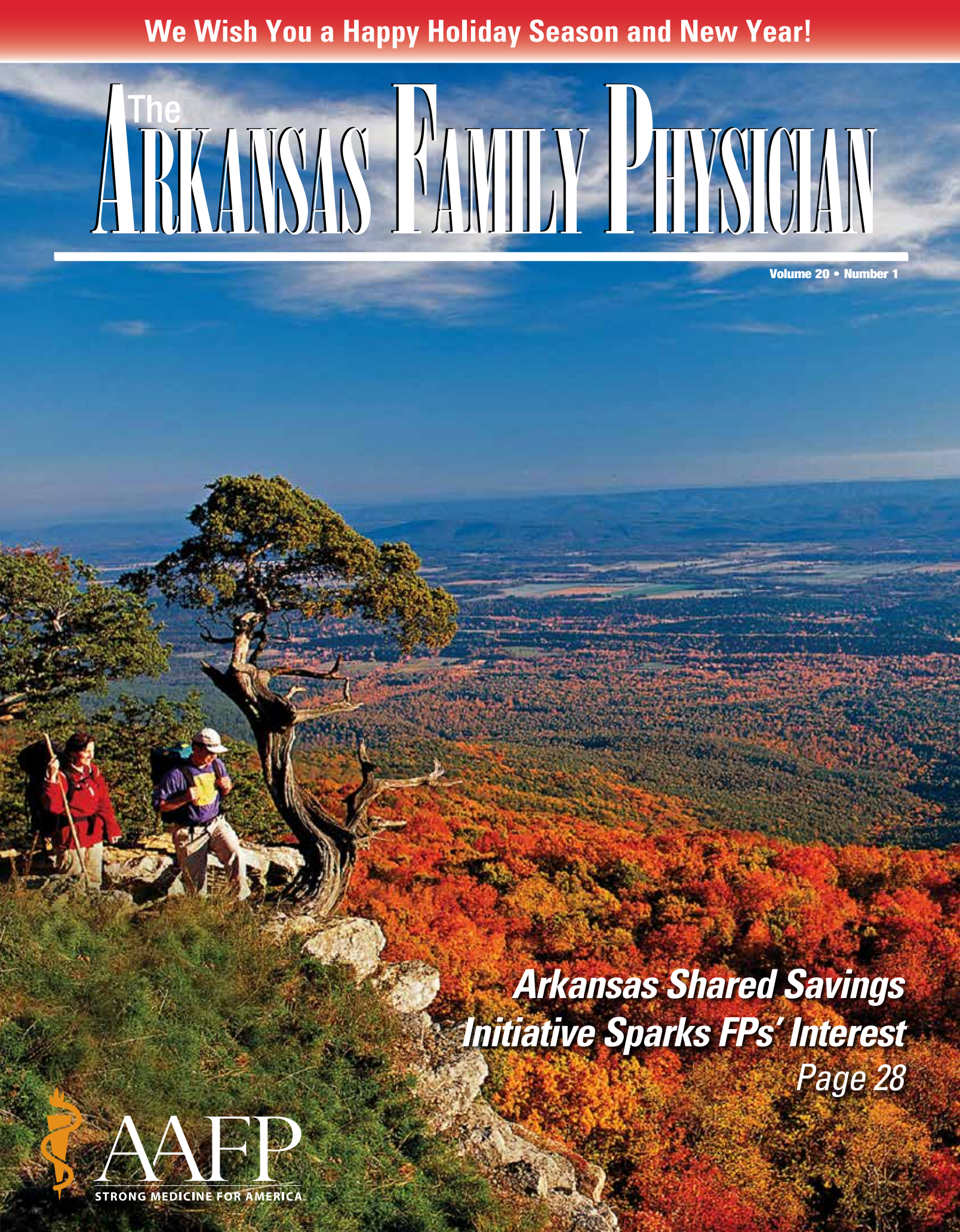
We Wish You a Happy Holiday Season and New Year!

The Arkansas Family Physician

Volume 20 • Number 1



Arkansas Shared Savings Initiative Sparks FPs' Interest

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The Arkansas Family Physician

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

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Edition 74

Dear Academy Member,

The Arkansas Chapter was well represented at the recent AAFP Congress of Delegates in Denver, Colorado with Delegates Julea Garner, M.D., Dennis Yelvington, M.D., Alternate Delegates Lonnie Robinson, M.D., Jeff Mayfield, M.D., President J. Drew Dawson, M.D. and Carla Coleman, Executive Vice President. It was a remarkable meeting especially watching the candidates forum for officers and directors and attending the reference committee meetings where policy of the AAFP is discussed. More on the Congress is elsewhere in this Journal. See more on page 4 and page 10.

As you will notice advertised on the front cover of this issue, three of our Family Doctors in Arkansas made the recent AAFP NEWS NOW in an article on the Arkansas Shared Savings Initiative. And, there is a synopsis of the Stephens Group Consulting Firm recommendations which was presented to the Arkansas Legislative Healthcare Reform Task Force for reforming the current traditional Medicaid Program and a replacement for the Private Option.

The next meeting your leaders will attend will be the Annual Multi State Meeting in February in Dallas where chapter leaders from 13 states meet and share ideas and best practices.

By the time of this printing the Board of Directors will have met and adopted a budget for the coming year. Excluding any payroll increases, the budget prepared is in the amount of $365,900 in income and $316,365 in expense. For year to date, we have current assets in the amount of $699,610 and no liabilities. Income for the year todate is in the amount of $261,250 and expense in the amount of $259,055. Our dues will arrive this month through March of next year which will raise our income quite a bit. Our largest income item was the Annual Scientific Assembly in the amount of $103,247 and expense of $55,556. Resulting in a net income for the meeting of $47,600. Dues for the year received are in the amount of $146,670.

Reminder of your dues to the AAFP/ARAFP were mailed in October for the coming year and for the nearly 100 of you that are due for re-election 12/31/15, please be reminded that we are ready to assist you in reporting your hours for re-election to membership (150 total hours for the past three year period with 75 of these being Prescribed or formal course credits and 20 "live" hours).

One final reminder: Please mark your calendars for an all new Annual Scientific Assembly in 2016. We will be at the Embassy Suites in Little Rock August 4-6!!! Free parking, all rooms are suites and we know you will want to attend! A Pre Assembly course will be planned for Wednesday August 3. More information on the program will be forthcoming!

As we come to the end of another year, we thank you for your membership and support and extend to you our very best wishes for a blessed holiday season and New Year!

