Ar AFP's Pre Assembly Course "Urgent Care Potpourri" August 2

The Arkansas Family Physician

Volume 21 • Number 1

70th Annual Scientific Assembly

Thursday, August 3 – 5

70th Annual Scientific Assembly

Embassy Suites, Little Rock Arkansas

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AAFP

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May 19, 2017

The Arkansas Family Physician

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

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Email: arafp@sbcglobal.net

EDITION 80

Dear Academy Member

It's that time again!! Finalization of plans are being made for the AR AFP's 70th Annual Scientific Assembly – August 3-5 at the Embassy Suites in Little Rock with the opportunity to obtain more hours at the Pre Assembly Program on "Urgent Care Potpourri" on Wednesday, August 2. We are excited to have the AAFP President Elect Michael Munger of Kansas with us for our meeting . He will provide the keynote address on Thursday morning and will preside over the Fellowship Convocation as well as the Installation of Officers. The program with registration and hotel information is on pages 13-18 of this publication.

New this year will be the opportunity to obtain even more CME hours that the Prescribed hours offered through the Transition 2 Practice opportunity. We will have more information at the assembly on what an attendee must do to obtain these additional hours.

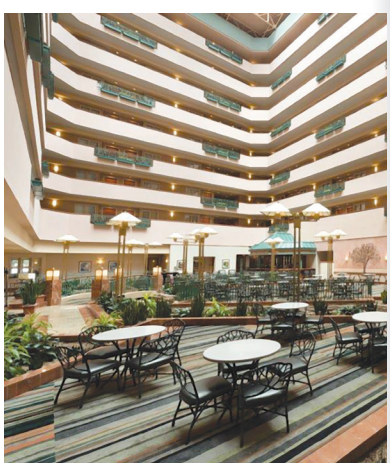
We do have a block of rooms at the Embassy during the convention dates – Double Room Suite or King Suite for $120.00 per night. Please use the link listed to obtain your room reservation under our block no later than July 12 or when the room block sells out. We look forward to seeing you in August!!

We are concerned that a nearly 100 Active members have lost their membership for failure to pay dues. Your membership is important to us. You can be reinstated by simply paying your dues to the American Academy - contact them direct at 1-800-274-2237. If you have lost your membership for CME hours, remember that there are many sources of CME that you may have missed reporting for the three year period ending 2016. A separate article is included in this issue for your convenience.

Please do not hesitate to give us a call if we can assist you in any way in reporting hours, reinstating your membership or assisting with a practice opportunity.

Carla Coleman

Executive Vice President



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ARAFP Slate of Officers and Directors Announced

To be voted upon by the members in attendance at the Business Meeting of the AR AfP on Thursday, August 3 during the Assembly will be the following slate of officers and directors as proposed by the Nominating Committee:

President Elect.....Scott Dickson, M.D., Jonesboro
Vice President.....Matthew Nix, M.D., Texarkana
Secretary/Treasurer.....Amy Daniel, M.D., Searcy
Alternate Delegate.....Jeff Mayfield, M.D., Bryant
Delegate.....Dennis Yelvington, M.D., Stuttgart

Directors:
Hunter Carrington, M.D., Hot Springs (serving a second term)
Leslye McGrath, M.D., Paragould (serving a second term)
Joseph Shotts, M.D., Cabot (serving a second term)

Resident Representative.....Caleb Dickson, M.D., Jonesboro
Student Representative..... Marissa De La Paz, Little Rock

2016 ReElection and 2017 Dues Cancellations

The Arkansas Chapter of the American Academy of Family Physicians had 114 members canceled as of May 2. The majority of these members are for non-payment of the 2017 membership dues. These dropped members will now be able to pay their 2017 dues online through the "Manage My Dues" section of the AAFP website until early August. This option only applies to those canceled for non-payment of dues. Dropped members can also provide payment for past dues by calling the Member Resource Center at (800) 274-2237 or remitting payment through the mail.

Those canceled for insufficient CME and those that have insufficient CME and still owe 2017 dues must call the Member Resource Center to be reinstated. You must have a total of 150 hours for each three year re-election cycle to include 75 Prescribed hours and 25 Group hours. These hours must have been obtained prior to December 31, 2016 but can still be reported to reinstate your membership.

Some courses that you may have failed to report would be ACLS, ATLS, and PALS as well as hospital meetings, medical staff meetings and other "enrichment" type activities which can count for some of your elective "live" credit hours. You may claim up to 25 hours each three-year period for such activities. In addition, you may claim up to 20 hours each year for teaching medical students, residents, or nurses. These hours are "Prescribed" or formal course credits.

Please do not hesitate to contact us at 1-800-592-1093, 1-501-223-2272 or arafp@sbcglobal.net if we may assist you with reporting your hours. You may also call the Member Resource Center at the American AFP to be reinstated at 1-800-274-2237!

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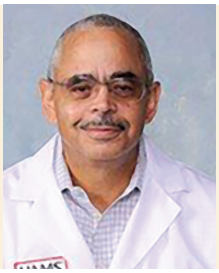
Fatal Metformin-Associated Lactic Acidosis: A Case Report



Muhammad S. Yusuf, M.D.,
Resident Physician
Steven Wright, M.D.,
Assistant Professor
UAMS (South Central) Family Medicine Residency

Introduction

Metformin is a biguanide oral anti-hyperglycemic medication used in the management of type 2 diabetes mellitus. Metformin may increase blood lactate levels and is occasionally associated with lactic acidosis.[1] Lactic acidosis is a life-threatening complication of metformin therapy with a mortality rate of 30-50%.[1,2] The estimated incidence of metformin-associated lactic acidosis is 0.03 cases per 1000 patient years.[3] Development of lactic acidosis appears to be unrelated to plasma metformin concentrations and even in persons with chronic renal insufficiency, metformin accumulation does not necessarily lead to lactic acidosis.[2,4] Development of lactic acidosis is almost always related to coexistent hypoxic conditions that are probably responsible for the associated high mortality rate. In one report, 91% of patients who developed lactic acidosis while being treated with metformin had a predisposing condition such as congestive heart failure, renal insufficiency, chronic lung disease with hypoxia, or age >80 years.[5] Thus, patients with compromised renal function or coexistent hypoxic conditions should not be given metformin. Chronic or acute intake of large quantities of ethanol may potentiate the effect of metformin on lactate metabolism. A careful history of ethanol use is therefore important before starting metformin therapy.[6] Here we present the case of a 61 year-old woman on metformin therapy at the time of hospital admission who subsequently succumbed to severe metabolic acidosis 30 hours after hospital admission.

