. Your office staff is encouraged to attend this pre assembly program.

The slate of officers and directors will be in the next Journal. This issue includes changes to the ByLaws which will be presented to those in attendance at the Annual Meeting for a vote.

Please pay your dues for the 2015 year and if you need hours for re-election for the period ending 12/31/14 please report them as soon as possible or call us and we will be happy to help you!

We urge you to get involved in the Academy, there are many areas we need your input. Just give us a call or email us at arafp@sbcglobal.net and we will put you to work!

Sincerely,

Carla Coleman

Executive Vice President

On the cover:
Arkansas State capital in Little Rock.

Daniel Knight, M.D.

President's Message

Daniel Knight, M.D., President

My presidency started out with pure chaos. Unfortunately, I booked a vacation prior to knowing when the inauguration for AR AFP President was. When I found out, I had nearly overbooked myself, leaving one-half day to arrive home from China and make it to the ceremony. As luck and our plane service to Arkansas would have it, my flight was canceled and moved to the next day. I made it home one and a half hours before the time for my installation, jet-lagged from a country a world-away and a great lack of sleep on the way home. All's well that ends well! We had a wonderful luncheon and a meaningful ceremony, starting my year as president off right!

The remainder of last year and the beginning of this year has followed a similar plan. As Arkansas decided to enter Medicaid expansion with a new plan-the Private Option, it has caused lots of chaos in the medical world. We have been accepting many new patients that are newly insured and have a myriad of poorly controlled medical problems. While we want to care for these patients and improve their health, it has been challenging to get their needs met. As we are proceeding into this expansion, uncertainty reared its head concerning the Medicaid expansion with an election of a new governor and a changed Arkansas legislature. For a moment, we were unsure whether the Medicaid expansion would remain in place. Fortunately, our governor has developed a plan to continue the expansion while we re-evaluate the needs and abilities of the state. While it is an exciting time, there have been many changes including Medicaid's plan to develop a payment system for patient-centered medical homes. The Board has been actively involved in this project including providing housing in our office for the Arkansas Community Cares program that provides training and personnel for offices that need care managers. This has provided some income to our organization as they have moved in with us which has allowed us to help shape this project to support family physicians.

As we have proceeded into the legislative period, we have had usual and unusual challenges in bills that have been presented. We have had the ubiquitous scope of practice issues, this year involving APN's practicing independently without supervision and being paid at a rate of a physician. There have been more unusual bills such as allowing newly graduated, non-licensed physicians to practice without a license under a licensed physician's supervision until they are able to progress in their training. APN's and PA's have asked to be able to write schedule II drug prescriptions. This has brought up much discussion among our members.

Personally, it has been a year of growth for me. Carla Coleman is an excellent teacher and leader and has given me the guidance to know where I was going and how to get there. We began the year by attending ALF (Annual Leadership Forum) in Kansas City where I interacted with many other wonderful leaders throughout Family Medicine. It was an exhilarating experience that gave me confidence to proceed to the presidency. After that, we have had a couple of board meetings, discussing both controversial and exciting plans for the board to act on. It is a new experience for me to lead while trying to find the gestalt of what all of the other board members believe and develop it into a plan that represents what our members want and support. While I have been a leader in other positions, this one has the widest and most diverse group of constituents that I have been involved with. It takes quite a bit of listening and discerning to know what is the right path and how to get there.

The annual AAFP Congress of Delegates was a new experience for me. While I knew we had representatives to the Congress from our chapter, I didn't know what amount of work our delegates put into this. I found that we have 2 delegates and 2 alternates that attend yearly and can serve up to 6 years. Prior to becoming a delegate, they must serve as an alternate delegate. Therefore, these members put in a commitment of up to 12 years to become an AAFP delegate. That is an amazing amount of hard work and dedication to help make Family Medicine better. They read a library full of bills on everything from Coca-Cola support to euthanasia. They must decide whether to pass them, kill them or make them something worthwhile. I really admire the dedication of our members to this endeavor.

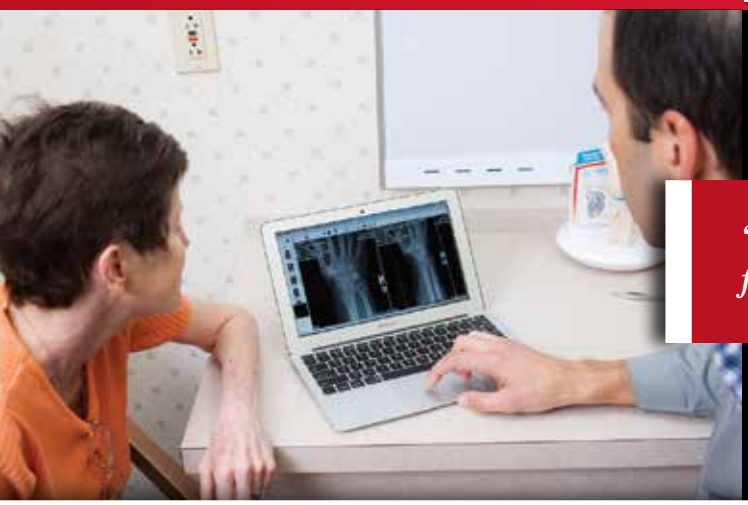
I look forward to the remainder of my year as president with your support. I believe we have an excellent group of board members who give a lot of their busy lives to serve. We are also gifted with an excellent Chapter Executive in Carla Coleman who knows her way around and makes my job easy! So, have a great new year. It promises to be exciting!

Dan Knight

Have you heard the hype?

"Being an Athletic Trainer, it is important to myself and my clients to have injury care after hours and on weekends. The Saturday Sports Clinic and weekday Walk-In Injury Clinic have been very beneficial for myself and my clients. The professionalism of the OrthoArkansas staff and physicians always exceeds expectations." **Richard Green**

Hear what our patients are saying.



"It was very pleasant, professional and speedy with extremely friendly staff." **Didi Sallings**

2014 Best of the Best
Arkansas Democrat Gazette

*"I injured my leg and was pleased to find out from my primary care physician that OrthoArkansas now has an **After Hours Injury Clinic**. The staff was efficient, friendly, and very helpful, and I was quickly seen by a doctor—all this without having to make an expensive and time-consuming visit to a hospital ER. I would recommend the OrthoArkansas After Hours Injury Clinic to anyone with an unexpected sports injury."*
OrthoArkansas After Hours Injury Clinic Patient Testimonial

OrthoArkansas
INJURY + CLINIC

(501) 604-4117
www.orthoarkansas.com

OrthoArkansas is first again.

Our new Ortho Injury Clinic is the first in the area and is receiving rave reviews. You can count on OrthoArkansas. We've got you covered!

Available Monday - Thursday, 5-8pm • 10301 Kanis Road

No Appointment is Necessary and Walk-Ins are Welcome.

Arkansas AFP Bylaws to be Modified Upon Vote by Membership June 11

At the membership meeting of those Ar AFP members in attendance at the Annual Scientific Assembly, several bylaw amendments will be presented to be more aligned with the AAFP bylaws and to also correct some bylaw requirements that are no longer effective as follows: (bolded areas are changes to the bylaws or additions to the bylaws)

1. Chapter III Section *1* **The mission of the Arkansas Chapter is to promote excellence in healthcare and the betterment of health of the American people. To Provide responsible advocacy for and education of patients and the public in all health related members: To preserve and promote quality cost effective health care; to promote the science of art of Family Medicine and to ensure an optimal supply of well trained Family Physicians; To promote and maintain high standards among physicians who practice Family Medicine; To preserve the right of Family Physicians to engage in any medical and surgical procedures for which they are qualified by training and experience; To provide advocacy, representation and leadership for the specialty of Family Medicine and To maintain and provide an organization with high standards to fulfill the above purposes and to represent the needs of its members.**

2. Chapter VII Section 4 **"Dues for Active members shall not exceed the sum of $300. unless approved by ¾ of the membership attending the Annual Scientific Assembly**

   (please note it currently says $250. This does not mean we are increasing dues – in fact our state dues have not increased for over 12 years but it allows in future years a dues increase if needed)

3. Chapter VII Section 5. **Dues for Supporting members shall not exceed the sum of $300., unless approved by ¾ of the membership attending the Annual Scientific Assembly**.

   (please note it is currently $250. This category of membership's dues have not increased in over 12 years – same as Active but allows for in future years if needed).