Carla Coleman
Executive Vice President

On the cover:

Mount Magazine Fall Colors

J. Drew Dawson, M.D.

President's Message

J. Drew Dawson, M.D., President

When I agreed to serve as an officer of the Arkansas AFP, I knew that someday, I would likely be the President. Part of the responsibility of the President is to attend some national meetings, specifically the American Academy of Family Physicians Congress of Delegates. Meetings have never been my strong suit, and something I usually try to avoid, especially those that are far away, and have little to offer. So it was with a quiet sigh that I nodded my head in affirmation of my attendance, when the EVP asked. I'm sure my partial dread was not nearly as concealed as I had thought.

I can't be gone right now...I thought to myself. Like many of you, I was leaving a choked office schedule, mountains of administrative work, and a very robust 6 year-old's football practice and game schedule. As I reluctantly booked my airfare and registered for the conference, my consolation was the thought of some cool mountain air in my lungs, and the hope to climb a 14,000ft peak. The actual meeting was the last thing on my mind.

Boy was I wrong! While the yellow aspens and mountain air were great; and I did make that 14,000 foot peak; those were hardly the highlights of the trip. It was my first experience at an AAFP national meeting and Congress of Delegates, but I hope it is not my last. The experience was fantastic. I came home energized, enthusiastic, and optimistic about my career and Family Medicine in general. It's an experience that I strongly recommend to my colleagues.

Time away from the office is precious to all of us. When I get the opportunity, I try to mentally "punch out" of the medical world, and devote myself to whatever endeavor I am pursuing. All part of that elusive work-life balance we sometimes read about. After spending some time on what I would call professional development at the AAFP Congress of Delegates, I believe I have found something missing from my work-life balance scale.

It's really easy to view our daily grind at work as our job. It is in a sense, but more importantly, it's our career. There is a difference. Careers in every field are built on and revolve around relationships. Family Medicine is no exception. We all recognize that when it comes to our practice and our patients, but we often overlook the importance of professional relationships as it relates to our satisfaction and happiness in our careers. The Congress of Delegates has reminded me of the importance of building those relationships and the value they bring to my daily "work" life. For three days, I was surrounded by Family Medicine docs from around the nation, most with similar concerns, but all with an enthusiasm. What a great chance to meet, swap ideas, and collaborate on common issues and problems. I came home re-energized about the real opportunities we have as Family Physicians, and was re-affirmed that we can and do make a difference. I can also see the danger in having my brain in career mode while not in the office, and focusing on professional development (evident by the collective eye-roll of my entire office staff when I blow in the back door with a fresh set of ideas and a revitalized enthusiasm).

Overall, the AAFP Congress of Delegates was a great experience. It's a meeting that I dreaded, and avoided as long as I could, but now strongly recommend to our membership as a way to inspire you and help advance your career as a Family Physician.

The Arkansas Delegation – Julea Garner, M.D., Drew Dawson, M.D., Lonnie Robinson, M.D., Jeff Mayfield, M.D., Dennis Yelvington, M.D. and Carla Coleman

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Violent disease in 19th century Arkansas

Dr. Sam Taggart is a retired doctor/ writer/ marathon runner in practice in Benton for the last 35 years. He recently published *The Public's Health: A narrative history of health and disease in Arkansas,* published by the Arkansas Times. His two other books, *With a Heavy Heart* and We All Hear Voices are available at your local booksellers or online at Amazon.com

At the beginning of the 19th century the place that we call Arkansas was truly a wilderness. There were fewer than 5000 humans total and most were Native Americans. Malaria and typhoid were a fact of life that had to be contended with.

By the time of the Civil War there were 436,000 people, one-fourth of who were black slaves. By the beginning of the 20th century the population had grown to 1.2 million. Even with this exponential growth in population ninety-plus percent where widely scattered, living in small family groups on the land they farmed.

90 + percent of population lived in the country

Two major changes in technology had a dramatic effect on the population of the state: steamboats began making their way up the waterways of Arkansas in the early 1820's and railroads established a major presence in Arkansas after the Civil War. With these new forms of transportation came significant waves of immigrants looking for a place to claim as their own. Population centers began to develop along the river ways and the rail lines; with the waves of immigrant came waves of diseases.

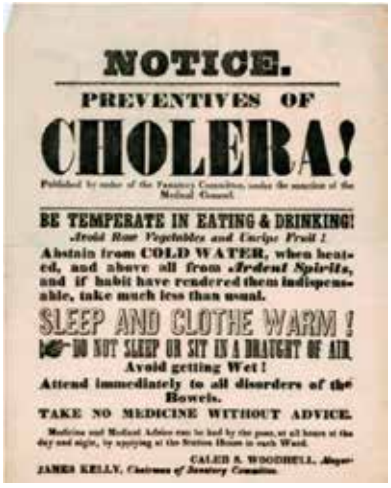
Child with smallpox

There were three violent diseases that altered the history of health and disease in Arkansas during the 19th century: smallpox, cholera and yellow fever.

Smallpox was not new to Europe or the newly formed United States but it tended to be more easily spread in dense population centers. With the arrival of steamboats in the 1820's the newspapers were full of references to smallpox concerns. New Orleans and the other cities along the lower Mississippi regularly reported outbreaks of the dreaded smallpox. Documented outbreaks of smallpox occurred in the Middle Mississippi Valley as early as 1826. Arkansas Post on the Mississippi was the first to report an outbreak of smallpox. Quarantine of steam boats was common, requiring them to dock a quarter mile outside of town so the boat could be boarded and inspected by medical personal of the town. One of the first forays into the public's health was established under Dr. Mathew Cunningham, physician and Mayor of Little Rock. In February of 1931 the steamboat *Waverly* was boarded, a black man was determined to have early smallpox. A building was rented, a pest house was established in the western outskirts of Little Rock and the man was quarantined; several days later he died. The city businessmen quickly began to contend that it was not smallpox but some less virulent disease; they did not want the word to get out that Little Rock was a repository of smallpox. The ruse would probably have worked except that within a few days several others folks came down with the dreaded pox. For the next eighty-five years Arkansas was plagued with repeated rounds of smallpox.

The small pox vaccination was already available and went by the commercial name *Kine Pox.* The Arkansas Gazette encouraged people to go to Dr. Cunningham's and get the vaccination. There is no question that the vaccination worked at preventing the disease but almost everyone was hesitant to get vaccinated. The anti-vaccination movement that we continue to deal with today had its origins in the late 18th century. As late as the early 20th century five to seven thousand cases of smallpox were reported around the state each year. Smallpox would not begin to disappear as a major health threat in Arkansas until 1915 when Kensett, Arkansas became one of the first Arkansas school to require vaccination for its student, teachers and other employees. Despite two failed Arkansas Supreme Court challenges in the 1920's smallpox vaccination became the law of the land after that point and the disease slowly disappeared.