Case Presentation

A 61 year-old African American woman presented to the ED with complaint of worsening shortness of breath over the preceding 3 weeks. Her past medical history was notable for type 2 diabetes mellitus, congestive heart failure, hypertension, hyperlipidemia and severe obesity (BMI 51). Her list of medications included metformin 1000 mg twice daily, glipizide 5 mg twice daily, pravastatin 40 mg at bedtime, Lisinopril 20mg daily, furosemide 20 mg daily and aspirin 81 mg daily. She had been previously seen by both her primary care physician as well as in the ED for this complaint and had completed three antibiotic regimens for community-acquired pneumonia without improvement and was currently on Augmentin 875 mg twice daily. She described profound fatigue, exertional dyspnea but denied chest pain. Initial vital signs showed an oral temperature 98.9 ^{o}F; blood pressure of 106/67 mmHg; heart rate 51/min; respirations 29/min and pulse oximetry 83% on room air with a GCS score of 15. An electrocardiogram showed sinus tachycardia with non-specific changes. Her breathing was labored and shallow with wheezes and coarse crackles in all lung fields. A chest radiograph showed borderline heart size but no pulmonary vascular congestion, infiltrates, or effusions. The D-dimer was 3.82 and her V/Q scan was low-probability for pulmonary embolism. Other significant laboratory findings included WBC 22.6 K/cm^3, troponin I of 0.66 ng/mL, creatinine 4.7 mg/dL (baseline 1.3 mg/dL)potassium 5.9 mMol/L, and serum lactate 11 mMol/L (see Table 1). A working diagnosis of acute renal failure with hyperkalemia, myocardial infarction and systemic inflammatory response syndrome (given her leukocytosis, tachypnea, and hypoxia on ABG) was established. She was admitted to the ICU, blood and urine cultures were obtained and she was empirically started on intravenous antibiotics with vancomycin and cefepime. A heparin infusion was started.An arterial blood gas showed pH 7.21 pCO_2 20 pO_2 73 HCO_3 8 and did not improve with increase of nasal canula oxygen from 3 to 7 LPM. (see Table 2) Her oxygen therapy was changed to BiPap given her increased work of breathing and consultation with Pulmonology, Cardiology and Nephrology staff was obtained. Her respiratory status and blood pressure continued to deteriorate

and she sustained cardiac arrest. She required intubation and mechanical ventilation and ultimately inotropic support on epinephrine, norepinephrine, phenylephrine and dopamine. She remained anuric. She received aggressive infusion of bicarbonate for worsening metabolic acidosis and lactic acidosis which was attributed to sepsis (with undefined source) with worsening leukocytosis despite antibiotics. Her respiratory failure, renal failure, hypotension and NSTEMI were considered reflection of multi-organ dysfunction from severe septic shock. She remained afebrile. Her blood cultures showed no growth. Her antibiotic regimen was adjusted to vancomycin, piperacillin-tazobactam and and levofloxacin and she was begun on stress doses of hydrocortisone. She again sustained cardiac arrest later on the second hospital day and died about 30 hours after hospital admission. After six days her blood cultures still showed no growth of organisms.

Discussion

Metformin is the recommended first-line treatment for overweight patients with type 2 diabetes. It has multiple mechanisms of action including reduction of hepatic gluconeogenesis, increased peripheral uptake of glucose and decreased fatty acid oxidation. A potential serious complication of metformin therapy, lactic acidosis, is linked with elevated plasma metformin levels and/or a coexistent condition altering lactate production or clearance. The mortality rate for metformin-associated lactic acidosis approaches 50% and metformin is contraindicated for patients with moderate or severe renal impairment to minimize potential toxic levels.[7] Routine assessment of plasma metformin levels is not readily available in all laboratories; however, plasma metformin levels measured in the emergency department can eliminate metformin as the cause of lactic acidosis if low serum levels of the drug are detected.

Metformin has little plasma protein binding and is excreted unmetabolized in the urine without direct nephrotoxic action. The half-life is approximately 6.5 hours in an individual with normal renal function but is extended in patients with renal failure.[8] Two different types of lactic acidosis related to metformin therapy have been proposed: MALA (metformin-associated lactic acidosis) is caused by metformin accumulation in the presence of precipitating factors such as dehydration or acute kidney injury. Less common is MILA (metformin-induced lactic acidosis) where metformin seems to be the only cause of lactic acidosis without apparent associated pathology and is usually related to acute intoxication.[9] Identified risk factors for MALA include acute kidney injury, hypoxemia, sepsis, alcohol abuse, liver failure, radiologic contrast media administration, myocardial infarction, and shock.[10]

It has been questioned whether metabolic acidosis with increased lactate levels occurs with routine metformin use. A large systematic review of therapeutic RCTs and cohort studies revealed no difference between mean serum lactate levels in patients on metformin therapy compared with controls although this analysis did not include any overdose cases.[11]

The most common features of metformin-associated lactic acidosis are related to the gastrointestinal tract (e.g., nausea, vomiting, and diarrhea), followed by an altered mental status, shortness of breath, hypothermia, and hypotension.[12] The presence of an anion gap does not predict clinically significant hyper lactatemia, so all patients with unexplained metabolic acidosis should have measurement of serum lactate.[13]

In this patient the focus of the treatment team was on establishing the underlying cause, and treating, suspected sepsis which was assumed to be the cause of metabolic acidosis. Her clinical presentation with SIRS coupled with her history of repeated treatment for pneumonia and current antibiotic treatment focused the attention of her physicians on this diagnosis. Her hyperlactatemia was initially attributed to sepsis and serum metformin levels were not obtained and in fact MALA was not suspected until very late in her clinical course. Indeed, although hemodialysis was actively considered for her given her anuria and acute kidney injury, her hypotension precluded this. Since metformin has a low molecular weight and plasma protein binding is negligible, it can be removed by dialysis (up to 170 mL/min under good hemodynamic conditions).[14] However, even in the face of hypotension, continuous hemofiltration might have improved the clinical outcome in this case.[15]

This case highlights the importance of considering a broad differential for SIRS. SIRS is nonspecific and can be caused by ischemia, inflammation, trauma, infection, or several insults combined. For patients presenting

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with acidosis and hyperlactatemia who are taking metformin, a high index of suspicion for metformin-associated lactic acidosis should be maintained. The unavailability of rapid determination of serum metformin and the inconsistent association between metformin levels and hyperlactatemia dictates physicians be hypervigilant. Clinical awareness in the setting of metformin use with SIRS and lactic acidosis should prompt consideration of MALA as a primary diagnosis. This will enable the treating physician to aggressively pursue hemodialytic therapy to offset the high morbidity and mortality of metformin-associated lactic acidosis.

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Table 1. Selected Laboratory Values for Case

	Admission	8 hours	17 hours	22 hours	24 hours	26 hours
WBC(Thousand/cm^3)	22.6	25	30	35.7	25.8	25.9
Segs (%)	81	77	73	82	85	85
Hgb (g/dL)	11.0	10.8	10.3	10.3	8.2	8.4
Hct (%)	35.9	35.8	34.1	34.5	27.1	28.2
Plts (Thousand)	191	187	175	151	114	122
Sodium (mMol/L)	136	141	142	142	155	154
Potassium (mMol/L)	5.9	6.7	6.4	6.5	5.2	4.8
Chloride (mMol/L)	100	99	97	94	95	98
Carbonate (mMol/L)	11	10	13	13	26	16
BUN (mg/dL)	62	68	72		71	66
Creatinine (mg/dL)	4.7	5.2	5.9		5.1	5.3
GFR (mL/min; calc'd)	11	10	8		10	10
Troponin I (ng/mL)	0.681	0.666	0.687			
Lactic Acid (mMol/L)	11			14.7		17.6