Chapter IX – Board of Directors

Section 2. **The Board of Directors shall meet at least four times per year *<u>including</u>* the Organizational meeting of the Board. (the current bylaws state "*excluding*" the Organizational meeting)**

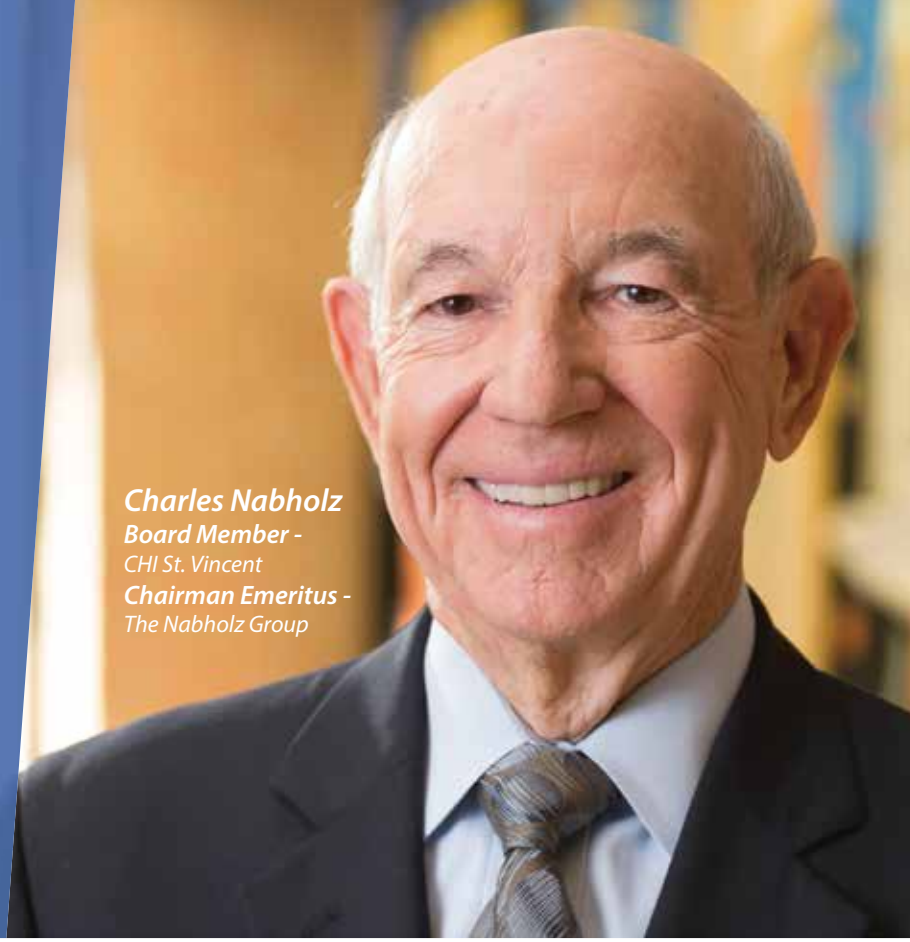
Section 7**. All members of the Board are expected to attend all regularly scheduled meetings of the Board and shall attend the Annual Scientific Assembly annually. If a Director misses two meetings in a year they are "presumed to have resigned." Shall an Officer or Director fail to attend the Annual Scientific Assembly, they shall be subject to dismissal from the board.**

Should a director or officer fail to be in attendance for installation as an officer or director, they will be subject to dismissal from the board depending on the reason for non attendance.

Chapter XV. Section 2: The order of business at the Organizational Meeting of the Board during the Annual Scientific **Assembly shall include an orientation session for new members and all members of the Board who wish to vote shall be required to complete a Conflict of Interest Statement.**

If anyone desires a complete copy of the current bylaws, please contact the AR AFP office and a copy will be emailed or mailed upon request!

Across Arkansas. Across America.



Charles Nabholz
Board Member -
CHI St. Vincent
Chairman Emeritus -
The Nabholz Group

BEST REGIONAL HOSPITALS
U.S.News & WORLD REPORT
CENTRAL ARKANSAS
RECOGNIZED IN 5 SPECIALTIES
2014-15

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

CHI St. Vincent leads the way to better health.

Our founders envisioned better healthcare, a community where innovation, compassion and world-class outcomes would be the standard of care. Over 127 years later, CHI St. Vincent has realized the vision.

U.S. News & World Report ranks CHI St. Vincent Infirmary in Little Rock as the number one top-performing hospital in Arkansas, as well as a high-performing hospital in geriatrics, nephrology, neurology and neurosurgery, orthopaedics, and urology.

It's also the first and only hospital in Arkansas to earn Magnet® Recognition for excellence in nursing leadership, clinical practice, innovations and positive outcomes.

With top rankings and top-rated physicians in the country, CHI St. Vincent is building a better future. Just imagine what we'll do next.

CHI St. Vincent

Imagine better health.℠

ARcare Accepting Applications for Primary Care Doctors!!

AR Care is accepting applications for a board certified Physician. Must have current licensure in the State of Arkansas; Must be Certified with prescriptive authority and ability to relate with consideration and effectiveness to patients and staff of ArCare. Openings exist in Hazen, Augusta, Wynne, Cabot West, Conway and Lonoke.

The Staff Physician works as part of a medical provider team providing medical services to the patients of ArCare. In addition, Staff Physicians unless specifically exempted by the Chief Medical Officer and Medical Director, shall be qualified to serve on the active Medical Staff of a local hospital, provide inpatient care services, assume "on call" after hours responsibilities and supervise community health center PAs or NPs as appropriate. The Staff Physician also has the responsibility to coordinate and monitor all aspects of patient care services in accordance with the Patient Centered Medical Home model of care.

For more information, contact Terry Hill at Terry.hill@arcare.net or call 870-919-1315

When you need it.

Medical professional liability insurance specialists providing a single-source solution | ProAssurance.com

ProAssurance.
Treated Fairly

Getting Paid

Notes on Coding and Reimbursement

Five issues to watch in 2015

Family physicians spent much of 2014 wrestling with the seismic changes affecting medicine across the United States and in their practices. That won't slow down in 2015. "The coming year will again be one of major transition for the U.S. healthcare system," said Lou Goodman, PhD, president of The Physicians Foundation and chief executive officer of the Texas Medical Association, in a statement announcing the Foundation's "Physician Watch List for 2013." The list, based on the Foundation's own research, policy papers, and physician surveys, identifies the five issues most likely to affect physicians and their patients this year.

1. Accelerating consolidation.

Hospitals and health systems are buying up small practices and absorbing solo physicians at a faster pace. Besides affecting local competition, costs, and patient choice, the trend has physicians worried about clinical autonomy. The Foundation's 2014 Biennial Physician Survey found that 69 percent of those participating said they had concerns about autonomy and being able to make the best decisions for their patients. It said that as the consolidation isn't expected to slow down, hospitals and physicians must work together to prevent bureaucracy or other organizational factors from influencing medical decision-making.

2. The physician-patient relationship is stressed.

The increased documentation of value-based reimbursement systems and perceived interference of health care employers are considered key external pressures on the relationship between patients and their physicians. In particular, physicians have told the Foundation that these factors are eating into their face-to-face interactions with patients while also limiting their choices of practice types and requiring more time spent negotiating with payers and vendors. These pressures will call for more reliance on practice support staff to help the physician retain as much focus on the patients as possible.

3. ICD-10 finally arrives.

Physicians were given a one-year reprieve when the Centers for Medicare & Medicaid Services (CMS) postponed the implementation date for the new ICD-10 coding structure to Oct. 1, 2015. But the extra time likely won't improve many physicians' outlook or support. According to the Foundation's survey, half of respondents expected ICD-10 to cause severe administrative problems in their practices and three-quarters said it will unnecessarily complicate coding. Still, it's highly unlikely CMS will delay ICD-10 again, so practices need to make the necessary investment of time and money to be ready for the change.

4. Patients demanding the true cost of care.

Medical costs were once a hidden algebra to the public, deciphered only by payers and health care administrators. But media focus in recent years on the lack of transparency in billing practices, as well as higher out-of-pocket costs for patients, has the public much more frustrated. The seeming arbitrariness of what certain procedures actually cost stands to make it harder for physicians to make the best clinical decisions and calls for policymakers, providers, and payers to build a more straightforward cost of care structure.

5. Patient access to care.

As more people are gaining access to health insurance through the Affordable Care Act and demanding health care services, the overall number of physicians is declining or reducing the amount of time available to see patients. According to the Foundation, 44 percent of respondents in its survey said they were planning to reduce access to their services, such as shrinking their panels, retiring, going to part-time work, or taking non-clinical jobs. This could reduce patient access to care by tens of thousands of full-time equivalents (FTEs) in the future. The Foundation, along with the University of North Carolina-Chapel Hill, has developed a tool to help analysts and lawmakers to better gauge future shortages of physicians. Goodman said the list shows the continued threat to small medical practices and that policymakers must "bring physicians into the fold to ensure the policies they implement are designed to advance the quality of care for America's patients in 2015 and beyond."