The next violent disease that raised its head in Arkansas was Cholera. The Indian Removals promulgated by the Andrew Jackson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Cholera poster

continued on page 8

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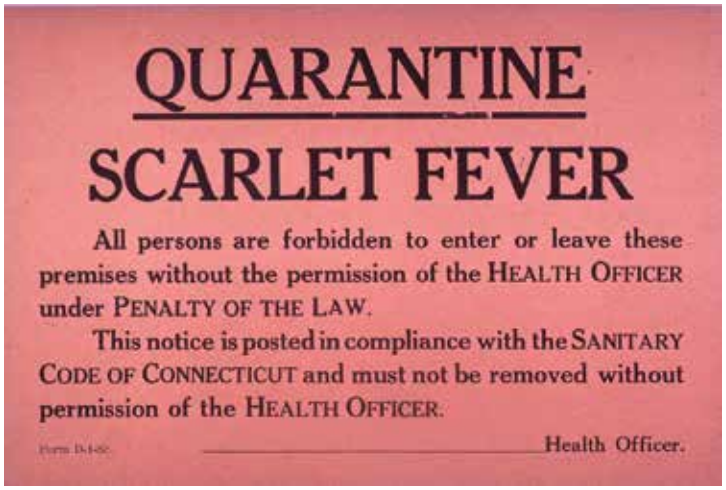
continued from page 6

administration began in 1831 with the first removal of the Choctaw Indians of Mississippi to what would be Oklahoma. In the spring of 1832 cholera, an overwhelming violent water-and-food based diarrhea disease, moved across the Atlantic to Canada and then to the United States. It progressed down the east coast, into the Caribbean and up the Mississippi River. It struck the Choctaws first on the Mississippi river. Eventually several steamboats of these forced emigres were struck with the devastating disease in the small community of Rock Row (the present town of Clarendon) on the White River. Dr. Cunningham in Little Rock created a temporary Board of Health and triggered what was probably the first real public health investigation in Arkansas. He appointed a team of personal headed by Dr. B.W. Lee who made the trip to Rock Row and reported back that this did appear to be the dreaded cholera and that there were large numbers of the Native Americans dying every day. The board then contacted the U.S. government agent and made sure that the Choctaws did not come through Little Rock on their way to Oklahoma. One of the members of the Board wrote several articles that were published by the Gazette. It is important to remember that these people did not have the benefit of the germ theory. Most of the advice had to do with avoiding night air, cool breezes and certain fresh vegetables and fruits.

> In 1878 more than 5000 people died in Memphis and east Arkansas in one season.

Cholera would continue to plague the state throughout the 19th century and was especially severe during and just after the Civil War. It would take the advent of the germ theory and the ultimate establishment of clean water and adequate sewer systems before cholera would be completely pushed back from the plate.

Yellow Fever, a mosquito-borne disease, had a major presence in the continental United States since the mid-18th century; it was worse in the population centers of the East Coast. With the establishment of river traffic in the 1820's yellow fever made its way up the Mississippi and had a significant impact on New Orleans, Vicksburg and Memphis in the 1840s and 1850's. There is some question that it may have made its way to Fort Smith during this timeframe but the documentation is sparse. The first documented Yellow Fever outbreak in Arkansas was 1855 in the river port town of Helena. As late as the 1850's the medical population was still arguing about whether this was a contagious disease. Interestingly, despite the uncertainly in the medical profession, the general populace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SCARLET FEVER

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Yellow Fever poster

was convinced that this was a contagious disease. In 1855 the town of Helena was a busy port of 1500 people and when word got out that a young newspaper boy in town had contracted yellow fever the town was abandoned. The people who could not flee were cared for by a small group of physicians headed by Dr. Charles Edward Nash and three men who acted as nurses. Two of the men who acted as nurses were Pat Cleburne and T. C. Hindman, both of whom would go on to be Generals in the Confederate Army. With the frost and the death of the deadly mosquitos the epidemic abated.

For the next forty-five years yellow fever plagued the Mississippi, lower Arkansas, White and Red Rivers. In the 1870's Memphis, Vicksburg, Shreveport and a number of small towns in the Arkansas Delta region such as Hopefield (West Memphis), Marianna, Forrest City and Augusta were struck. Eighteen seventy-eight was the worst year.

Over 5000 people died in Memphis alone, one-fourth of the population of Shreveport died. There was very little reporting of the disease in the rural part of the Arkansas Delta but it was most certainly not spared.

The one positive that came out of these dramatic epidemics was the establishment of the first National Board of Health. Thanks to a number of forward thinking men in the newly formed Arkansas Medical Society a Permanent State Board of Health was created. Despite the word permanent in the name, the organization and its financing lasted only a couple of years. Quarantine administered by the Federal and State government was established as a rational approach to dealing with problems that went beyond the resources of the individual and the small community.

With the advent of the 20th century these three illnesses: smallpox, cholera and yellow fever were beginning to recede into the realm of history as effective strategies were developed for each. As we will see in future articles the state of Arkansas would face other equally deadly challenges.

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AAFP Congress of Delegates Elects New Officers and Directors

Dr. John Meigs, Jr., of Brent, Alabama was elected as President Elect of the AAFP for the coming year

Dr. Javette Orgain of Chicago – Speaker of the Congress

Dr. Alan Schwartzstein of Oregon, Wisconsin

Directors – John Bender, M.D., MBA of Fort Collins, Colorado: Gary LeRoy , M.D., of Dayton, Ohio and Carl Olden, M.D., of Yakima, Washington

New Physician Board Member - Marie Elizabeth Ramos, M.D. of Mount Shasta, California

Resident Board Member – Richard Bruno, M.D., M.P.H., of Baltimore

Student board Member – Tiffany Ho, M.P.H., of Baltimore

Wanda Filer, M.D., of York, Pennsylvania was sworn in as President of the American Academy immediately following the adjournment of the Congress of Delegates on September 28. Highlights of her speech are as follows:

"WE are the healthcare that this country needs and deserves; we are the solution." "We have never been in greater demand. Second year residents are telling me about the onslaught of job offers at salaries once unthinkable, loan forgiveness packages and stipends to help them get through residency if they sign on the dotted line now."

Dr. Wanda Filer

"There are however valued colleagues who are feeling immense pain and grief, suffering disillusionment and the anger of betrayal and I want you to know I am committed to addressing the factors that have created this and as is your AAFP Board and the entire organization. I ask each of you to recognize these suffering colleagues and support them, lift them and when necessary connect them to resources at the AAFP or individual chapters to get help."