Table 2. Arterial Blood Gas Analysis

	8 hours	12hours	20 hours	22 hours	24 hours	26 hours	28 hours
pH	7.210	7.020	7.120	6.810	6.870	7.130	7.160
paCO2	20.0	28.0	30.0	43.0	34.0	43.0	48.0
pO2	73.0	83.0	105.0	139.0	123.0	119.0	107.0
HCO3	8.0	7.2	9.8	6.8	6.2	14.3	17.1
O2 LPM	3.0	7.0	------	-----	-----	-----	-----
FiO2			50%	100	100%	100%	100%

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Part 3

The evolution of pharmacy in Arkansas

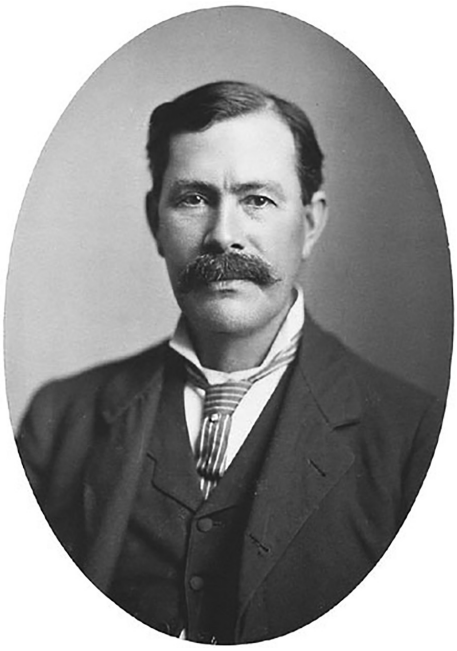
by: Sam Taggart, M.D.,
Family Physician and Author

With the formulation and acceptance of the Germ Theory in the 1860's, medicine including pharmacy underwent a revolution. Important labs in the northern Europe and especially those of Dr. Robert Koch in Germany began the process of identifying the various microscopic organisms that were at the root of many of the major diseases; the bacteria that cause tuberculosis, anthrax, cholera and typhoid were among the first to be identified. These same labs then turned their attention to developing vaccines and anti-toxins. In a number of cases, for the first time in history the medical profession had something other than quarantine and surgery that was effective in dealing with disease.

As noted in a previous article, in the post-Civil War Era what began as local apothecary shops slowly morphed into what we think of the major multinational drug manufactures: Glaxo Smith Kline, Abbott Laboratories, Eli Lilly and Upjohn are good examples.

Another important element in this story began in the 1880's when German dye makers began to isolate individual organic compounds from coal tar and other mineral sources. Organic chemical synthesis became a reality and scientists began to vary the structure of chemical substances and explore the biological effect of these changes. Beecham, Pfizer, Bayer, Roche and CIBA companies are examples of this movement.

As in other parts of the United States, professionalism began to emerge. The first attempt at organizing the Arkansas medical profession was a licensure law passed in 1831 by the legislature. This early attempt at licensing physicians was vetoed by then Governor Pope. The American Medical Association was created in 1847. The first attempt at



establishing a local Medical Society in Arkansas was the Crawford County Medical Society in Van Buren created by Dr. James Dibrell in the 1840's. In the early 1870's the first iteration of the Arkansas Medical Society was created; it smoldered in controversy for several years. Later in that decade a second association was established and it was successful. During the Yellow Fever epidemics of the late 1870's the leadership of this new organization, with the help and acquiescence of the Governor was successful in creating a funded statewide board of health. Within two years and the passing of the Yellow Fever threat, the State Board of Health folded and was replaced by temporary local boards of health until the 1910's when the Permanent State Board of Health was created. The new Arkansas Medical Society persisted.

In 1882 the Arkansas Association of Pharmacists was founded. These men were primarily physicians who had chosen to devote their time and efforts to pharmaceuticals. Prominent in the formation of this organization were representatives from several areas of the state including Little Rock, Fort Smith, Batesville, Hot Springs and Pine Bluff. Several of these men including Dr. John B. Bond (we discussed his emergence in a previous article), Dr. J.J. McAlmont, J.E. Gibson, E.J. Schaer played leading roles in the AAP over the next few years. Over the next nine years several attempts were made to pass a Model Pharmacy Act. All of these attempts failed until 1891 when a bill was passed and the Arkansas Board of Pharmacy was created. This was a board of five registered pharmacists appointed by the governor who would examine prospective pharmacists, issue licenses, and prohibit the sale of adulterated drugs.

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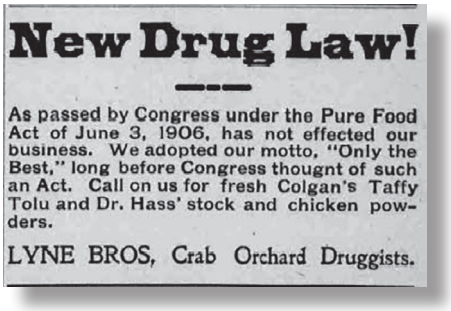
The Federal Pure Food and Drug Act of 1906 was a piece of Progressive Era legislation that went a long way toward forcing drug manufacturers into accurate labeling of the contents of the products that were sold to the public in interstate commerce. The act also specified that the purity levels could not fall below that of the USP-NF. Soon after the federal legislation was passed, the Arkansas Medical Society began an effort to "require all patent and proprietary medicines sold in the state to have their formula printed on the label." Dr. Bond and AAP reluctantly joined forces with the medical society. The first bill before the legislature called the Patterson-Black Bill caused a split between the two societies and was defeated in the legislature and a second, more conservative bill, called the Greenhaw Bill proposed by Senator Frank Greenhaw closely followed the Federal Pure Food and Drug Act. It required that all medicinal preparations be labeled to disclose the amount of alcohol, opium, morphine and other drugs unless the drug was prescribed by a physician or was on the National Formulary. What the law did not accomplish was require the manufacturer to list a formula of the active ingredients in the product. In fact, the law was far more conservative than the Patterson-Black Bill; it was more reform than regulation. In the next couple of years over twenty states passed similar legislations.


New Drug Law!

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The next major step in the manufacture, distribution, sale and use of potentially dangerous drugs was the Federal Harrison Narcotic Act of 1914. In the 19th century opiates and cocaine were completely unregulated. By 1911 opiate addiction had become a major problem in the United States; three out of four of these addicts were women who used physician or pharmacist prescribed drugs for "female complaints." The law was an attempt to reduce the use and distribution of narcotics and cocaine. A clause in the act allowed for the distribution by physicians of these products "in the course of professional practice only." Clearly, limiting the prescribing of these products to physician prescription only was not the primary focus of this law but it went a long way in instilling that tradition in our medical world.

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

70th Annual Scientific Assembly

Wednesday, August 2 – 1:00 P.M. – 4:15 P.M. - PRE ASSEMBLY CME
"Urgent Care Potpourri"

Thursday, August 3 – 5
70th Annual Scientific Assembly
Embassy Suites, Little Rock Arkansas

Arkansas Academy of Family Physicians 70th Annual Scientific Assembly

"URGENT CARE POTPOURRI"

Wednesday, August 2, 2017

Pre Assembly: - 1:00 p.m. – 4:15 p.m.