CCS
CORRECT CARE
SOLUTIONS

...the right people...doing the right things
...doing those things right

Come be a part of
the solution.

CCS is a healthcare provider that has provided comprehensive healthcare to correctional facilities since 2003.

Full and Part Time Physician Opportunities

For more information, please contact:
Alex English
Phone (800) 592-2974 ext. 5513
Email: aenglish@correctcaresolutions.com

For more information visit
correctcaresolutions.com

The Impact of Expanded Coverage on Arkansas's Health Care Safety Net Clinics

Arkansas's safety net clinics are responding to a major change in the health care environment. In 2014, approximately 250,000 low income Arkansans gained access to health care through newly available coverage options in the Arkansas Health Insurance Marketplace and the Arkansas Health Care Independence Program.[1] As a result, the number of uninsured has dropped precipitously. Prior to 2014, safety net providers in the state were unsure exactly how this shift in the health care coverage landscape would impact them, their business models, and their clientele. A year later, safety net clinics across the state have had an array of experiences, and now face new and different challenges. This issue brief will provide background information on the Arkansas health care safety net and a sampling of experiences in this changing environment.

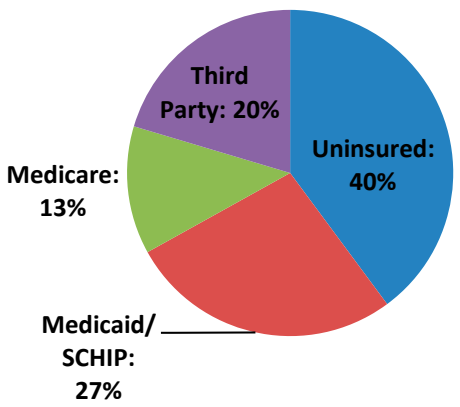
Introduction

There are both national and statewide efforts to increase the number of people with access to affordable health care coverage, which is expected to lead to better health outcomes.[2] Arkansas's efforts have been more successful than most,[3] thanks to bipartisan leadership, innovative programs, and comprehensive, system-wide transformation strategies. As a result, providers in Arkansas are seeing an infusion of previously uninsured patients who now have the ability to pay for health care services.

Clinics that have focused on providing care to uninsured and underinsured individuals—safety net clinics—are adapting in this dynamic environment. Will these new coverage programs continue in the current political conditions? Will newly insured clients continue to seek care in safety net clinics now that they have a payment source? Will safety net clinics retain access to reduced drug pricing, and if not, will it affect their budgets? Will safety net clinics have a disproportionate increase in uninsured patients? How will safety net clinics gain negotiating strength in a more expansive, private market?

To assess the experiences related to coverage expansion, the Arkansas Center for Health Improvement (ACHI) identified safety net clinics with guidance from the Arkansas Department of Health and the Community Health Centers of Arkansas (CHCA). CHCA supports community health center sites, which are Federally Qualified Health Centers (FQHCs). ACHI then reached out to a sample of clinics across the state, covering a range of geographic and socioeconomic areas. ACHI conducted key informant interviews with managers of two FQHCs and five charitable clinics. This brief provides descriptive information about the preliminary impact of expanded coverage in Arkansas as relayed by clinic managers.

Figure 1: 2013 Health Center Data



Patient characteristics of those seen in 12 federally qualified health centers in Arkansas
Source: "2013 Health Center Data." Accessed on January 16, 2015 at http://bphc.hrsa.gov/uds/datacenter.aspx?year=2013&state=AR

Safety Net Clinic Background

The health care safety net refers to providers that deliver a significant level of health care to uninsured, Medicaid, and vulnerable populations,[4] many of which—either by mandate or adopted mission—offer care to patients without regard to coverage.[A] Presently,

[A] Although rural health clinics (RHCs) are not surveyed in this brief, many RHCs serve as part of the safety net in Arkansas's rural areas.

there are well over 100 free or low-cost health centers in Arkansas, including charity clinics and FQHCs. The safety net clinics in Arkansas have long served as the sole avenue through which Arkansans without health insurance could receive care outside of the emergency room, including access to basic primary care, dental care, and some pharmacy services. These providers generally offer care in areas that face a shortage of health care services, regardless of insurance coverage.

According to the Uniform Data System of the Health Resources and Services Administration (HRSA), in 2013, 51 percent of patients served by FQHCs nationwide were between the ages of 25 and 64.[5] This included 94 CHCA sites located around the state. In addition to CHCA sites, many smaller operations, which are mostly faith-based, are scattered in both urban and rural areas. These independent clinics are often part of a larger, community-based operation partnered with food banks, churches, or senior centers.

Several programs, including federal grants, support these clinics because they successfully provide necessary primary and acute care, often costing far less than alternatives. Additionally, many of these clinics have benefitted from the HRSA 340B Drug Pricing Program.[6] This program allows specific types of health care facilities to receive and utilize prescription medications at a much-reduced cost.[7]

National Trends

Nationally, the number of uninsured individuals has decreased, but many safety net clinics still expect to serve uninsured clients. These may include undocumented individuals, as well as individuals who do not qualify for subsidized private coverage through the health insurance marketplace or traditional Medicaid.[8] Until the Schanging health insurance market reaches a steady state, questions will remain about the viability of safety net clinics. Once the market is more stable, clinics may need to examine whether and how they can change their business models to adjust to the new market. To date, at least one free clinic in Arkansas

continued on page 14

continued from page 13

has closed, attributing its closure to the increased health coverage and lack of need for their services,[9] which has been noted by other clinics as described in the following section, Arkansas Experiences. Clinic responses to reduced demand for services have varied from a business perspective, but several clinics noted that they were glad their patients would now have better access to comprehensive care.

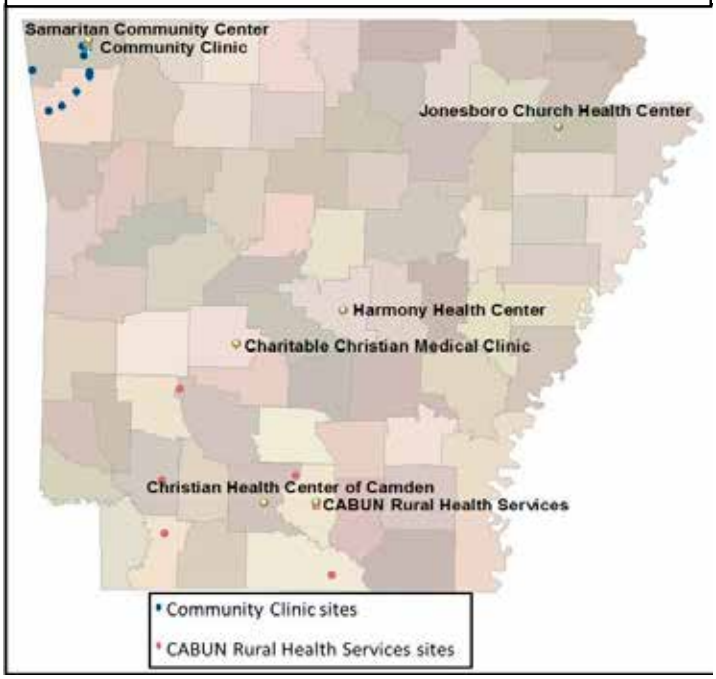
Arkansas Experiences

In Arkansas, there are many different types of safety net clinics. Likewise, there have been a variety of experiences since the increase of the insured population. No two clinics have identical missions or business models; therefore, no two clinics have been impacted identically. However, a few themes have emerged. The faith- and mission-based clinics are facing a period of internal reflection to determine if the needs of their patients would be better addressed through new avenues. One clinic, the Charitable Christian Medical Clinic of Hot Springs, redirected its model of care to provide additional ancillary services, such as community education. Several others have managed to continue despite a smaller patient load, and are waiting to learn if those newly insured will continue to have coverage after 2015, in order to determine if they should follow suit. CHCA sites have seen less of a decrease in demand, but must adjust to shifts in revenue sources. For example, some have anticipated billing less through Medicaid and more through private insurance carriers.

Community Health Centers

Since 1985, CHCA has provided programmatic support and advocated for Community Health Centers' (otherwise referred to as FQHCs) interests in areas that otherwise would lack adequate health care services. There are currently twelve CHCA Centers around the state, and each manages a number of CHCA clinic sites, totaling 103. As FQHCs, the CHCA sites are required to serve an underserved area,[10] and are often the sole health care provider in a community. While they are required to provide care regardless of the ability to pay, they have traditionally accepted payment from a variety of sources, including private coverage, Medicare, Medicaid, and a sliding fee scale for those without insurance.