"I ask you today to tell the good news of Family Medicine to our colleagues, our medical teams at home, to our patients, to our legislators. Take your rightful place as the disciple for Family Medicine in your community. We need all hands on deck right now, telling the Family Medcine value proposition for American healthcare."

2016 Arkansas Patient Centered Medical Home (PCMH) Enrollment

Arkansas Medicaid PCMH Enrollment

Arkansas Medicaid's Patient Centered Medical Homes enrollment process began September 1, 2015 and will end on November 13, 2015. The enrollment process continues to require current PCMH practices to re-enroll for 2016 using the abbreviated form sent out in August to designated PCMH leads. Any new practice interested in joining PCMH can access the PCMH enrollment application on the AHIN portal. Please submit all enrollment forms via fax at 501-374-0549 or via e-mail at ARKPII@hp.com with the subject line "Attn: PCMH."

QHP/ Commercial Open Enrollment for 2016 Patient Centered Medial Home begins October 1, 2015 and ends December 1, 2015.

Instructions on how to enroll with participating payers is listed below:

Arkansas Blue Cross PCMH Enrollment

Arkansas Blue Cross and Blue Shield is pleased to announce our online enrollment process for our 2016 Patient-Centered Medical Home program! Enrollment will be open to primary care practices on the AHIN PCMH portal. Please visit the AHIN portal at https://secure.ahin-net.com to enroll. Log in to AHIN, hover over APII portal and select "BCBS 2016 PCMH enrollment" link from the drop down menu. Once the enrollment form has been completed, you will be prompted to print the PCMH agreements. An original signature for each provider is required for participation in this program. Please return the completed PCMH agreements to:

Arkansas Blue Cross Blue Shield Primary Care, 4S 601 S. Gaines Little Rock, AR 72201

AmBetter of Arkansas PCMH Enrollment

AmBetter of Arkansas will offer open enrollment for participation in the 2016 Patient-Centered Medical Home program. Any Provider practice that is currently accredited by NCQA as a PCMH practice at any level may apply for participation in the 2016 program. Please contact Provider Relations at AmBetter of Arkansas to request participation.

Send an email to: ambetterarproviders@ambetterhealth.com

Place PCMH in the subject line and a packet will be emailed for your completion.

Call us at: 1-877-617-0390 enter 3 then 5 then 3 when the phone message allows.

Note your interest in joining PCMH and a packet will be returned via email for completion.

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Connecting Across Professions is Essential

When providing continued care for those living with spinal cord injury it is essential to connect with other professions and specialists.

Physicians and their patients have access to a certified physical medicine and rehabilitation specialist, otherwise known as a physiatrist. Phone and telemedicine consultations assist in diagnosis to help make care determinations. Knowing how to provide SCI care and how to detect secondary complications such as neurogenic bladder, neurogenic bowel, pressure ulcers and autonomic dysreflexia can be a challenge. Most of these conditions require immediate treatment. Treatment varies for a patient with SCI as compared to patients without disability. If left untreated these conditions can progress and could lead to expensive emergency room visits or hospitalization. Use of the Triumph Call center can avoid emergency care and often the need to travel to Little Rock to see a SCI specialist.

SCI Care Delivery and Education in Rural Arkansas Communities.

Arkansas Spinal Cord Foundation (ASCF) launched an initiative designed to stimulate health care cost-savings through an efficient around-the-clock and evidence-based mode to advance spinal cord injury (SCI) care delivery in rural communities across Arkansas. The program also provides SCI educational webinars with CME and CEU credits offered to clinicians and care providers; and are available for individuals with SCI, their families and caregivers.

ASCF supports its collaborating partner UAMS Center for Distant Health Triumph Call Center in its effort to anchor and function as the preeminent resource for spinal cord injury (SCI) telemedicine health care. This resource provides quality care improvement through consultations, hands-on guidance, and provides the foundation's SCI education platform.

The 24/7 access is available to enhance quality of life and increase immediate care among SCI patients, families and rural providers. Telemedicine appointments and video assessments are available just by accessing the Call Center.

Treatment varies for a patient with spinal cord injury (SCI) as compared to patients without disability.

ASCF Advancing SCI Health Care in Rural Communities is made possible through grant funding provided by the Craig H. Neilsen Foundation.

Arkansas Legislative Healthcare Reform Task Force

Consultants Recommendations for Reforming the Current Traditional Medicaid Program and a Replacement for the Private Option

The Stephen Group,who is the Legislative Task Force's Consulting Firm presented their recommendations on October 7 to members of the Task Force and the Governor's Advisory Council on Medicaid of which the Arkansas AFP is represented.

Key Principles:

Providing health care access and services for low income Arkansas Residents:

Moving Residents from assistance to independence:

A commitment to wellness built around the notion of residents taking personal responsibility for their health based on increased health literacy and education:

Working to ensure that the medically frail obtain health screening and prevention services:

Improve the quality of care from providers through accountability to achieve measureable performance advances:

Enhance the program integrity to reduce waste, fraud and abuse, delivering accountability for beneficiaries, providers, carriers, and taxpayers:

Reduce the impact of uncompensated care on health care costs:

Ensure that all parties commit to providing the right care in the right setting reducing the use of inappropriate care (unnecessary emergency room visits or preventable readmissions):

Providing incentives to encourage health care providers to achieve measurable performance outcomes and bring transparent scorecards for carriers.

1. **HCIP** : Bring personal responsibility, wellness and accountability and focus on Transition and promoting "ladder of opportunity" – meaningful work engagement

2. **Traditional Medicaid**: Chose one of two overarching directions, either:
   Expand Care management through Patient Centered Medical Homes, Episodes of Care, and health home model with risk/reward and accountability for **outcomes for all populations, including elderly, and those with developmental disabilities and severe and persistent mental illness**
   Use the private sector to bring managed care to all Medicaid beneficiaries or at the minimum high cost beneficiaries

3. **Enhance** eligibility and program integrity across the entire Medicaid enterprise

4. **The Private Option** - Replace the Private Option with a new program known as the Transitional Health Insurance Program (T-HIP). Some of the primary differences between T-HIP and the private option center on a shift in focus to more personal responsibility and accountability while creating incentives for going to work (the study found that 40% of Private Option enrollees were not employed). Some of the recommended features of the new program are as follows:
   Improve the Eligibility Verification Process: Retention of Employer Sponsored Coverage – would use wrap around funds to pay premiums for employer sponsored plans to cover deductibles and co pays for those who would otherwise be eligible for Medicaid/T-HIP.