Wednesday August 2

1:00 p.m.	***"How to Prepare for Office Emergencies"***
	Barry Pierce, M. D. , Family Physician and Emergency Physician, Mountain View, Arkansas
1:45 p.m.	***"Pediatric Emergencies"***
	Amanda Hollingsworth, M.D., Assistant Professor, Department of Pediatrics, Emergency Medicine, Arkansas Children's Hospital/University of Arkansas for Medical Sciences, Little Rock, Ar
2:30 p.m.	***"Cardiovascular Emergencies"***
	Barry Tedder, M.D., Interventional Cardiologist, St. Bernard's Medical Center, Jonesboro: Chair – Arkansas STEMI Advisory Council, Arkansas Department of Health
3:15 p.m.	***"Stroke Recognition"***
	Rachel Freeze Ramsey, M.D. , Emergency Medicine Physician – Assistant Professor, College of Medicine, UAMS: Co-Director, UAMS Stroke Center, Little Rock, Ar
4:15 p.m.	Adjourn

Thursday, August 3

8:15 a.m.	**Opening Ceremony –** Honor Guards, National Anthem
8:30 a.m.	**KEY NOTE SPEAKER –** ***"The Future of Family Medicine"***
	Michael L. Munger,M.D.,FAAFP, Family Physician, Overland Park, Kansas; President Elect, American Academy of Family Physicians
9:15 a.m.	***"Psoriasis : A Primary Care Perspective"***
	Mark Thomas Jansen, M.D., Diplomate, American Board of Family Medicine: Associate Professor, Department of Family and Preventive Medicine; Medical Director, UAMS Regional Programs (AHECs), University of Arkansas for Medical Sciences, Little Rock, Ar
10:15 a.m.	**Break –** Visit Exhibits
10:45 a.m.	***"Update on Hot Topics in Therapeutics"***
	Dosha Cummins, PharmD, BCPS; Associate Professor, Vice Chair of Basic Sciences, NYIT@AState, Jonesboro, Ar
11:30 a.m.	**Business Meeting and Fellowship Convocation**
12:00 p.m.	**Physician Lunch Meeting –** State Volunteer Mutual Insurance Company
	"The Business Side of Medicine"
	Thomas H. Stearns, FACMPE, VP, Medical Practice Services, State Volunteer Mutual Insurance Company, Brentwood, Tennessee
1:20 p.m.	**Break -** Visit Exhibits
1:45 p.m.	***"Pre and Post Exposure Prophylaxis of HIV"***
	Keyur S. Vyas, M.D., Associate Program Director: Assistant Professor, Internal Medicine, Division of Infectious Disease, University of Arkansas for Medical Sciences, Little Rock, Ar
2:30 p.m.	***"Update on NYIT COM"***
	Shane Speights, D.O., Dean , NYIT College of Osteopathic Medicine, Jonesboro, Ar
3:00 p.m.	***"The Return of the NICU Neonate to the Community Physician"***
	Douglas Seglem, D.O., Clinical Assistant, Professor, Department of Pediatrics, Section of Neonatology, Medical Director, St Bernard's Medical Center NICU, Jonesboro, Ar
3:45 p.m.	***"Dermatology Update"***
	Scott Dinehart, M.D., Dermatologist, Arkansas Skin Cancer and Dermatology Center, Little Rock, Ar

Friday, August 4:

7:00 a.m.	**Breakfast Meeting**, Arkansas Foundation for Medical Care ***"Addressing Arkansas' Prescription Drug Abuse Epidemic"*** Jan Caldwell, LCSW, M.Ed, Assistant Director, MidSOUTH Center for Prevention & Training George Konis, M.D., Medical Director of Substance Abuse Treatment, The Bridgeway
8:20 a.m.	**Break –** Visit Exhibits
8:40 a.m.	***"Adverse Childhood Experiences"*** Leanne Whiteside- Mansell, Ed.D., Professor, Department of Family & Preventive Medicine: Director, DFPM Research and Evaluation Medicine – RED, College of Medicine, University of Arkansas for Medical Sciences, Little Rock , Ar
9:20 a.m.	***"Managing Anxiety in Children and Adults"*** Peter Jensen, M.D., Professor and Director of Training and Research: Director, PSYCH TLC Program, Child & Adolescent Psychiatry, University of Arkansas for Medical Sciences, Little Rock, Ar
10:00 a.m.	***"Ask the Chair"*** Representative Jeff Wardlaw, Chair, Public Health and Welfare Committee of the Arkansas House of Representatives
10:30 a.m.	**Break –** Visit Exhibits
11:00 a.m.	***"Cervical Cancer Screening"*** Erin Large, M.D., Obstetrics/Gynecology: HerHealth, Washington Regional, Fayetteville, Ar
11:50 a.m.	**Installation of Officers** – Ballroom I,II, III
12:15 p.m.	**Installation Lunch** – Ballroom IV
12:40 p.m.	**Final Exhibit Visitation**
1:15 p.m.	***"Tick Borne Disease"*** Robert Bradsher, M.D., Professor of Medicine, Division of Infectious Disease, Department of Internal Medicine, University of Arkansas for Medical Sciences, Little Rock, Ar
2:00 p.m.	**TED TALKs –** Men's Urological Health ***"Overactive Bladder Benign Prostatic Hyperplasia and Hematuria"*** Tim Goodson, M.D., Urologist, Arkansas Urology, Little Rock, Ar ***"Prostate Cancer and Screening"*** Tim Langford, M.D., Urologist, Arkansas Urology, Little Rock, Ar ***"Value of Pathway Management & MACRA/MIPs Payment Systems"*** Scot Davis, M.B.A., C.M.P.E., Chief Executive Officer, Arkansas Urology, Little Rock, Ar
3:10 p.m.	***"Basic Principles of Healing Chronic Wounds"*** Angela K. Driskill, M.D., FAAFP, Diplomate, American Board of Family Medicine; DABPM/UHM; PWCC, AAFPWCA; Advanced Wound Care and Hyperbarics, P.A., North Little Rock, Ar
4:00 p.m.	***"2017 Legislative Update: Medical Marijuana and Other Laws Impacting Physicians"*** Jennifer Smith, JD, RN, Associate General Counsel, University of Arkansas System, University of Arkansas for Medical Sciences, Little Rock, Ar
5:00 p.m.	**Adjourn**

Saturday, August 5

7:30 a.m.	**Breakfast –** Ballroom IV
7:50 a.m.	**TED TALKs:** ***"The Miracle Drug"* –** Ross Halsted, M.D., Family Physician, Harrison, Ar ***"Stroke and STEMI System for Arkansas"* –** Appathurai Balamurugan, M.D., DrPH, MPH
Ballroom I, II, III	
8:40 a.m.	***"Physician Burnout"* –** Jeffrey Mayfield, M.D., Family Physician, Bryant, Ar
9:40 a.m.	**TED TALKs** ***"End of Life Care"* –** Leslye McGrath, M.D., Family Physician, Paragould, Ar ***"ADHD and Insomnia"* –** Matthew Nix, M.D., FAAFP, Family Physician, Texarkana, Ar ***"Scribes in the Medical Practice"* –** Lonnie Robinson, M.D., FAAFP, Mountain Home, Ar
10:45 a.m.	**Adjourn**

GENERAL INFORMATION

PROGRAM OBJECTIVES

Physicians attending this program will receive current information on a diversity of medical topics pertinent to patient care in a Family Practice setting. Subject material was chosen based on assessed needs, future trends and relevance to quality patient care. At program conclusion, registrants will have a working and applicable understanding of the topics presented and will be provided with written materials for future reference provided by each speaker. This meeting will also allow for residents, medical students, Family Physicians, educators and faculty to interact academically, professionally and socially.