Figure 2: Arkansas Safety Net Site Examples



Community Clinic

Community Clinic, a health care ministry of St. Francis House NWA Inc., has served the low-income population of Washington and Benton counties since 1996, and became FQHC qualified in 2004. They operate twelve locations throughout Rogers, Springdale, Siloam Springs and the surrounding areas.[11] Like all FQHCs, Community Clinic historically accepted Medicaid patients, and offered services to the uninsured on a sliding fee scale. In 2013, Community Clinic saw just over 27,000 individuals, 39 percent of whom were uninsured. With the expansion of insurance coverage, Community Clinic anticipated that rate would drop to near 25 percent in 2014. Three-quarters through 2014, their uninsured rate was closer to 31 percent, which they credited to several factors.

The first issue is the increased competition for the newly insured population, mainly with hospital-facilitated clinics. The second issue is that the uninsured population continues to face educational, cultural, and linguistic barriers that prohibit them from accessing care at traditional clinics. It is likely a combination of these factors that contribute to the uninsured rate staying relatively high, potentially straying from projected budgets.

Another contributing factor is that the clinic serves a higher representation of the medically frail population. The Health Care Independence Program (HCIP) was designed to keep eligible individuals having exceptional health care needs in traditional Medicaid coverage, expecting that amount to be about 10 percent of individuals deemed eligible for the Private Option. To date, Community Clinic has found that 13 percent of those newly eligible have been designated as having exceptional health care

continued on page 18

We are dedicated to helping our patients find a way to live happy lives!

When families become stressed by behavioral issues, they need a caring environment. Pinnacle Pointe is the largest child and adolescent behavioral care hospital in Arkansas.

Pinnacle Pointe Hospital offers no-cost assessments 24/7 to children and adolescents who are struggling with emotional or behavioral issues.

Please contact us today to find out more.

501.223.3322 • 800.880.3322
www.PinnaclePointeHospital.com

Pinnacle Pointe
BEHAVIORAL HEALTHCARE

Pinnacle Pointe Behavioral Healthcare System
1501 Financial Centre Parkway
Little Rock, Arkansas 72211

TRICARE®

All major Insurances, TRICARE® and Medicaid Accepted.

Explanation of Practice Transformation and Care Coordination

Practice transformation helps practices develop the systems and workflows to better manage your population, while care coordination actually touches those patients that are complex and high risk. The two efforts are synergistic and not duplicative and the maximum benefit occurs when you have the systems and processes in place at the practice to manage your patient population and then have skilled care coordinators to work as a part of the health care team intervening on those patients that will benefit the most.

Practices that contract with Arkansas Community Cares will be provided boots on the ground **direct patient outreach** and care coordination for their complex patients. Working directly with practices and complex patients in managing their health care needs ensures the following occurs:

Assessing the needs of the patient – performing an initial comprehensive assessment.

- Implementing a patient-centered care plan in the practices electronic medical record.
- Outreaching, educating and coordinating patient care as a member of the primary care provider's health care team.
  - In larger practices care coordinators may be embedded within the practice
  - At a minimum care coordinators will spend time in each practice weekly
- Coaching patients on self-management of chronic conditions.
- Performing Medication management and home visits where appropriate
- Developing ongoing population health processes and procedures (work flows) for their patient populations.
- Supporting and assisting to establish a "medical neighborhood" environment with community based collaborations and knowledge of available resources.
- Assuring that all Arkansas Community Cares care coordinators are continually and consistently trained in evidence based practices which allows for the identification and spread of best practice.

Practices that are ready to begin intensive outreach and population management may contact Arkansas Community Cares to discuss in more detail. Susan Beasley, Program Director @ 919.236.9957 or sbeasley@ARcommunitycares.com.

2015 Arkansas 68th Annual Scientific Assembly
June 10-13, 2015
Doubletree Hotel, Little Rock, Arkansas
PREVIEW

Although the program has been finalized for the Academy's 68th Annual Scientific Assembly, we are "tweaking the times and making sure all of the information is correct before going to press!" The official program will be in your offices by the end of March complete with registration and hotel reservation information! We will also post it on our website arkansasafp.org

The Pre Assembly begins on Wednesday morning with a program by State Volunteer Mutual Insurance (they will do their own registration, etc. and promotions).

We will provide a combined session beginning at 1:15 pm for our Pre Assembly program entitled, "Team Based Care and ICD 10 Preparedness". This session will end at approximately 4:15 pm.

On Thursday, June 11 our Annual Assembly kicks off with our first keynote of the week being Arkansas Surgeon General Gregory Bledsoe, M.D. followed by a 40 minute session by Doctor Joe Tollison of the American Board of Family Medicine who will be available to answer questions afterwards about anything pertaining to the boards and certification.

Thursday's program continues with a presentation by Dr. Richard Fry on "Diagnosis of Autism" followed by "Anticoagulants" by Dr. Randy Minton. A lunch meeting will be held that day presented by State Volunteer Mutual Insurance on "Managed Care and Payment Reform".

The afternoon session on Thursday will kick off with a "New Drug Update" by Dosha Cummins, Pharm.D., of Jonesboro followed by "ENT Potpourri" by Dr. Graves Hearnsberger of Little Rock. The last lecture of the day will be "Diabetes – Making the Right Choice in a Sea of Treatment Options" by Dr. Louis Kuritzky of Gainesville, Florida.

Concluding the Thursday program will be something new for us as we offer 75 minutes of Roundtable Interractive Sessions on: "Diabetes" led by Dr. Louis Kuritzky:: "CPCI" by Dr. Julea Garner and Rachel Wallis: "Women's Health" by Dr. Leslye McGrath: "New Drugs Update" by Dosha Cummins, Pharm.D., "PCMH" by Dr. Lonnie Robinson: "Rural Medicine" by Dr. Amy Daniel and "Insulin" by Dr. Jeff Mayfield and "Resident/Student Involvement" by Dr. Tasha Starks and Dr. Scott Dickson.

Friday will begin with a breakfast meeting hosted by Arkansas Foundation for Medical Care with their Medical Director Dr. Beth Milligan presenting, "Practice Transformation."

Our second keynote address will be provided that morning by President elect of the AAFP, Dr. Wanda Filer on "An Update from the American Academy of Family Physicians" followed by a presentation by Dr. Shane Speights and Dr. Joe Stallings on "Disaster Planning for your Practice." The final lecture before the Installation of Officers Luncheon will be Dr. Harvey Makedon on "Overview of GLBT Issues."

The afternoon session begins with "End of Life Issues" by Dr. Sara Beth Harrington followed by "Thyroid Nodules" by Dr. Brendan Stacks and "Update in Pediatric Infectious Disease" by Dr. Gary Wheeler.

Saturday's program will begin with a breakfast meeting by Legacy Neuro on "How to Diagnose and Treat Disorders of Pain, Numbness or Weakness" by Doctor Scott Schlesinger and Dr. David Rubin; Doctor Mark Jansen will present "Nailing the Problem – Primary Disorders of the Nails and Secondary Changes due to Systemic Disease States." An overwhelming request for "Direct Pay Patient Models" will be presented by Doctor Randall Oates of Fayetteville followed by our final presentation by Doctor Lonnie Robinson on "Family Docs on a Mission".

Please be looking for the program the end of March with hotel and registration information! There is a room block at the hotel for our group offering a discounted rate that we will post in the official program. We hope you will join us for a great CME event!!!

continued from page 14

needs (i.e., medically frail). Since the clinic has traditionally served those without insurance who also lack adequate care coordination, it stands to reason that their medically frail patient panel would be slightly higher.

CABUN Rural Health Services

CABUN Rural Health Services Inc. manages six clinic sites in and near Hampton, Arkansas. The Center traditionally served patients in Calhoun, Bradley, and Union Counties, giving them their unique name. Over the past year, CABUN has not seen a significant change in the overall number of patients, but there has been a change in the makeup of their patient panel. The clinic has seen up to 25 percent of its previously uninsured patient population gain coverage through newly available options. As the opportunity to enroll approached in late 2014, they hoped to continue assisting patients in gaining coverage. There are still a significant number of uninsured individuals seeking care there, and the clinic expects the need to continue to exist.

The largest issue CABUN sees for its patient population is the gap in knowledge about available programs and how these programs can benefit them. There seems to be a great deal of confusion among the public, patients, and even some providers about the details of what is being offered. CABUN is trying to alleviate this issue by using two federally funded full-time Assistors to hold education events and assist people with enrollment through a variety of methods.

Independent Clinics

In addition to two CHCA Centers, ACHI had conversations with representatives from five independent safety net clinics from around the state to learn about their experiences since the state expanded health coverage. Many of these clinics have grown from faith-based responses to unmet needs demonstrated by the uninsured. These responses supported by local charitable giving provide some immediate access to health care services but do not remove the financial barrier to a comprehensive set of primary care, specialty and pharmaceutical needs. With the availability of comprehensive health care coverage the role of charitable clinics in eliminating financial barriers to care is expected to change.