continued on page 14

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continued from page 12

Introduce Mandated Work Referral - Beneficiaries not working a set number of hours a week would be required to participate in employment related activities like job training. Failure to participate would result in maximum federally allowed premium and co payment levels
Enhance Cost Sharing – Beneficiaries with substantial assets (primary residence worth over $200,000. Or cash equivalent assets of $50,000) would be required to pay $100 per month in premiums plus $4. Per month for each $1,000 above the limited mentioned

Carrier Requirements – the Consultants recommends establishing publicly available scorecards on T-HIP carriers, benchmarked against other carriers and national data. It would also require carriers to offer education about appropriate use of emergency rooms, primary care physicians and treatment for chronic disease conditions

Employer Support - Employers who offer employer sponsored insurance who hire individuals receiving T-HIP would receive a one time payment of $1,000. To help defray the cost of traditional health insurance.
T-HIP participants would be required to sign a membership agreement requiring them to visit his or her PCP within the first six months of signing; comply with follow up instructions and agree to the work referral requirements. Failure to comply would trigger several penalties including maximum premiums and co pays. For those violating the member agreement or fail to pay the premium or other cost sharing requirements, they would be "locked out" of the program for a specified period of time.
Strengthen and streamline eligibility process and create legislative oversight – monitoring outcomes and approve significant policy changes

Governor's 7 Points:

- Mandatory HIPP – included in T-HIP (need enhanced program integrity function)
- Premiums above 100% FPL – Following wellness plan as way of avoiding premiums (or all income levels)
- Training referrals for unemployed – T-HIP
- Non Emergency Transportion – Not in T-HIP – return on investment warrants continuation
- Limit Access to private market for non workers – not included in T-HIP – premium tax impact and larger marketplace pool
- Cost Savings in traditional Medicaid – included in recommendations
- Strengthen program integrity – included in recommendations

To view the entire 60 page report by the John Stephen Group, go to: http://www.ArkLeg.State.Ar.US/assembly/2015/Meeting%20Attachments/836/IL4099/TSG%20

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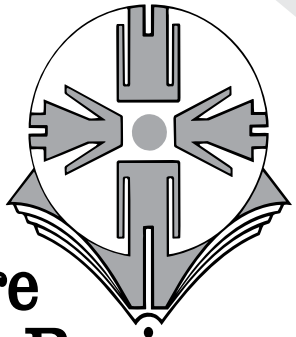

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ARKANSAS NEWS

Patient Centered Medical Home Shared Savings

2014 Shared savings payments amounting to $5.3 Million were awarded October 1 to 19 of 37 PCMH entities with payments ranging from $8,000 to $900,000. To qualify for shared savings, the PCMH entities successfully completed practice support activities, reduced overall per beneficiary cost of care and met two thirds of required quality metrics as outlined in the PCMH policy manual. Final payments are anticipated the first quarter of 2016.

Per Beneficiary Per Month Payments will be paid the first of November

If you are in your second year of the Arkansas Medicaid PCMH program, you will soon receive a request from PCMH QA for your care plans. You should download your most recent quarterly report from the AHIN portal released September 22 and compare your beneficiary list with the past quarter to identify any changes. Please contact pcmh@afmc.org for any questions or concerns.

Comprehensive Primary Care Initiative (CPCI)

On October 7 CMS announced promising results of the first shared savings performance year for the CPCI. In 2014, CPC practices showed positive quality results with hospital readmissions lower than national benchmarks and high performance on patient experience measures, particularly on provider communication with patients and timely access to care. CPC practices that demonstrated high quality care and reduced spending above a threshold shared in savings generated for Medicare. Four of the CPC initiatives regions, Arkansas, Colorado, Cincinnati-Dayton region of Ohio and Oregon generated gross savings. The Greater Tulsa region decreased costs in excess of the CPC care management fees generating net savings of $10.8 million and earning more than $500,000 in shared savings payments.

Quality highlights include: Over 90 percent of CPC practices successfully met quality targets on patient experience as determined by the Consumer Assessment of Healthcare Providers and Systems surveys and utilization (hospital admission and readmission) measures, indicating quality scores that matched or exceeded national comparisons. All regions had lower than targeted hospital readmission rates. Patients receiving care from CPC practices scored their primary care physicians highly particularly on how well clinicians communicate and on getting timely access to care.

During this first shared savings performance year, the initiative decreased Medicare Part A and Part B spending compared to spending targets while achieving high quality outcomes. The CPC initiative generated a total of $24 million in gross savings overall excluding the CPC care management fees. These results reflect the work of 483 practices serving approximately 377,000 people with Medicare and more than 2.7 million patients overall.

FULL TIME FACULTY (PRE DOC) DIRECTOR NEEDED:

The University of Arkansas for Medical Sciences, Department of Family and Preventive Medicine is seeking a full time faculty undergraduate education (Pre-Doc) Director. This position will provide both inpatient and outpatient care, as well as teach residents and medical students (OB optional). The Department is located in Little Rock and offers affordable homes and big city amenities in a small town atmosphere. Women and under-represented groups are encouraged to apply. Please contact Mrs. Jamie Rankins at JLRankins@uams.edu or call 501-686-6606 for additional information.

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From AAFP Governmental Affairs

House Passes Partial ACA Repeal in Budget Reconciliation – By a largely party line vote of 240-189 on October 23, the House passed the Restoring Americans' Healthcare Freedom Reconciliation Act (HR3762). The bill would repeal several components of the Affordable Care Act including the individual and employer mandate requirements, medical device tax and the tax on high cost health plans. The bill would also terminate the Prevention and Public Health Fund prohibit funding to Planned Parenthood for one year and eliminate the ACA's employer automatic enrollment requirement. It is not clear when the Senate will act on the measure but it does face a certain Presidential veto.

The AAFP has joined the White House Program against Prescription Drug Abuse at which President Obama announced new efforts to address the prescription drug abuse and heroin epidemic. The October 22 event highlighted the AAFP's commitment to increase:

- Family physician education in opioid prescribing practice
- The number of family physicians who complete medication assisted training for the treatment of opioid addiction and
- Overall awareness of opioid abuse and pain management

The AAFP was one of 195 organizations to sign the Friends of AHRQ letter to the House and Senate appropriators urging congressional legislators to work together to enact sequestration relief and keep the Agency for Healthcare Research and Quality's budget at $364 million for fiscal year 2016. The House Appropriate Committee bill would cut AHRQ's budget by 35 percent. The current stopgap appropriations bill expires December 11.

Congress Looks at Primary Care in the Veterans Administration - On October 22 the House Veterans Affairs Subcommittee on Health held a hearing on Evaluating VA Primary Care Delivery, Workload and Cost. The hearing was in responses to the GAO's report, VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care. The GAO found that the VA is missing opportunities to improve the efficiency of primary care service delivery through the lack of reliable data and wise variation in expenditures across VA medical facilities. The witnesses from the VHA agreed with the GAOs findings however the VA defended their progress with patient centered medical homes. The VHA stated that since the 2010 move to the PCMH model of care, they have been considered a national leader with findings that patients who have been placed in well implemented medical homes have had lower hospital readmission rates, improved levels of patient satisfaction and higher results on measures of quality care.