COMMERCIAL SUPPORT/DISCLOSURE

It is the policy of the Arkansas Academy of Family Physicians to ensure balance, independence, objectivity and scientific rigor in this educational program. All faculty participating in this program are expected to disclose any associated or apparent conflicts of interest that may affect or be related to his/her presentation. These written disclosures are included in the syllabus

ROOM RESERVATION

Embassy Suites special rate for our group is $120.00 for Double or King Rooms. For reservations, please call Embassy Suites at 501-312-9000 and specify you are with the Arkansas Academy of Family Physicians group, **GROUP CODE: AFP or you may go to our personalized website at** http://embassysuites.hilton.com/en/es/groups/personalized/L/LITCPES-PHD-20170801/index.jhtml **The deadline for making reservations for our block is July 12 or until the group block is sold out, whichever is first.**

PARKING

Complimentary surface parking is available for all meeting attendees and overnight guests or a charge of $10.00/day to park in the parking garage. Complimentary outdoor self parking available for meeting attendees and overnight guests.

CME ACCREDITATION

The Scientific Program has been reviewed and is acceptable for up to 19.5, (including the Pre-Assembly). Prescribed credits by the American Academy of Family Physicians. AAFP Prescribed Credit is accepted by the AMA as equivalent to AMA PRA Category I for the AMA Physicians Recognition Award. AAFP Presribed Credit is also accepted by the AOA, the American Academy of Physician Assistants and the American Academy of Nurse Practitioners. **Portions of the program will also include a Translation 2 Practice opportunity for additional hours.**

2017 GRANT PROVIDERS

The Arkansas Academy of Family Physicians' 70th Annual Scientific Assembly is made possible with the help of generous grants from the following companies. Please make a point of thanking your representative for these contributions to our program. These companies will also receive special recognition through signs and ribbons in our exhibit hall.

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Registration Fee includes admittance to all functions and social events. Please wear your name tag at all times for admittance.

Cancellations prior to July 14, 2017 will be refunded less $50.00 by written request.

IRS Tax Information - Registration fees for this meeting may count as a business donation, not as a charitable contribution.

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AR AFP – 70th ANNUAL SCIENTIFIC ASSEMBLY

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Scientific Assembly Fees – 8/3-8/5

Academy Members -	$425.00	Resident Members -	No Charge
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Inactive\Life -	$150.00	Spouse\Guest -	$40.00

Wednesday, 8/2 Pre Assembly Fee - $150.00 All Registrants

To Obtain Free Registration, Students and Residents MUST PRE-REGISTER!

Complete And List Appropriate Fees:

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Registrant Lunch – Thursday ..... _____
Registrant Breakfast – Friday..... _____
Installation of Officers/Registrant Lunch – Friday..... _____
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AAFP President Michael L. Munger, M.D., to Participate in AR AFP's Annual Assembly

Michael L. Munger, M.D., FAAFP, President Elect of the American Academy of Family Physicians will be our special guest from the AAFP for our Annual Scientific Assembly. Dr. Munger, a family physician from Overland Park, Kansas has practiced in the Kansas City metropolitan area for over 30 years and currently practices at Saint Lukes Medical Group in Overland Park where he serves as Vice President of Medical Affairs for primary care.

Dr. Munger has been a member of the AAFP since 1986 and served on numerous commissions and committees before being elected to the AAFP Board of Directors in 2013.

As the AAFP President Elect, he advocates on behalf of family physicians and patients nationwide to inspire positive change in the U.S. health care system.

He is also an active member of his local community and has volunteered for over a decade at the Kansas City Free Health Clinic.

He earned his Bachelor of Arts Degree and Medical Degree from the University of Missouri at Kansas City and completed his family practice residency at Goppert Family Practice Residency Program at Baptist Medical Center in Kansas City.

Board certified by the American Board of Family Medicine, Dr. Munger also has the Degree of Fellow, an earned degree awarded to family physicians for distinguished service ad continuing medical education.

Dr Munger will provide the Key Note Address on Thursday morning, August 3 at 8:30 a.m. He will also conduct the Fellowship Convocation Thursday, August 3 at Noon and install our newly elected officers and Directors Friday, August 4.

The 2017 membership dues invoices were mailed in October! If you have not already done so, please renew your AAFP membership now. You can pay in one of three ways:

- Return your invoice and payment in the envelope provided
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Thank you for maintaining your membership in the AAFP!

From AAFP NEWS NOW:

AAFP Recommends Against Pelvic Exams in Asymptomatic Women

■ Guidance Differs From USPSTF Final Recommendation

April 25, 2017 12:42 pm

By Chris Crawford

On March 7, the U.S. Preventive Services Task Force (USPSTF) published its final recommendation statement(www.uspreventiveservicestaskforce.org) and evidence review(www.uspreventiveservicestaskforce.org) on screening asymptomatic, nonpregnant adult women for gynecologic conditions using pelvic examination. The task force found that current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic exams in these women -- an "I" statement.(www.uspreventiveservicestaskforce.org)

After reviewing this final recommendation and scouring its evidence report, however, the AAFP has made its own recommendation against screening pelvic exams in asymptomatic women -- a "D" recommendation.

In an April 11 memo to AAFP Board Chair Wanda Filer, M.D., M.B.A., of York, Pa., representatives of the AAFP Commission on Health of the Public and Science (HOPS) Subcommittee on Clinical Preventive Services noted that malignancy and pelvic inflammatory disease are the leading gynecologic causes of morbidity and mortality in women.

"Screening for other conditions that have limited effect on morbidity or mortality (is) unlikely to provide substantial benefit," said the memo. "There is evidence of harms for performing screening pelvic exams in asymptomatic women due to the increased risk of invasive testing and unnecessary treatment. Given the low likelihood of benefit and the increased risk of harm, the AAFP recommends against screening pelvic exams."

Story highlights

- In a departure from a recent U.S. Preventive Services Task Force recommendation, the AAFP recommends against conducting screening pelvic exams in asymptomatic women.
- In its review of evidence, the AAFP focused on gynecologic conditions that cause the majority of morbidity and mortality in women: malignancy and pelvic inflammatory disease.
- In 2014, the AAFP endorsed the American College of Physicians guideline recommending against performing screening pelvic exams.

It should be noted that this was the first time the USPSTF had reviewed evidence on screening for a wide range of gynecologic conditions using pelvic examination. The task force had previously made separate recommendations on screening for cervical cancer, gonorrhea and chlamydia using tests that are often performed during a pelvic examination (e.g., Pap smear, HPV test and nucleic acid amplification tests), so screening for these conditions was not included in the USPSTF's current evidence review.