Charitable Christian Medical Clinic

In downtown Hot Springs, Arkansas, the Charitable Christian Medical Clinic has operated for 17 years as the primary health service location for the uninsured of Garland County. The mission of the organization has always been to provide services for those who lack access to care. In early 2014, the organization decided that it needed to alter the services provided in order to fully carry out its mission in the future. As of late 2013, the clinic was managing and delivering care to about 1,000 uninsured individuals. A year later, that number is just 150. Operating under a new name, Cooperative Christian Ministries and Clinic (CCMC), they recognized that their new strategy should be to help enroll patients into newly available insurance options, provide ancillary services, and refer patients to traditional primary care providers in the community.

CCMC continues to provide direct care for those who remain ineligible for insurance—mainly the undocumented population in West Central Arkansas. A new challenge has surfaced; many of the programs and grants that funded CCMC operations in the past do not cover the undocumented population. While their operational costs for direct care have greatly dropped with a drop in patient volume, they still face issues arranging care for those without insurance.

Another major change has been the new hours during which CCMC is open for care. Previously, the clinic was open three days per week from 8:00 a.m.–5:00 p.m., as well as two evenings each month. Now, with the drop in uninsured patients seeking care from them, they are open just half a day each week and one evening per month.

Christian Health Center of Camden

The Christian Health Center of Camden (CHCC), located in Camden, Arkansas, has been in operation since 1997. It seeks to provide care to the uninsured of Ouachita County and serve as a resource for other community needs. Like many charitable clinics, CHCC provides services on a sliding scale. Since the implementation of the Private Option, CHCC has seen its patient load drop by 60 percent as local residents are now able to receive care from traditional providers. CHCC often partners with the Delta Alliance for Healthcare—a non-profit organization aimed at stopping generational poverty in the Delta region—to combine resources to improve care.

While access to insurance coverage has improved, access to health care providers continues to be an issue for many Arkansans, especially those in the Delta region. CHCC encourages patients to work with an identified primary care physician but continues to see the same patients while they struggle to get appointments. Some patients have historically faced 30-60 day appointment delays, so CHCC provides for them in the interim to help prevent care gaps. The clinic accepts and then distributes other goods that their patients may have trouble acquiring. For example,

they collect used crutches and wheelchairs which are distributed to new patients in need. Because of cost and access issues related to medical equipment, these donation services are likely to continue to be in high demand.

Samaritan Community Center

In Rogers, Arkansas, the Samaritan Community Center has been in operation since 1989 serving as a food pantry and clothing ministry. Over time they realized the lack of health care access for the uninsured in their community was a large barrier for their constituents. They began offering a weekly medical clinic, called the Samaritan Health Center (SHC), in the evening hours for the uninsured, hoping to provide opportunities for locals to seek health care. The SHC served approximately 30-35 people each month who otherwise did not have access to a physician. Since the beginning of 2014, they have seen a steady decline in patient numbers. With fewer patients requesting appointments, they then began operating clinic hours on a biweekly basis. The patients who continue to seek care are largely in need of ancillary services such as care coordination or help navigating the health care system. SHC works with their local CHCA Center to provide coverage information and help enroll people into newly available insurance options. SHC encourages already established clients to connect with a local primary care physician and is often actively involved in scheduling appointments as well as helping with medication reconciliation.

While SHC's medical operations are on the decline, the clinic continues to see a need for dental, vision, and behavioral health services. The SHC director mentioned the medical clinic may cease to exist in a year's time but they are working on plans to expand their other service lines. These services are often not provided in standard health insurance plans and are therefore cost prohibitive for low-income populations. In response, SHC offers the entire spectrum of dental services from cleanings, screenings, and X-rays, to extractions and emergency dental care. SHC has continued to see the demand for these services increase and is constantly seeking more volunteers to meet the needs of this growing demand.

Harmony Health Center

While Little Rock, Arkansas is home to a wide array of primary care, public health, and specialty clinics, those without health insurance in central Arkansas can still face barriers receiving care outside of emergency services.

continued on page 20

continued from page 19

In 2005, a group of citizens concerned with this underserved population came together to create the Harmony Health Clinic (HHC). Located a few miles from downtown Little Rock, HHC provides services for the uninsured, transient, undocumented, and homeless groups directly and through all local shelters.

Since the implementation of the Health Care Independence Act, HHC has seen a 50 percent decrease in its patient population. Unlike other clinics, they continue to operate the same amount of clinic hours but now require the services of only one physician instead of two. They also continue to offer two full time, in-person Assistors to educate those now eligible for insurance. While their patient numbers have decreased dramatically, HHC is confident that their services will continue to be needed. They know that people will continue to experience gaps in the health care system. This includes some individuals who will go through periods of transition between insurance carriers and some who require care outside of traditional settings.

Patients who have become eligible for the Private Option often want to continue their relationship with HHC despite now having insurance coverage. HHC continues to act as a care connector and educator instead of direct care provider. Conversely, the demand for other services provided by HHC continues to grow. The demand for their dental care exceeds their supply of trained volunteers, creating a desire to be able to expand those services.

Jonesboro Church Health Center

Since 1992, Jonesboro Church Health Center (JCHC) has been open five days per week offering preventive and acute services to the uninsured population in Jonesboro, Arkansas. JCHC continuously saw an increase in the number of patients served, reaching capacity with 5,463 individuals in 2013. The center operates mainly through the Arkansas Department of Health Charitable Clinics Grant Program,[12] a large annual fundraiser, and several individual and faith- based donations. They also traditionally charged a flat $15 office visit fee to help ensure patients kept appointments.

Since the beginning of 2014, JCHC has seen approximately 100 fewer patients each month. This has caused a decrease in revenue for the clinic that they are temporarily managing through reserves. JCHC will look to its Board of Directors to determine if any operational changes are needed should this decreasing trend continue. The patients that are still seen at JCHC have reported a mixture of issues such as not being eligible for new insurance programs, or the plans offered still being too expensive. Access to primary care physicians in the local area is another large issue; many patients have returned to JCHC saying that their new insurance was not accepted, or they could not get an appointment without an extended waiting time, often causing care gaps for very ill patients.

Conclusion

A year after Arkansas experienced an increase in its number of covered lives, many of the state's community and faith-based clinics have adjusted to decreases in demand. However, a new challenge for these groups may be just around the corner. The potential for the Arkansas Health Care Independence Act to be repealed or unfunded looms on the horizon, causing the clinics to question whether to expect a sudden increase in demand after having changed operations. Those clinics that now accept different insurance carriers face the challenge of decreased demand for primary care services and an increased demand for specialty care such as behavioral health, dentistry, and vision care. An interesting facet of these challenges is that the mission of these clinics is to serve those in greatest need and most clinics are not disappointed to see the need met by more comprehensive and integrated providers.

The majority of charitable clinics who shared experiences reported a dramatic decrease in the number of uninsured walking through their doors seeking care. This has mainly affected demand, but also revenue, as programs aimed to benefit the uninsured are being eliminated. Yet the attitude of several operational managers is positive; they are glad to be losing patients if that means patients are receiving more comprehensive care elsewhere. They know that their previous patients are better served by a traditional primary care setting and are grateful so many of them now have access to health coverage, and through that, direct access to care.

It is unlikely that safety net providers will completely cease to be in demand due to the needs of undocumented, transient, and economically sensitive populations, even if the HCIP continues. The efforts to increase the number of Arkansans who are covered by affordable health insurance have been successful in many ways, as demonstrated by the decrease seen in many strictly charitable clinics. More work is needed to strengthen the network of providers in disparate areas as well as to educate the newly eligible about the options available to them. In

order for safety net providers to continue to be successful, they will need to identify funding streams for the changing services that are being demanded of them.

References

[1] Health Care Independence Act of 2013, Act 1497, Act 1498.

[2] Andrulis, DP. "Access to Care is the Centerpiece in the Elimination of Socioeconomic Disparities in Health." *Annals of Internal Medicine,* 1998;129*(5)*:412-6. doi:10.7326/0003-4819-129-5-199809010-00012

[3] Witters D; Gallup Well-Being. "Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate: Medicaid Expansion, State Exchanges Linked to Faster Reduction in Uninsured Rate." Washington, DC: Gallup, Inc., August 5, 2014. Accessed online at http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx.