Joint Letter Sent to HHS on Quality Measure Funding – In a coalition letter sent to HHS and CMS on October 7, medical organizations asked for funding to be used for the development of quality measures and for technical assistance to small practices under the Medicare Access and CHIP Reauthorization Act (MACRA). The letter called for timely and targeted funding for these two activities critical to the success of physician payment reform. The letter called the CMS to fund these activities and to give priority to efforts generated by or in concert with the medical profession.

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Thomas Bodenheimer, MD, MPH, professor emeritus of Family and Community Medicine and co-director of the Center for Excellence in Primary Care, University of California, San Francisco

Stop Whining, Start Leading: Reclaiming the Future of American Health Care

Halee Fischer-Wright, MD, MMM, CMP, president and chief executive officer of the Medical Group Management Association, Englewood, CO

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- **Practice Management Bootcamp:** Participate in a half-day workshop for residents and new faculty (extra fee).
- **Invited Presentations on the Family Medicine for America's Health Core Topics:** Topics covered will include practice, payment, workforce, technology, research, and engagement.
- **Coding Conundrums Workshop:** A preconference workshop on billing and coding (extra fee).
- **Joint Exam and Injections Workshop:** A preconference workshop by the National Procedures Institute (extra fee).
- **Invited Sessions:** Topics will include direct primary care, social determinants of health, meaningful use, medical Spanish, and the changing environment of payment reform.

Visit www.stfm.org/cpi to learn more and register

This conference is produced by the Society of Teachers of Family Medicine with support from the American Academy of Family Physicians.

ARKANSAS MEMBERSHIP NEWS

Invoices for 2016 membership dues for the American and Arkansas Chapter were mailed in mid October. There were 68,449 invoices mailed to Active members in the U.S. compared to 67,693 mailed last year! Please pay your dues direct to the American Academy of Family Physicians!

In our state, we now have a total of 1266 members in all categories with 846 Active: 4 Inactive: 96 Life; 152 Residents: 165 students and 3 Supporting members.

Of our Active members, 611 are Male: 233 Female - No response from 2: 153 are Fellows of the AAFP: 686 are U.S. Medical School Graduates and 802 are FP Residency Trained.

The largest number of our Active members are between the ages of 40 and 44.

RE-ELECTIONS DUE 12/31/15

Our Chapter has 99 Active members who are due to be re-elected 12/31/15 that do not yet have the necessary CME hours. Please remember to qualify for re-election, a total of 150 hours of CME must be reported to the AAFP by 12/31/15 of which 75 must be "Prescribed" credit or formal courses and 20 hours must be "live" courses. If you need any help with reporting your hours, please give us a call at 1-800-592-1093 or 501-223-2272 or call the AAFP at 1-800- 274-2237.

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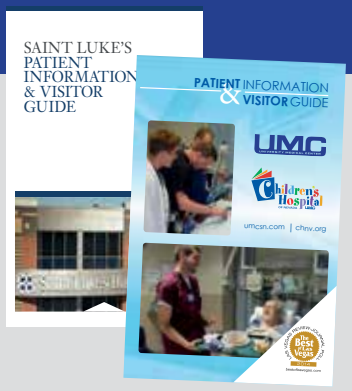

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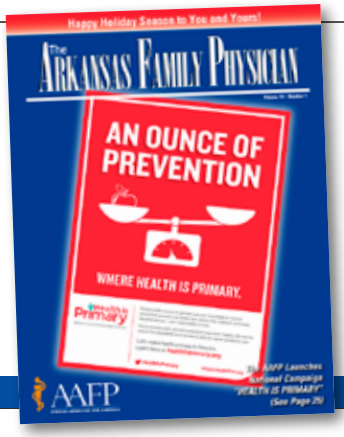

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For a Better State of Health

Screening for Hazardous Alcohol Use

By David A. Nelsen, Jr., MD, MS

Approximately 20 percent of patients who present to a primary care physician (PCP) have high-risk alcohol use or alcohol use disorder (AUD). The physical, mental, social and societal effects of alcohol use are immense and non-controversial. The identification and management of patients with high-risk alcohol use and AUD is a high priority for the medical community; however, evidence exists that these entities are commonly overlooked.[1]

In their 2013 guideline statement, the U.S. Preventive Services Task Force (USPSTF) recommends routine screening for alcohol use in adults over age 18.[2] Additionally, it recommends counseling interventions for patients with high-risk alcohol intake (as opposed to patients with AUD who generally require specialty treatment).

The USPSTF specifically recommends the Alcohol Use Disorders Identification Test (AUDIT) and the abbreviated AUDIT-Consumption (AUDIT-C). The AUDIT-C consists of three questions and takes approximately one minute to complete. The AUDIT, a 10-item scale, takes less than five minutes to complete. The USPSTF also recommends the National Institute on Alcohol Abuse and Alcoholism (NIAAA) single-question screening. These instruments are all sensitive for the presence of high-risk alcohol use and AUD.

The management of high-risk drinking behavior as well as co-management of patients with AUD is clearly within a PCP's scope of practice. The PCP may be the only physician that a high-risk drinker will encounter; this provides a crucial opportunity to address the problem.

The NIAAA has published a clinical guide[3] and an evidence-based review[4] that function as a tool kit for clinicians who wish to improve their management of patients with high-risk alcohol use. The guide includes tools necessary to undertake quality improvement activities to identify and manage patients with high-risk drinking behavior and AUD.

Identify high-risk drinking

Current guidelines recommend that men under age 65 should consume no more than four "standard" drinks per day or 14 drinks per week. Men over age 65 and all women should consume no more than three drinks per day or seven drinks per week. The NIAAA recommends that, following a pre-screening question (alcohol yes/no), physician practices should use either a written self-report tool (AUDIT) or the verbal single-question screen, "How many times in the past year have you had five [for men] or four [for women and adults older than 65 years] or more drinks in a day?" One or more is considered a positive response. These screening activities can be done by a non-physician as part of an office visit intake. Patients who consume alcohol above these limits should be reminded of the recommended limits and your openness to discuss the topic. Perform re-screening annually. Physician offices, emergency departments and hospitals should routinely screen for alcohol use.

Identify AUD

Those who screen positive for high-risk drinking should receive additional evaluation to determine if there is a maladaptive pattern of alcohol use, AUD.