AAFP Recommendation Explained

Jennifer Frost, M.D., medical director for the AAFP HOPS Division, told *AAFP News* the USPSTF's recommendation differs from most other of its recommendations in that it is not about screening for or preventing a specific disease state. Instead, the task force considered the potential benefits of the pelvic exam to reduce morbidity and mortality.

What the USPSTF determined, said Frost, was there were many potential conditions that could be found through screening pelvic exam, but there weren't studies for all of them, which led to the "I" recommendation.

"While we agree there is insufficient evidence for all potential gynecologic conditions, the AAFP focused on those that cause the majority of morbidity and mortality in women: malignancy and pelvic inflammatory disease," she explained.

Frost said ovarian cancer is a malignancy frequently screened for with pelvic exam and there is adequate evidence that pelvic exam isn't a good screening test for this condition. The harms of pelvic exam include unnecessary laparoscopies or laparotomies, fear, anxiety, embarrassment, pain and discomfort, she added.

"Although there are not studies to determine the benefits and harms of screening pelvic exam for fibroids, we determined that the potential for improving morbidity and mortality in an asymptomatic woman with fibroids and without symptoms was minimal," Frost said.

Endorsement of ACP Guideline

On a similar note, in 2014, the AAFP endorsed the American College of Physicians (ACP) guideline(annals.org) recommending against performing screening pelvic exams.

The subcommittee members said in their memo that accepting the USPSTF's "I" recommendation wouldn't have been consistent with this stance and would actually be contradictory. However, the AAFP's "D" recommendation *is* consistent with the ACP guideline.

Like the AAFP's recommendation, the ACP's guidance was based on evidence that pelvic exam isn't an effective screening test for the main conditions that cause morbidity and mortality in women: malignancy, STDs and pelvic inflammatory disease.

"The ACP recommendation did not consider the potential benefit of screening for fibroids or pelvic floor dysfunction," the memo said. "While

the detection of these conditions in asymptomatic women may or may not affect outcomes, the potential for causing harm through evaluation and treatment is real."

Frost said it's important to remember that the AAFP's recommendation applies to asymptomatic, nonpregnant women.

"Family physicians have a lot to address with their patients, with limited time," she said. "We encourage family doctors to prioritize screening tests that have proven benefit for their patients."

Look for MIPS Participation Status Letters in May

May 08, 2017 04:03 pm
News Staff

Throughout the month of May, family physicians -- as well as certain other eligible clinicians -- will receive letters from their Medicare administrative contractors, better known as MACs, that will provide information about a practice's 2017 participation status in the Merit-based Incentive Payment System (MIPS).

In the same envelope will be a second document with additional participation information and a list of frequently asked questions.

CMS notified stakeholders about the mailing during a national stakeholder call on April 25 that focused on the Quality Payment Program(qpp.cms.gov); key AAFP staff members participated in that call.

According to *Family Practice Management's* April 27 Getting Paid Blog post, titled "Are You Participating in MIPS This Year? Watch Your Mailbox," the letters are intended to inform physicians "whether the group and the individuals within the group are exempt from the MIPS reporting requirements."

Blog author Erin Solis, an AAFP regulatory compliance strategist, writes, "CMS uses both historical claims data and data from the performance period to make this determination."

Furthermore, "Participation in MIPS requires clinicians and groups to report data in four performance categories in 2017 in order to avoid a negative payment adjustment in 2019," she writes.

CMS Launches MIPS 'Look Up' Tool

CMS just announced the launch of an online tool(qpp.cms.gov) created to help physicians and other clinicians determine their participation status in the Merit-based Incentive Payment System for 2017.

Once on the site, it's a one-step process; physicians simply enter their 10-digit national provider identifier.

Check now to ascertain your status!

According to a copy of the CMS letter that *AAFP News* reviewed, practices were identified via their taxpayer identification numbers.

"Starting in 2017, clinicians will participate in the new Quality Payment Program as a group or individually either through the Merit-based Incentive Payment System or participation in an Advanced Alternative Payment Model (APM)," says the letter.

The correspondence informs health care professionals whether they are considered exempt from MIPS, which would be because:

- they are not among the categories of clinicians included in the program in the first year, or
- they fall below the low-volume threshold criteria that pertain to clinicians who billed Medicare Part B less than $30,000 in allowed charges or provided care to fewer than 100 Medicare Part B patients.

In addition to physicians, the letter spells out the other clinicians eligible to participate in MIPS in 2017; they are physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists -- unless 2017 is their first year of Medicare participation.

The correspondence provides instructions on what steps MIPS participants need to take and reinforces deadlines to help physicians avoid a 4 percent negative payment adjustment for not participating.

Q&A: MIPS Eligibility and Reporting Options

This frequently asked questions document answers common questions concerning eligibility and reporting for individuals and groups for the Quality Payment Program (QPP) and the Merit-based Incentive Payment System (MIPS). Most of these answers are lightly edited from information provided by the Centers for Medicare & Medicaid Services (CMS) QPP Support Center or the CMS QPP Overview Fact Sheet.

Question: How do I know if I am part of the Quality Payment Program?

Answer: You are a part of the Quality Payment Program in 2017 if you are in an Advanced Alternative Payment Model or if you bill Medicare more than $30,000 in Part B allowed charges a year and provide care for more than 100 Medicare patients a year. If you are not in an Advanced APM but meet both the minimum billing and the number of patients to be in QPP, then you will participate in the Merit-based Incentive Payment System (MIPS). For MIPS, you must also be a physician, physician assistant, nurse practitioner, clinical nurse specialist or certified registered nurse anesthetist.

Question: How will providers know if they don't qualify for MIPS? Will there be some kind of verification letter sent to them or will they have to make the determination to participate on their own?

Answer: For the low-volume threshold, in order to be eligible for the 2017 MIPS Performance Year, a clinician must bill more than $30,000 in allowable charges under the Medicare Physician Fee Schedule AND see more than 100 Medicare beneficiaries. In other words, both criteria need to be met to be eligible. For example, if a clinician billed $29,000 and saw 101 patients, that provider would be EXEMPT from the program because he did not bill more than $30,000 (i.e., he didn't meet both requirements). If a provider billed more than $30,000 in allowable charges but saw 90 Medicare patients, she would be exempt and therefore would not have to report for the program in 2017.

Note: CMS held the Low-volume Threshold Assessment Period from Sept. 1, 2015, through Aug. 31, 2016. If CMS found that a provider fell below either $30,000 billed to Medicare in allowable charges OR below 100 individual Medicare Part B patients seen during that assessment period, CMS will be notifying you via letter that the provider is exempt from 2017 reporting.

Question: Would you clarify the difference between reporting at an individual versus group level? Also, if an individual clinician has a low volume, can he and is he expected to be a part of group reporting if his or her group exceeds the low-volume criteria?

Answer: Since CMS has not required advance registration for reporting, participation in MIPS will be at the level at which data is submitted to CMS. (Note: Group Web Interface or submission of the Consumer Assessment of Health Providers and Systems [CAHPS] patient satisfaction survey data to satisfy requirements for MIPS does require registration by June 30, 2017.) Thus, if individual data is submitted, feedback will be on the individual level; if group data is submitted, feedback will be at the group level.