[4] Institute of Medicine. "America's Health Care Safety Net: Intact But Endangered." National Academy of Sciences, 2000. Accessed online at http://iom.edu/~/media/Files/Report%20Files/2000/Americas-Health-Care-Safety- Net/Insurance%20Safety%20Net%202000%20%20report%20brief.pdf

[5] "2013 Health Center Data." Health Resources and Services Administration; Accessed on January 16, 2015 at http://bphc.hrsa.gov/healthcenterdatastatistics/index.html.

[6] "340B Drug Pricing Program: Important Benefit, Significant Responsibility." Health Resources and Services Administration, June 1, 2014; http://www.hrsa.gov/opa/update.html.

[7] "340B Drug Pricing Program." Health Resources and Services Administration, Accessed on June 1, 2014 at http://www.hrsa.gov/opa/.

[8] Kane A; for The Denver Post. "Colorado Clinics Scramble to Find Place in new Health Care Environment." *Denver and the West;* The Denver Post, March 2014*;* http://www.denverpost.com/news/ci_25672493/colorado-clinics-scramble-find-place-new-health- care.

[9] Mac Neal C; TPM Livewire. "Arkansas Free Clinic Closing, Citing More Insured Through Obamacare." TPM Medial LLC., April 10, 2014. http://talkingpointsmemo.com/livewire/arkansas- clinic-closing-because-obamacare-enrollment.

[10] "What are Federally qualified health centers (FQHCs)?" Health Resources and Services Administration, Accessed on January 28, 2015 at http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html

[11] "Locations." Community Health Centers of Arkansas, Inc. Accessed January 29, 2015 http://www.chc-ar.org/locations.

[12] "Arkansas Department of Health: Arkansas Charitable Clinics Grant Program." Arkansas Department of Health. Accessed on January 28, 2015 at http://www.healthy.arkansas.gov/programsServices/hometownHealth/ORHPC/Pages/Programs.aspx.

SVMIC
State Volunteer Mutual Insurance Company

ARKANSAS MEDICAL SOCIETY EXCLUSIVELY ENDORSES SVMIC

BRENTWOOD, Tenn. – The Arkansas Medical Society has selected State Volunteer Mutual Insurance Company (SVMIC) as their exclusively endorsed carrier for Medical Professional Liability/Malpractice (MPL) coverage effective January 2015. SVMIC has been insuring physicians in Arkansas for 25 years, making it the largest and longest continual writer of MPL coverage in the state.

"SVMIC and the Arkansas Medical Society share a deep commitment to the physicians of our state. SVMIC provides Arkansas physicians with a proven partner who has the integrity and financial strength to support their long term promise to Arkansas policyholders," said David Wroten, Executive President of the Arkansas Medical Society.

Further, John H. Mize, SVMIC's President and CEO, adds, "We are proud to have been selected by the Arkansas Medical Society as their exclusive endorsed MPL carrier and look forward to continuing to work with the AMS as we bring our unique, powerful combination of physician-focused MPL coverage and broad risk management resources to bear in the interest of Arkansas physicians."

SVMIC and AMS both recognize the value of physician involvement in governance; SVMIC's Arkansas Advisory Committee is composed of 9 physicians from various specialties throughout Arkansas. In fact, says Dr. Dennis Yelvington, Chair of the Board of Trustees of the Arkansas Medical Society, "SVMIC has a local presence to support us including 3 local representatives living in Arkansas, as well as a fully staffed office in nearby Memphis. Further, we feel as though Arkansas physicians are well represented in the leadership of the SVMIC Board of Directors and are proud that an Arkansas physician, Dr. John Lytle of Pine Bluff, has been elected as the next Vice-Chair of SVMIC's Board. This structure gives me great confidence that SVMIC will continue to be in close touch with the issues faced by Arkansas physicians."

SVMIC was founded by physicians in 1976 and provides MPL coverage in Tennessee, Arkansas, Virginia, Kentucky, Georgia, Alabama and Mississippi. SVMIC has maintained an "A" (Excellent) or better rating from A.M. Best Company for more than 30 years.

Arkansas Membership Statistics

During the week of February 9, the American Academy processed members due for re-election on December 31, 2014 who have reported sufficient CME for re-election for the three year period January 1, 2012 through December 31, 2014.

Regretfully, 46 Arkansas AFP members have yet to fulfill the CME requirements for continued membership and will be dropped from the membership roles in May if the CME requirements are not reported by March 31.

Requirements for continued membership in the AAFP are a minimum of 150 hours of CME as acceptable to the AAFP of which one half (75 hours) must be Prescribed Credit or formal course credits. Twenty five of these hours must be "live" (or not by online courses). Elective hours make up the remainder which are enrichment type activities such as courses not approved by the AAFP: hospital staff meetings , etc. If you are one of the 46 members who have not reported sufficient hours for continued membership – please contact us and see if we can assist in reporting your hours. Precepting a nurse, a medical student or other health professional can be reported for up to 20 Prescribed Hours per year. We can be reached at 501 223 2272 or arafp@sbcglobal.net.

Demographic characteristics of the Arkansas Chapter as of 1/31/15 show 855 Active members of which 617 are male and 238 are female. 152 of this number are an AAFP Fellow: 715 are U.S. Medical School graduates and 810 are graduates of a family medicine residency program.

The average age of an Arkansas Chapter member is between 40 and 44 years of age.

Other membership categories are: Resident members – 92: Student Members – 86: Supporting members – 1: Life members – 88 and Inactive members – 3 for a total membership of the Arkansas chapter of 1280.

Membership dues are being paid for the 2015 year ahead of schedule as compared to last year. Dues statements went out in October, 2014. As of this date, February 13 , we have received a total of $115,791. for Arkansas member dues!!!

Congratulations to our new members as follows:

Andrew Christopher DeClerk, Student

Barrett Burger, Student

Morgan Drake, Student

Heather Collier, Student

James Mitchell, Student

Jake McMillion, Student

Jim Awar, Student

Anthony Rooney, Student

David Blackburn, Student

Lonna Bufford, Resident – Texarkana

Jonna Michelle Dyer, M.D., Fayetteville – Active Member transfer from Missouri

Arkansas Legislative Session In Full Swing!!

There are several bills that have been filed of interest to Family Doctors described below. Emails will be sent out as we obtain information on when they will be heard. It is possible by the time this Journal reaches you, the bills will have been heard. The bills are as follows:

SB 133 (Bledsoe) - Telemedicine - Establishes the licensure requirements for physicians and others utilizing telemedicine, requires the "in person" standard as the basis for patient relationships in order to utilitize telemedicine and establishes coverage and payment requirements for insurance carriers. **SUPPORT**

HB 1136 - (Magie) - A bill allowing APRN's and Pas to continue writing hydrocodone combination products that were reclassified as Schedule II. Requires specific authorization from the collaborating physician and requires the Board of Nursing to adopt rules for treatment of chronic, non-malignant pain that are as stringent as those of the State Medical Board. **SUPPORT**

HB 1160 – (Hammer) – APRN SCOPE OF PRACTICE - Another effort by the APRNs to practice medicine. APRNs who practice in "medically underserved areas (73 of 75 counties) may obtain a permit from the Nursing Board that would allow them to prescribe ALL Schedule II drugs, serve as the equivalent of a Primary Care Physician, head of the Patient Centered Medical Home and receive reimbursement equal to a physician. After two years under a Collaborative Practice Agreement, they can request from the Nursing Board an exemption to allow full practice without collaboration. **STRONGLY OPPOSED**

HB 1165 (Gonzales) - Full Schedule II Drugs. This bill allows APRNs and PAs to write "ALL" Schedule II drugs. **STRONGLY OPPOSED**

Members of the Senate Public Health Committee:
Chair – Senator Cecile Bledsoe
Vice Chair – Senator Stephanie Flowers
Senator John Cooper
Senator Scott Flippo
Senator Keith Ingram
Senator Missy Irvin
Senator David Sanders
Senator Gary Stubblefield

Members of the House Public Health Committee:
Chair – Representative Kelley Linck
Vice Chair – Representative Deborah Ferguson
Representative Mary Bentley
Representative Justin Boyd
Representative Ken Bragg
Representative David Branscum
Representative Charlene Fite
Representative Kim Hammer
Representative Ken Henderson
Representative Fredrick Love
Representative Robin Lundstrum
Representative Stephen Magie
Representative David Meeks
Representative Josh Miller
Representative Betty Overbey
Representative John Payton
Representative Chris Richey
Representative Dan Sullivan
Representative Jeff Wardlaw
Representative Richard Womack

Health Literacy:
Challenges and Strategies

By Lynda Beth Milligan, MD, FAAFP, CPE, CHCQM

Health literacy is a more serious problem than many health care professionals realize, and it affects the majority of your patients. Public health leaders are shifting the health literacy focus from hospitals to the community to improve how people understand and use health information in their lives.