Under DSM-IV, alcohol abuse (problems with work, family, law, etc.) is differentiated from alcohol dependence (tolerance, withdrawal, inability to quit). The NIAAA tool kit contains a questionnaire, derived from DSM-IV, to facilitate this step. Patients who exhibit high-risk drinking behaviors without a DSM-IV diagnosis may still be at risk for accidents, medical problems and future AUD. The clinician should clearly state that the patient is drinking more than is considered medically safe and address the patient's readiness to change. Brief counseling interventions in a primary care setting are effective in patients who engage in at-risk drinking behaviors, and they should be customized to the patient's needs.

Advise patients with AUD to abstain from alcohol use. The clinician should consider referral to an addiction medicine specialist, particularly if there are indications of alcohol dependence. A mutual help group such as Alcoholics Anonymous may prove beneficial. Comorbid mental health conditions are common in patients with alcohol use disorder; these must be identified and managed.

Follow-up with a physician is important as it is for any chronic health issue. Patients who are successful should be commended and encouraged. Patients who are not successful should continue to receive your support and care.

Medication treatment

Medication therapy has been shown to reduce drinking behavior and prevent relapse. The Food and Drug Administration has approved acamprosate (Campral), naltrexone (ReVia) and disulfiram (Antabuse) for the treatment of alcohol use disorders.

continued on page 26

TODAY, ALCOHOL WILL CONTRIBUTE TO

241 deaths in the United States.

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

continued from page 24

A 2014 Agency for Healthcare Research and Quality (AHRQ) clinical effectiveness review found modest support for the use of acamprosate and naltrexone to treat alcohol use disorders.[5] AHRQ did not find sufficient evidence to recommend other medications as useful in the management of AUD.

Acamprosate (Campral) acts on GABA and glutamate and is thought to mitigate the symptoms of protracted abstinence. Although clinical trials have had mixed results, acamprosate may be more effective for patients with a prolonged history of alcohol dependence. Naltrexone is an opioid antagonist that blocks the "reward center." It can reduce the craving associated with alcohol abstinence. Naltrexone comes in both an oral form as well as an injectable preparation that can be dosed monthly.

Alcohol use is prevalent in modern society. According to the Centers for Disease Control and Prevention, as many as 24 percent of men and 15 percent of women are binge drinkers. At the end of the spectrum are patients with AUD. PCPs should implement specific strategies to identify and manage these patients All patients who drink should be reminded of the evidence-based maximum safe drinking limits. PCPs should offer individualized recommendations to patients who drink too much in an effort to lower their risk and prevent progression to AUD. Patients with AUD should receive specific treatment including referral to addiction medicine specialists. All patients should receive ongoing management, support and guidance.

Dr. Nelsen is associate professor, Family and Preventive Medicine, University of Arkansas for Medical Sciences.

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

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From AAFP NEWS NOW:

Arkansas Shared Savings Initiative Sparks FPs' Interest

■ Program Shows Promise in Improving Care for Medicaid Beneficiaries

September 28, 2015 02:56 pm
Michael Laff

Tracking down rural patients after they leave their primary care physician›s office can be as difficult as counseling them to change their health habits. So family physician Julea Garner, M.D., gives her staff in Hardy, Ark., the same instructions for every patient regardless of his or her condition: "Make sure we have a current address and phone number."

Arkansas family physician Drew Dawson, M.D., examines a young patient who has come in for a well-child visit with her dad.

One of the basic tenets of primary care is keeping in touch with patients, and it's especially important in an era of payment reform that rewards continuity of care. But even in an age of smartphones, email and social media, maintaining that connection is not always easy for rural physicians. Patients may change phone numbers frequently or fill out office paperwork with a temporary address. It's just one of many complications that rural physicians wrestle with.

Because of Arkansas' extensive rural areas, the state is a testing ground for health payment reform projects. One that has attracted some primary care physicians is the Arkansas Health Care Payment Improvement Initiative,(www.paymentinitiative.org) which includes an episode-of-care component for acute conditions and a patient-centered medical home (PCMH) program(healthaffairs.org) to improve care coordination. Practices do not have to be recognized as PCMHs to participate.


© 2015 Courtesy of Drew Dawson, M.D.

An estimated two-thirds of all Medicaid providers in the state are enrolled in the program, which requires participating practices to have a minimum of 300 Medicaid patients to receive a per-member, per-month medical home support payment. Eligibility for shared savings requires at least 5,000 Medicaid patients -- a number that most practices cannot meet, so the state allows practices that have the same tax ID to pool their patients.

Three physicians shared their experiences and thoughts about the state's initiative with *AAFP News*: two who are finishing their first year in the program and Garner, who recently applied to take part.

Patient Attribution

One year into the program, Lonnie Robinson, M.D., said he hopes the initiative succeeds, but he wonders whether the investment was worth it if his practice does not receive shared savings.

Overall, early returns for the program have been modest, Robinson explained, with net savings to the state's Medicaid program totaling $9 million in its first year. Still, he said, he remains optimistic

"That's a drop in the bucket (in terms of total cost), but it's certainly promising," Robinson said. "Current numbers are very early, but it's obviously better than continuing to see costs rise. The first year of the program is not typically when such programs see big returns in terms of cost savings because practices are still adjusting to the new paradigm and getting organized. The model has promise if it is given time to work."

Medicaid initiated the medical home program and pays $4 per member, per month. Blue Cross entered the program this year and pays $5 per member, per month.

"It is a potential new revenue stream that requires some changes, but it largely fits what we already do," said Robinson, who is one of eight primary care physicians in a practice based in Mountain Home.

To optimize his participation in the program, Robinson began delegating more tasks to staff. For example, he recently hired a scribe to handle electronic health record (EHR) data entry.

Lonnie Robinson, M.D., and staff nurse Sally Hambelton, R.N., review patient records at Robinson's Mountain Home, Ark., office. Robinson is participating in an Arkansas payment reform initiative.

"It frees me up to take care of patients instead of spending time pointing and clicking," he explained.

The Arkansas PCMH program involves selecting high-priority beneficiaries the practice sees twice a year and for whom the care team must develop detailed care plans. Medicaid assists by providing practices with a list of candidates based on claims data. Practices can then select the list as a default, or they may modify their selection based on what they know about their patients.

The program is not without its challenges, Robinson, acknowledged, with patient attribution proving to be particularly vexing. One of the program's performance measures requires the practice to follow up with a patient within 10 days after a hospital discharge. There is only one hospital in the area, so Robinson expected the practice's scores to be high. He discovered from reports that they were not.