Reporting as an Individual: If you submit MIPS data as an individual, your payment adjustment will be based on your performance. An individual is defined as a single National Provider Identifier (NPI) tied to a single Tax Identification Number (TIN). You will send your individual data for each of the MIPS categories through a certified electronic health record, registry or a qualified clinical data registry. You may also send in quality data through your routine Medicare claims process.

Reporting as a Group: If you send your MIPS data with a group, the group will get one payment adjustment based on the group's performance. A group is defined as a set of clinicians (identified by their NPIs) sharing a common TIN, no matter the specialty or practice site. (Find more information in the Final Rule, page 1,192.)

An eligible clinician may be identified as having a status that does not exceed the low-volume threshold at the individual (TIN/NPI) level, but if such eligible clinician is part of a group that is identified as having a status exceeding the low-volume threshold, that eligible clinician would be required to participate in MIPS as part of the group because the low-volume threshold is determined at the group (TIN) level for groups. (Final Rule, page 209.)

Groups must report either entirely as a group or entirely as individuals; groups may not have only some individuals reporting. Groups must decide to report as a group across all four performance categories. (Final Rule, page 303.)

To learn more about MIPS, visit https://tmfqin.org/qpp. To request free technical assistance with MIPS for practices or systems with more than 15 eligible clinicians, contact QualityReporting@tmf.org. To request free technical assistance with MIPS for small and rural practices, contact QPP-SURS@tmf.org.

Len Kemp, M.D. to be Installed as AR AFP President August 4

Doctor Len Kemp of Paragould will be installed President of the Arkansas AFP on Friday August 4 during the Installation of Officers ceremony at the Embassy Suites Hotel.

Dr Kemp graduated and received his M.D. degree from the University of Arkansas for Medical Sciences in 1978 and completed a Family Medicine Residency at John Peter Smith Hospital in Texas.

He is board certified by the American Board of Family Medicine and has practiced Family Medicine in Paragould for 36 years.

He enlisted with the Army Reserves in 2003 at the start of the crisis in Iraq and served the Reserves for six years after which he joined the Arkansas Army National Guard for another six years serving in Germany, two tours in Iraq and two in Afghanistan.

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Antibiotic Stewardship is Essential Step for Physicians

By Mandy Palmer, RN, CPHQ, CPPS

Antibiotic usage comes with a serious and growing threat to our nation's health and economy. Antibiotic resistance leads to more than 2 million illnesses and 23,000 deaths per year in the United States.[1] Approximately $20 billion in excess direct health care costs are due to antibiotic resistance.

Inappropriate antibiotic prescribing is the most important modifiable risk factor for antibiotic resistance. Nearly half of antibiotic prescriptions are inappropriate in terms of selection, dosage, duration and unnecessary prescribing.[2,3,4] More than 60 percent of antibiotic expenditures for humans in the United States are from the outpatient setting.

Arkansas is sixth highest in the nation in the rate of antibiotic outpatient prescriptions dispensed, with 1,155 antibiotic prescriptions per 1,000 people, compared to the national average of 835.[5]

Like no other drug, antibiotic usage in one patient can compromise efficacy in another. Patients receiving antibiotics will have a seven- to 10-fold increased risk of developing Clostridium difficile. It alone accounts for 453,000 infection cases and 15,000 deaths annually; plus $1 billion in excess direct health care costs and readmissions.[6] Antibiotics cause adverse drug events leading to 142,000 emergency department (ED) visits per year; they are the most common cause of drug-related ED visits in children. Additionally, there is growing evidence that associates antibiotic use with chronic disease, due to disruption of the microbiota and microbiome.

CDC's stewardship plan

The Centers for Disease Control and Prevention (CDC) is actively working to improve antibiotic usage to combat antibiotic resistance. Antibiotic stewardship activities in hospitals, nursing homes, clinics and other health care settings include measuring and improving the efficacy of antibiotic prescribing, minimizing misdiagnoses or delayed diagnoses leading to underuse of antibiotics, and ensuring selection of the right drug, dose and duration.

The Arkansas Hospital Association and the Arkansas Association of Health-System Pharmacists are addressing the problem with their Pharmacist-Led Collaborative. The Arkansas Department of Health joined the initiative as a collaborating partner, providing ongoing clinical expertise. This collaboration created a shared learning community of 22 hospitals that have established the core elements of an antimicrobial stewardship program in their facilities. Seventeen of these facilities have increased their core activities by at least one between 2014 to 2015. From this collaborative, we have learned there is no one-size-fits-all program because each entity is different in terms of size, location and resources.

A set of core elements for Antibiotic Stewardship Programs – Core Elements of Hospital Antibiotic Stewardship Programs and Core Elements of the Nursing Homes were released by the CDC in 2014 and 2015. The Joint Commission adopted antibiotic stewardship standards for hospitals that were effective January 2017 and align with the CDC's core elements.

In November 2016, the CDC released the Core Element of Outpatient Antibiotic Stewardship along with a checklist for clinicians and facilities. These elements are intended for clinicians (including physicians, physician assistants, nurse practitioners and dentists) in primary care clinics, EDs, health care systems,

continued on page 28

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continued from page 26

outpatient specialty and subspecialty clinics, retail and urgent care clinics and dental clinics.

The CDC's Core Elements are:

1. **Commitment:** Demonstrate dedication to and accountability for optimizing antibiotic prescribing and patient safety.

2. **Action for policy and practice:** Implement at least one policy or practice to improve antibiotic prescribing, assess its effectiveness and modify as needed.

3. **Tracking and reporting:** Monitor antibiotic prescribing practices and offer regular feedback to clinicians, or have clinicians assess their own antibiotic prescribing practices.

4. **Education and expertise:** Provide educational resources to clinicians and patients on antibiotic prescribing and ensure access to needed expertise on optimizing antibiotic prescribing.

For more information on CDC's core elements, visit http://www.cdc.gov/mmwr/volumes/65/rr/rr6506a1.htm

What you can do

Implementing an antibiotic stewardship program may feel overwhelming, but start small and identify one thing to do now. For example, displaying commitment posters in your clinic lobby and exam rooms can serve as a reminder of accountability and are great conversation starters for patient education. The CDC's website (https://www.cdc.gov/getsmart/community/materials-references/print-materials/) includes commitment posters and numerous educational tools for patient education.

Determine if you are using evidence-based diagnostic criteria and treatment recommendations. Many patients diagnosed with common bacterial infections in doctors' offices, EDs and hospital-based clinics are not receiving the most appropriate antibiotic for their conditions. In 2010 and 2011, U.S. prescribing data indicated that sinus infections, middle ear infections, and pharyngitis accounted for 44 million antibiotic prescriptions each year. However, only 52 percent of patients with these infections and treated with antibiotics received the recommended first-line drugs based on established practice guidelines.[7]

Implement a policy for "watchful waiting" when appropriate. Antibiotics are frequently prescribed for noninfectious or nonbacterial syndromes. Provide symptomatic relief with a clear plan for follow up if infection symptoms do not improve.

Delay antibiotic prescriptions is another evidence-based approach that can safely decrease antibiotic use when used in accordance with clinical practice guidelines.