Health literacy means having the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow treatment instructions.[1] Only 12 percent of American adults meet this standard of health literacy and less than half have any health literacy skills, according to the National Institutes of Health. Adequate health literacy also includes the ability to provide informed consent, to understand preventive treatments, and possess math skills sufficient to understand dosages and calculate premiums, copays and deductibles. Low health literacy has multiple causes, including the fact that more than 90 million American adults have limited literacy skills.[3] Less than 60 percent have English as their first language. Most American adults read on an eighth-grade level, but most medical information is written on a twelfth-grade level.[3] After a doctor's office visit, patients misunderstood instructions more than 60 percent of the time.

Low health literacy has a direct and negative impact on compliance, outcomes and cost. Some studies have placed the cost of health illiteracy at more than $236 billion per year.[7] The health care costs of low-literacy-level Medicare beneficiaries are four times higher than costs for beneficiaries with a high level of literacy.[2] People with limited health literacy are much more likely to avoid important preventive measures such as mammograms, Pap smears and flu shots.[4] They are more likely to have chronic conditions and are less able to manage them effectively. They have more preventable hospital visits and admissions.[5]

Populations most likely to experience low health literacy are older adults, racial and ethnic minorities, people with less than a high school degree or GED certificate, people with low-incomes, non-native speakers of English, and people with a compromised health status.[6]

No one can determine health literacy levels by observation alone. Low-literacy adults have learned to hide their inadequacy with excuses such as, "I forgot my glasses," or "I'll wait to decide this until I can talk to my family about it." Most are too embarrassed to ask questions or fear asking a "stupid" question. Other clues include not being able to explain their medical or health concerns, what their medications are for, or how to take them. They don't follow through with tests and appointments, and are non-compliant with medications and treatments.

It is the primary responsibility of public health professionals and the healthcare and public health systems to increase patients' understanding of health care instructions, treatments and background information. The following are tips to start using with your patients:

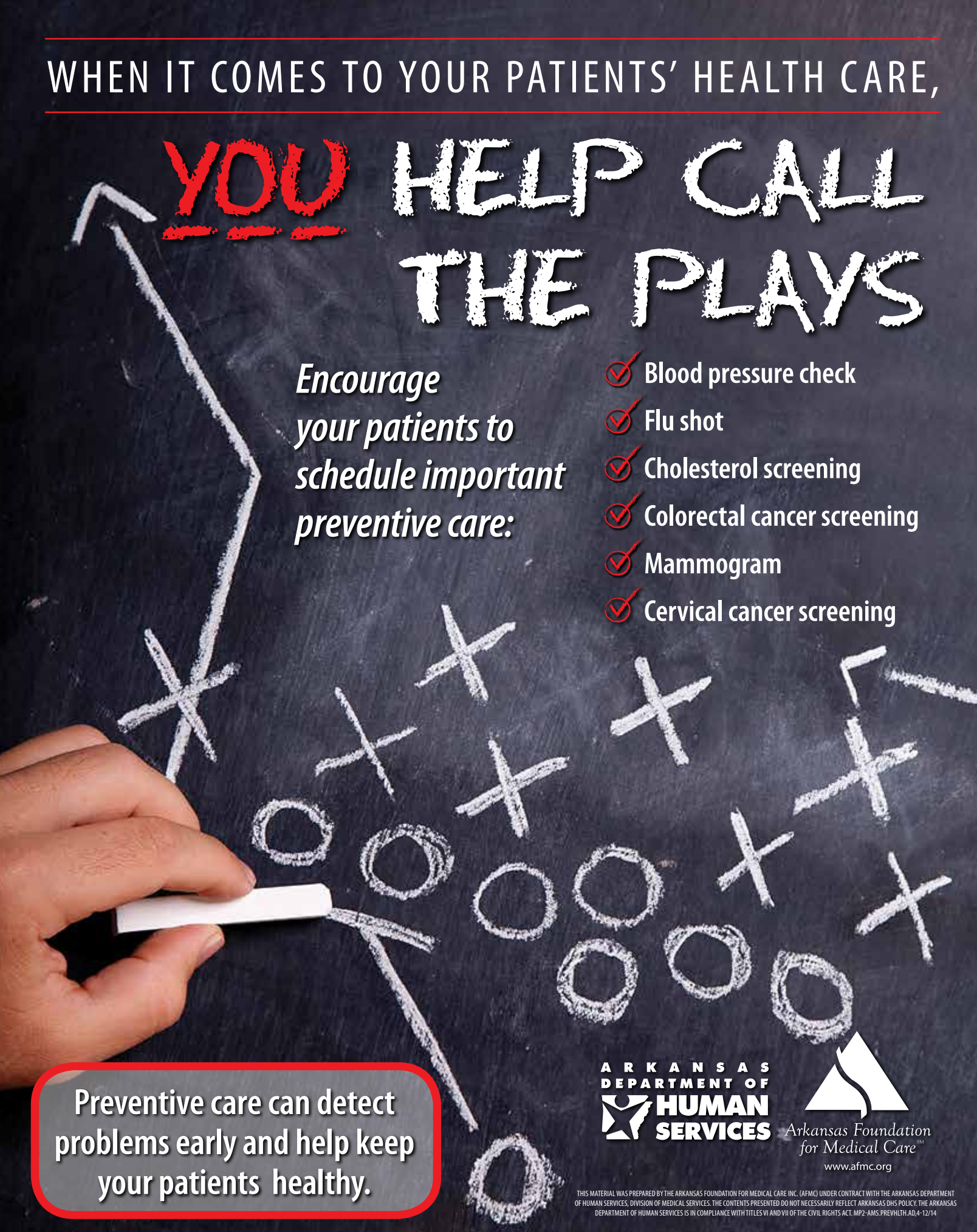
continued on page 26

WHEN IT COMES TO YOUR PATIENTS' HEALTH CARE,

YOU HELP CALL THE PLAYS

Encourage your patients to schedule important preventive care:

- Blood pressure check
- Flu shot
- Cholesterol screening
- Colorectal cancer screening
- Mammogram
- Cervical cancer screening



Preventive care can detect problems early and help keep your patients healthy.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Foundation for Medical Care℠
www.afmc.org

THIS MATERIAL WAS PREPARED BY THE ARKANSAS FOUNDATION FOR MEDICAL CARE INC. (AFMC) UNDER CONTRACT WITH THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES. THE CONTENTS PRESENTED DO NOT NECESSARILY REFLECT ARKANSAS DHS POLICY. THE ARKANSAS DEPARTMENT OF HUMAN SERVICES IS IN COMPLIANCE WITH TITLES VI AND VII OF THE CIVIL RIGHTS ACT. MP2-AMS.PREVHLTH.AD,4-12/14

continued from page 24

- Use plain language, free of medical jargon. Slow down the pace of your speech. Avoid vague terms. "Take on an empty stomach" may be confusing, but "Take one hour before you eat breakfast" leaves less room for misinterpretation. Listen to the patient and use the same terms he or she uses.

- Keep instructions short and simple. Only tell them what they need to know unless they ask specific questions. Reinforce and repeat instructions.

- Focus on one to three key messages, and repeat and reinforce that information in different ways. Use pictures, concrete and specific examples, and verbal illustrations.

- Ask patients to list one to three of their top concerns or questions. Patients are more likely to retain the answers to their own questions. Combine patients' concerns with your key messages to simplify and focus your instructions to a manageable amount of information.

- Focus instructions on what you want the patient to do. Explain specific behaviors and personalize your instructions.

- Develop short and simple explanations for common side effects and frequently encountered medical conditions. Test these with patients and revise your words until all patients can teach it back to you without hesitation.

- Instructions and educational background materials should be explained verbally and include written and pictorial versions. Handouts should focus on the patient's experience with a condition rather than disease pathophysiology.

- Train all staff in your organization to recognize and respond appropriately to patients with literacy and language needs.

- Ask patients to "teach back" what they have been told. After explaining a new concept, new medication or treatment plan, ask the patient to repeat what you said, in his or her own words. The patient's response will tell you far more about the level of understanding. Continue to reassess comprehension and adjust your response until the patient has a full understanding. "Teach back" is one of the top 11 patient safety practices for reducing medical errors.[7]

These links provide free downloadable tools to help physicians improve communication with low-health-literacy patients:

- **http://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/downloads/ToolkitPart05Chapter06.pdf**

- **ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/pharmlit.pdf**

The communications gap between patients' understanding and the skills required to comprehend typical health care information must be narrowed. Putting the burden of effective communication and understanding on yourself, makes patients more at ease and willing to make an effort to comprehend.

Dr. Milligan is vice president, corporate medical director with the Arkansas Foundation for Medical Care.