One problem is that if a patient listed Robinson as his physician when applying for Medicaid -- despite, for example, not having visited the office for a decade -- the practice loses points if that patient fails to follow up after a hospital discharge. For that reason, patients who have moved or who are no longer considered active should not be counted for attribution purposes, said Robinson.

The program tracks several performance targets, such as the percentage of

beneficiaries who receive a hemoglobin A1c test at least once a year and the proportion of patients with congestive heart failure who are prescribed beta blockers. Because of the limited time the practice has participated in the program, however, Robinson said it has been difficult to determine whether the practice has qualified for shared savings. Medicaid will make a final determination by October.

Faced with that uncertainty, Robinson asked Medicaid officials whether the practice would receive shared savings if it lowers costs but comes up a few points short in meeting some performance targets. The state responded that practices are not expected to excel in every area and will not be downgraded for not doing so.

That's good news, according to Robinson.

"It could be a great thing for the state," he said. "If the system is perceived as fair, the number of participants will go up. If the financial incentives are seen as unobtainable, many practices may choose to withdraw or stay on the sidelines. For now, we feel it has been a good program for both patients and providers."

Working With EHRs

Garner, a former president of the Arkansas AFP and current chapter delegate to the AAFP Congress of Delegates, recently applied to participate in the initiative and will begin reporting in January.

Long an advocate for a comprehensive approach to care that showcases high-quality primary care, Garner said she supports that key concept behind the Medicaid initiative. Still, she added, the documentation requirements and ongoing technology hiccups could be problematic.

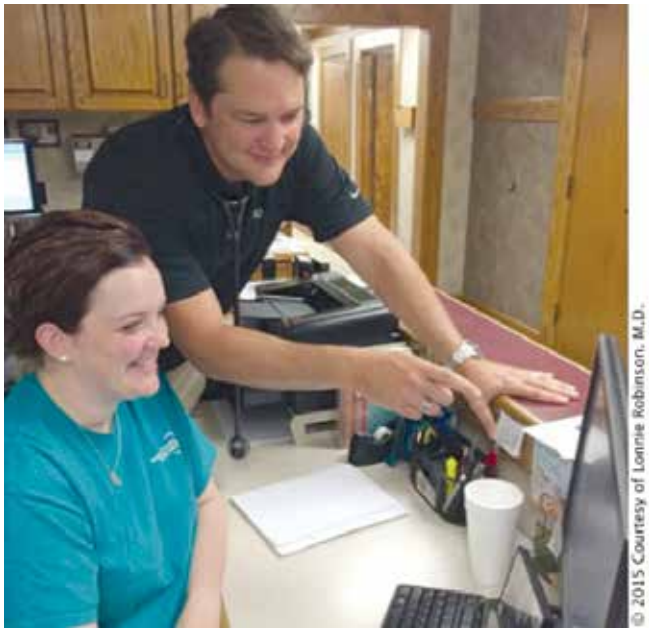
For example, with a practice panel that includes 700 Medicaid patients, Garner thinks combining practices to reach the 5,000-patient threshold needed to qualify for possible shared savings could pose problems because the practices will be graded as a group, not individually.

"If I improve and they don't, I don't get shared savings," she explained.

Another concern for Garner is the expectation that participating practices use their EHRs in coordination with those of other facilities as if they were all part of an integrated network -- when in reality, they are not.

As her family physician peers have previously noted, EHRs are often not well-suited to recording population health metrics. In Garner's case, staff members may speak with patients about smoking and mammograms -- as required for reporting -- only to discover that those data are not captured in the EHR. Similarly, foot exams for patients with diabetes, another requirement, are not reflected in the record.

Although Garner can certainly see the value in tracking these health factors in her patients, she is hesitant to invest in the expensive software upgrades needed to bring her EHR into compliance with the state's reporting protocols.



© 2015 Courtesy of Lonnie Robinson, M.D.

"The concept of team-based care and caring for patients is embedded in family medicine," she explained. "The tracking and giving information to a payer instead of patients is not what we have been about."

The Patient's Role

Connecting with patients is a big issue for Drew Dawson, M.D., who struggles to maintain contact with patients who either have no phone number or sometimes turn their mobile phones off. And attempts to reach patients by mail often result in a "return to sender" response because they've given office staff a temporary address.

The lack of reliable contact information makes chronic care management a tough task, he said, but he has a solution in mind.

"We're probably big enough for a care coordinator," said Dawson, who is based in Pocahontas, Ark. "We need someone who can figure out how to reach them."

Fortunately, the practice is using EHRs to ensure that patients who are due for a colonoscopy, an immunization or other preventive services are closely monitored. As a result, patients with chronic conditions such as diabetes are receiving more attention and suffer fewer ill effects from their disease.

But even though technology may help physicians stay up-to-date with care management, it cannot influence patient behavior. Dawson recalled instances in which he wrote out medication instructions and then asked the patient whether the instructions were clear. Sometimes, he said, the patient would say yes and leave the office, only to call back later to say he forgot the instructions or lost the paper altogether. Other times, a patient would fail to learn to use an insulin pump properly while professing that she could handle the process.

With greater accountability for patient care resting with the physician, Dawson hopes patients will take a more active role in their health.

"We used to joke that you need to pay an individual to drive to a patient's house to put a pill in their mouth," he quipped. "For some patients that may be cost-effective, but you are shifting the patient's responsibility to somebody else."

Yet despite the drawbacks and uncertainties, Dawson is in the process of reapplying to participate in the medical home initiative.

"In the long term, if we see that it moves the cost curve in the desired direction and saves money, there is no major downside," he said.

From AAFP NEWS NOW:

Survey shows More physicians Ready for ICD 10

Many Family Physicians, in a recent survey report that they were prepared for ICD 10 that began October 1. Medicare, Medicaid and private insurers will no longer accept billing without ICD 10 codes. The new code set contains more than 68,000 codes compared with just 13,000 for ICD 9.

CMS announced that during a one year grace period (http://aafp.org/news/practice-professional-issues/20150707icd10transition.html) CMS will not deny claims based on which code is selected as long as the selection is from an appropriate range of ICD 10 codes. Practices that participate in incentive programs will not be penalized for coding misteps during the grace period. CMs has also indicated it will work with practices that are still adapting to the changes, but it will not accept claims that use both ICD 9 and ICD 10 codes.

From Family Practice Management are "Coding Common Gastrointestinal Problems under ICD 10": "Documentation Elements for Common Diagnoses." For more information on the Major Differences for Five common diagnoses and for articles to assist you, please access Family Practice Management, http//www.aafp.org/fpm/icd10) for several articles and coding appropriately with ICD 10.



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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.

SVMIC is the exclusively endorsed professional liability carrier of

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.

SVMIC® Mutual Interests. Mutually Insured.

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