Measure your progress by tracking and reporting antibiotic usage is key to guiding your practice and measuring improvement progress. Existing quality measures data, automatic electronic medical record extraction or manual periodic chart review are all potential sources of data. Providing individual antibiotic prescribing reports can be an effective way to ensure adherence to evidence-based treatment guidelines.

Link to payment programs. Implementing an antibiotic stewardship program into your practice can help you obtain a positive payment adjustment through the new Merit Based Incentive Program (MIPS) by counting it as an Improvement Activity. Select two to four improvement activities that correlate with your antibiotic program from the eight different antibiotic quality measures. This accounts for 15 percent of your total score. Quality measure reporting is 60 percent of your MIPS score.

For more information and for specific quality measures, download our new tool: https://www.tmfqin.org/Portals/0/Resource%20Center/Quality%20Payment%20Program/QPP%20and%20ABS_508.pdf

Antibiotic stewardship requires commitment to change and thoughtful efforts to improve outcomes. Antibiotic stewardship is one the most important strategies in fighting antibiotic resistance, keeping patients safe and ensuring that antibiotics remain available for modern medical advances like surgery, transplants and cancer therapy.

References

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4. Suda KJ, Hicks LA, Roberts RM, Hunkler RJ, Danziger LH. A national evaluation of antibiotic expenditures by healthcare setting in the United States, 2009. J Antimicrob Chemother 2013;68:715–8.

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7. Hersh AL, Fleming-Dutra KE, Shapiro DJ. Frequency of First Line Antibiotic Selection Among US Ambulatory Visits for Otitis Media, Sinusitis, and Pharyngitis. JAMA Internal Med., Pub online 10-24-16 http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2571613

Ms. Palmer is a quality manager with AFMC.

UAMS College of Medicine Match Results

For the first time in several years, all of the graduating class of the UAMS College of Medicine matched with a residency after medical school!

Of the 158 seniors who participated in the match held in March, 63 matched with residencies in Arkansas and 95 matched with residencies in 31 different states. Sixty one percent matched with residencies in primary care, including 28 students choosing internal medicine and 26 choosing Family Medicine.

Current UAMS students come from 73 of the 75 counties in Arkansas. UAMS ranks second in the nation at retaining medical school and residency graduates in the state and 58 percent of practicing physicians in Arkansas are UAMS graduates. For five out of the last nine years, UAMS has ranked among the top ten Doctor of Medicine programs in the nation for the number of graduates who chose Family Medicine.

Sixty two of the class were members of the AR Academy of Family Physicians Family Medicine Interest Group. Of that number 27 chose Family Medicine with nine of those staying in Arkansas for their residency training. Six non members of the FMIG chose Family Medicine with four choosing Family Medicine residency programs in the state!

Congratulations to the following medical students choosing Family Medicine:

Darby BeDell, Hennepin Co Medical Center, MN
Evan Branscum, Cox Medical Centers, Springfield, Mo
James Cooper, UAMS Regional Programs, Pine Bluff, Ar
Mary Depper, UAMS Regional Programs, Magnolia, Ar
Hannah Eveld, UAMS Regional Programs, Fort Smith, Ar
John Fisher, UAMS Regional Programs, Jonesboro, Ar
Joshua Hall, AnMed Health, SC, Anderson, South Carolina
Nicholas Heathscott, Bayfront Medical Center, St. Petersburg, Fla
Julia Horton , UAMS Regional Programs, Fayetteville, Ar
Cameron Jones, UAMS Regional Programs, Pine Bluff, Ar
Joseph Kanopsic, St Marys Hospital, Grand Juncton, Co
Derek Karr, Naval Hospital, Jacksonville, Fla
Brian Kennedy, Cox Medical Centers, Springfield, Mo
Joseph McCutcheon, UAMS Regional Programs, Pine Bluff, Ar
Megan Minniear, UAMS Regional Programs, Fort Smith, Ar
Jonathan Moser, UAMS Regional Programs, Fort Smith, Ar
Amber Norris, John Peter Smith Hospital, Fort Worth, Tx
Grant Pahls, UAMS Regional Programs, Pine Bluff, Ar
William Peckat, UAMS Regional Programs, Texarkana, Ar
Kimberly Reynolds, University of Arkansas, Little Rock, Ar
Larry Robins, UAMS Regional Programs, Fort Smith, Ar
Cody Rogers, Resurrection Health, Memphis, Tn
Patrick Sullins, UAMS Regional Programs, Jonesboro, Ar
Danielle Audrey Tchoungang, Bon Secours Health System, Midlothian, Va
Theodore Toth, University of Arkansas, Fayetteville Comm Programs, Fayetteville, Ar
Huyen Trang Van, Halifax Medical Center, Daytona Beach, Fl

Join Project ECHO:
Be Part of Mental Health Integration in Your Community

Often, primary care clinicians are concerned with the next steps after screening patients for depression and alcohol use disorder. Specialty services for these conditions are generally difficult to access in rural areas, and many patients are hesitant to seek care. The Centers for Medicare & Medicaid Services (CMS) 2016 Quality Strategy includes an objective to improve behavioral health access and quality care. In support of this objective, CMS awarded a two-year contract to the TMF Quality Innovation Network Quality Improvement Organization (QIN-QIO), which is led by TMF Health Quality Institute in Texas and Oklahoma, in partnership with the Arkansas Foundation for Medical Care and Primaris in Missouri.

This new initiative will focus on treatment of depression and alcohol use disorder and the integration of behavioral health into primary care through Project ECHO (Extension for Community Healthcare Outcomes) and the Mental Health Integration (MHI) model.

Project ECHO is the perfect opportunity to reach rural primary care clinicians, and the TMF QIN-QIO Project ECHO initiative has partnered with the Dell Medical School at The University of Texas at Austin to provide behavioral health subject-matter experts who will mentor clinicians and give feedback on patient cases. The subject-matter experts are Garrett Key, MD, assistant professor, Department of Psychiatry; William Lawson, MD, PhD, DFAPA, associate dean, Health Disparities; Tawny Smith, PharmD, BCPP, assistant professor, Department of Psychiatry; and Stephen Strakowski, MD, chair, Department of Psychiatry.

Participating clinicians will gain expertise treating patients with depression and alcohol use disorder, improve patient satisfaction and reduce harm by implementing best practices to increase response rates and reduce emergency department use.

The first of four cohorts (spanning twelve weeks with a target of 20 clinicians per cohort) launched on March 1, 2017. The academic hub is based in Austin, Texas, and satellite sites have been established in Arkansas, Missouri, Oklahoma and Texas. The TMF QIN-QIO will collect data metrics from all participating clinicians at the provider and practice level to report back to CMS. This Project ECHO program will continue through September 2018.

To learn more about joining this initiative, please contact Caitlin Fenerty, MPH, project director, at Caitlin.Fenerty@area-b.hcqis.org.

Dr. Tasha Starks Elected Co-Convener for 2018 NCCL

Dr. Tasha Starks of Jonesboro was elected Co Convenor of the minority constituency for the National Conference of Constituency Leaders (NCCL) at the NCCL conference in Kansas City, Missouri.

Doctor Starks graduated from UAMS and completed her Family Practice Residency at AHEC NE in Jonesboro and has served on the AR AFP's Board of Directors for three years.

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