References:

1. U.S. Dept of Health and Human Services 2000. *Healthy people 2010.* Washington, D.C: U.S. Government Printing Office. Originally developed for Ratzan SC, Parker RM. 2000. Introduction. In *National Library of Medicine Current Bibliographies in Medicine*: Health Literacy. Sheldon CR, Zorn M, Ratzan SC, Parker RM, Editors. NLM Pub. No. CBM 2000-1. Bethesda, MD National Institutes of Health, U.S. Department of Health and Human Services.

2. Literacy of older adults in America. 1996. Washington, DC: National Center for Education Statistics, US Dept. of Ed.

3. U.S. Dept. of Health and Human Services. What is health literacy? Oct. 2014. Washington, DC. National Institutes of Health.

4. Scott TL, Gazmararian JA, Williams MV, Baker DW. 2002. *Health literacy and preventive health care use among Medicare enrollees in managed care organization. Medical Care.* 40 (5): 395-404.

5. Baker DW, Parker RM, Williams MV, Clark WS. 1997. *The relationship of patient reading ability to self-reported health and use of health services.* Amer Journal of Public Health. 87 (6): 1027-1030.

6. National Center for Education Statistics 2006. *The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy.* Washington, DC: U.S. Dept. of Education

7. Iowa Healthcare Collaborative. June 2013.Teach back basics. www.ihconline.org/aspx/general/page.aspx?pid=107

SAMUEL A. MOORE, D.O.

Orthopedics & Sports Medicine

- Total joint replacement of the hip & knee
- Arthoscopy of the hip, knee, shoulder
- Rotator cuff repair
- ACL reconstruction
- Fracture treatment
- PRP & Stem Cell Therapies

Accepting new patients in Little Rock, North Little Rock, Conway and Beebe offices

Call 501-663-6455 or 1-800-336-2412 for an appointment

Scan the QR code with your smart phone or search

Samuel Moore, D.O. - Orthopedic Surgeon

www.drsamuelmoore.com

www.facebook.com/DrSamuelMoore

THE BEST SURGEONS. THE BEST TREATMENT.
ALL FOCUSED ON YOU.

ORTHO SURGEONS
ORTHOSURGEONS.COM

From AAFP NEWS NOW:

New Report Highlights Savings Achieved by Medical Homes

Between 2009 and 2013, PCMHs supported by payment incentives had increased in number from 26 to 114, patients served (5 million to 21 million) and a number of states embracing medical home transformation (18 to 44) according to the PCPCC report which reviewed PCMH initiatives in several states. In all the report combined findings from seven state reports, seven insurance reports and 14 peer reviewed studies.

According to Rajul Rajkumar, a primary care physician and acting deputy director of CMS's Center for Medicare and Medicaid innovation, states three elements are essential for the medical home to be effective:

- The physician should receive incentives such as shared savings in the second or third year of the initiative
- The care team needs training to handle multiple tasks to preserve the physician's time
- All participating institutions need access to patient information at a specified time

Typically, studies have shown evaluations of medical homes put too much emphasis on cost savings often ahead of other considerations such as access to care.

Each initiative that researchers studied was measured based on cost and utilization, preventive health service offerings, C C xprimary care access and patient satisfaction. Oregon has been one of the early success stories in terms of expanded access and increase in primary care received. The Oregon Coordinated Care Organizations reported a 19 percent reduction in emergency department spending and a 17 percent reduction in emergency room visits during 2013. One Oklahoma initiative the Sooner Care program, reported it avoided 61,000 ER visits from 2009 to 2013 for a cost savings of $21 million. More than 90 percent of children and adolescents in the plan had access to a primary care physician in 2013.

Evidence suggests that trends continue to be positive for practices that are able to fully implement the PCMH model of care. The longer a PCMH practice has implemented the model, the more impressive the results.

For a complete copy of this article, it can be viewed on the AAFP website under AAFP News 2/9/15

Measles Outbreak Offers Discussions for Immunizations

The number of cases reported in January alone of Measles was more than the total seen in a typical year. According to widespread reports, most of the cases have been traced to DisneyLand in Orange County, California. AAFP President Robert Wergin observes that the elevated media exposure of this outbreak offers a perfect opportunity for family physicians to identify unimmunized patients in their practices and reach out to them to explain the importance of getting the measles, mumps and rubella (MMR) vaccine.

From January 1 to January 30, 102 people in 14 states were reported as having measles: Last year the CDC received the most measles case reports the agency had seen in 20 years - more than 600: On January 23 of this year, the CDC issued a Health Alert Network Advisory about the measles outbreak that included recommendations for health care professionals to use in their practices. One of those recommendations is to consider measles in the differential diagnosis of anyone with a febrile rash illness and clinically compatible symptoms who has traveled abroad recently or who has come in contact with someone who also has a febrile rash illness.

Given that it's the middle of flu season, measles should be added to the list of possible causes of febrile rash.

Immunization Schedules: http://www.aafp.org/patient-care/immunizations/schedules.html)

CDC, AAFP and Others Offer Flu Treatment Tips

Even though the 2014-15 vaccine has proven to be only 23 percent effective against H3N2 viruses, the CDC continues to recommend the vaccine for all eligible patients because it provides at least some protection against the H3N2 strain and protects against two or three other virus strains that could possibly circulate later in the season.

The CDC and several medical organizations are urging physicians and other health care professionals to help protect children under 2 and adults 65 and older by using antiviral drugs promptly when influenza is suspected. They note that flu activity is still high and likely will continue for weeks pointing out that influenza A viruses remain the most commonly circulating strains to date with more hospitalizations and deaths occurring in these two high risk patient populations during seasons when H3N2 viruses predominate.

The CDC recommends three influenza antiviral drugs: oseltamivir (Tamiflu), zanamivir (Relenza) and the IV drug peramivir (Rapivab).

Seasonal Getaways

7 Day Western Caribbean Cruise aboard the Carnival Dream. One of the newest and largest Fun Ships!

April 12, 2015

Prices for this cruise are based on double occupancy (bring your spouse, significant other, or friend) and start at only $846 per person (includes tour bus transportation to and from New Orleans) A $250 non-refundable per-person deposit is required to secure your reservations. Contact Teresa Grace at Poe Travel 800.727.1960.

Day	Port	Arrive	Depart
Sun	New Orleans, LA		4:00 PM
Mon	Fun Day At Sea		
Tue	Cozumel, Mexico	8:00 AM	6:00 PM
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	

Forget the airline security hassles, cramped seating, ear-piercing loud engines and long lines. We've chartered a 56 passenger motorcoach to whisk you to departure on our Caribbean Cruise! It's equipped with comfortable amenities like reading lights, internet service, DVD players, fully equipped restrooms, roomy luggage bins, fully adjustable seats, large tinted windows and complete climate-controlled comfort. Join us for a pleasant trip!

Reserve your seats now.

The Core Content Review of Family Medicine

Why Choose Core Content Review?

- CD and Online Versions available for under $250!
- Cost Effective CME
- For Family Physicians by Family Physicians
- Print Subscription also available
- Discount for AAFP members
- Money back guarantee if you don't pass the Board exam
- Provides non-dues revenue for your State Chapter

North America's most widely-recognized program for:

- Family Medicine CME
- ABFM Board Preparation
- Self-Evaluation

- Visit www.CoreContent.com
- Call 888-343-CORE (2673)
- Email mail@CoreContent.com

The Core Content Review of Family Medicine

Educating Family Physicians Since 1968

Find us on Facebook

Arkansas Academy of Family Physicians
500 Pleasant Valley Drive, Building D, Suite 102
Little Rock, Arkansas 72227

Multiple Tools for Arkansas Doctors

SVMIC is Uniquely Equipped to Help Arkansas Doctors Succeed

25+ Years of experience as the premier medical professional liability carrier for Arkansas physicians & surgeons; more continuous years protecting doctors in Arkansas than anyone else.

9 Number of physicians on the Arkansas Advisory Committee who review claims and make underwriting decisions for Arkansas doctors on behalf of SVMIC; local representation by 3 Arkansans on the SVMIC Board of Directors means the unique concerns and challenges of the state are well represented within SVMIC governance.

2,560 Claims handled by SVMIC attorneys from inception in Arkansas to date; unmatched claims expertise working with local defense counsel in Arkansas helps defend your personal and professional reputation if the time comes.

31 Consecutive years SVMIC has maintained an "A" (Excellent) or better financial rating from A.M. Best; industry-leading financial stability means we will be here when you need us.

We have local representatives in Arkansas to serve your needs. Contact Sharon Theriot or Mandy Holmes at mkt@svmic.com or call 800.342.2239.

Exclusively endorsed carrier of the Arkansas Medical Society

SVMIC® Mutual Interests. Mutually Insured.

Follow us @SVMIC • www.svmic.com