Officers and Directors Installed

Arkansas FP’s Receive Degree of Fellow

The Arkansas Family Physician

Volume 21 • Number 2

Dr. Len Kemp
Installed as President of the Arkansas AFP
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Dear Academy Member,

We are excited to show those of you not present at our recent Annual Scientific Assembly photos of those who were present, our newly installed President, officers and directors, our Fellowship Convocation and highlights of the meeting.

Our program in 2018 has been contracted again for the Embassy Suites in Little Rock August 1-4, 2018. We hope you will mark your calendars and plan to attend. If you have any speakers or topics to recommend, please let us know since we do start planning the program in February.

Our registration was down from last year with 154 physicians from across the state: three Family Medicine Residents and two medical students from UAMS.

Of the 27 speakers on the program, our own Family Physicians ranked at the top of the evaluations with Dr. Lonnie Robinson of Mountain View receiving the highest overall score of 99%. Other speakers on the program receiving high evaluations were: Dr. Robert Bradsher, Dr. Erin Large, Dr. Scott Dinehart and Jennifer Smith, J.D.

Suggestions from attendees asked for more time to interact with colleagues with no programs during meal functions; No handouts (which have been replaced with online access to every powerpoint from the speakers); Most liked the time and location of the program; the variety of topics; the organization of the event; the legislative update from Representative Jeff Wardlaw and reconnecting with colleagues!

As we begin a new year, our board meetings have been scheduled for November 1, January 31, 2018, April 11, 2018 and the assembly August 1-4.

Several of our Active members have been dropped in recent months for failure to pay dues and for CME. Dues billings for the coming year will be mailed from AAFP headquarters in about a month. These dues are combined state and national with our state not having a dues increase in 11 years. If you have any questions at 501-223-2272 or email arafp@sbcglobal.net.

Sincerely,

Carla Coleman
Executive Vice President

On the cover: Dr. Len Kemp and Family
Len Kemp, M.D., of Paragould was installed as the 70th President of the Arkansas Chapter of the American Academy of Family Physicians. The Installation of Officers was held at the Annual Scientific Assembly at Embassy Suites in Little Rock on Friday, August 4, 2017. Doctor Robert Wergin of Milford, Nebraska, Past President of the American Academy of Family Physicians presided over the Installation.

Doctor Kemp graduated and received his medical 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.

At the beginning of the Iraqi crisis, he enlisted with the Army Reserves in 2003 and served six years. He then joined the Arkansas Army National Guard and served in Germany, Iraq and Afghanistan.

Doctor Kemp has served on the Arkansas AFP Board of Directors since 2006 as a Director and was elected to Vice President in 2015 and President Elect in 2016.

He is married to Denise and has one son and two granddaughters.
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Course Director
Philip Levy, MD, MACE
Clinical Professor of Medicine
University of Arizona College of Medicine
Endocrinologist
Banner University Medical Group

Faculty
W. Timothy Garvey, MD, FACE
Butterworth Professor and Chair
Department of Nutrition Services
University of Alabama at Birmingham

Faculty
Debbie Head, Ed.D, RD, LD, CDE
Associate Professor-EPNED and Nutrition Specialist
University of Arkansas, Division of Agriculture Cooperative Extension Service

Faculty
Appathurai Balamurugan, MD, DrPH, MPH
State Chronic Disease Director
Medical Director, Chronic Disease Prevention and Control Branch
Associate Director for Science, Center for Health Advancement
Arkansas Department of Health

Agenda
7:00 am Registration, Breakfast in Exhibit Area
7:55 am Welcome and Introduction
8:00 am Update on T2DM and Obesity from the Arkansas Department of Health, including Epidemiology and Current Initiatives
8:30 am Nutrition Therapy Recommendations
9:15 am The Overlap of Metabolic Syndrome and Prediabetes: Pathophysiology, Early Identification and Intervention
9:45 am Practical Tools and Guidelines for Managing Obesity in Patients with T2DM
10:30 am Break, Refreshments in Exhibit Area
11:00 am Overview of Current Treatment Options: Comparing Efficacy and Adverse Events
11:30 am Update on Novel Antidiabetic Agents: Focus on SGLT2s, Incretins, Insulins, and Combination Therapies
12:30 pm Q&A Panel Discussion
1:00 pm Adjourn

CME Accreditation and Designation
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of St. Joseph’s Hospital and Medical Center, and MandatoryCE. St. Joseph’s Hospital and Medical Center is accredited by the ACCME to provide continuing medical education for physicians.

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Top Resources to Help You Navigate MIPS

QPP and MIPS Basics

The Quality Payment Program (QPP) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and contains two payment track options: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Clinicians who are eligible for MIPS have three “Pick Your Pace” options for reporting in the 2017 transition year.

Visit the main Centers for Medicare & Medicaid Services (CMS) QPP website at https://qpp.cms.gov. The QPP site lists in detail eligibility requirements, reporting options and measures. A detailed webpage is dedicated to the three MIPS categories that will be scored for the 2017 transition year: Quality Measures, Improvement Activities and Advancing Care Information.

TMF’s online MIPS Toolkit is another great resource. The MIPS Toolkit is an interactive guide to help walk you through the exact steps you need to succeed in MIPS, including details on eligibility, reporting options, and meeting and submitting measures for each category.

For video resources, access recorded and upcoming CMS webinars. You can also join weekly QPP Office Hour webinars with TMF (registration available on www.tmfqin.org/qpp), or you can access recorded Office Hours. TMF’s QPP Office Hours dive into detail on a different topic each week and answer attendees’ QPP questions.

CMS’ QPP Resource Library contains information on all areas of MIPS. A few recent additions include:

- 2017 CMS-Approved Qualified Clinical Data Registries (QCDRs)
- 2017 MIPS Quality Performance Category Scoring for MSSP and Next Generation ACOs
- 2017 Qualified Registries

Eligibility

Need to determine whether or not you need to participate in MIPS? Enter your National Provider Identifier (NPI) in the MIPS Participation Status checker to see if you are eligible at the individual level. You will find your participation status, clinician details, practice details and special status at this practice.

Quality Measures

Explore Quality measures and how you should select them on the CMS QPP Quality Measures webpage.

The Quality Measures page begins with a list of instructions for choosing your measures. You can then use the Select Measures tool to search and filter available measures. Use the Specialty Measure Set dropdown if you are a specialist or are in a hospital to find pre-selected measures for your specialty. These measure sets are chosen based on encounter codes seen in your specific billing locations, and this is a great place to start when choosing your measures (e.g., Claims, Registry).

Find the 2017 Quality Benchmarks for your measures. Once you identify your Quality measures, filter your current performance against the set benchmarks to assess your current points for your MIPS score.

Advancing Care Information

Check out CMS’ Advancing Care Information Fact Sheet for details on:

- Advancing Care Information (ACI) Objectives and Measures versus 2017 ACI Transition Objectives and Measures
- Base, Performance and Bonus points and scoring
- When the Advancing Care Information score can be reweighted

For details on all Advancing Care Information Objectives and Measures and 2017 Advancing Care Information Transition Objectives and Measures, access the Advancing Care Information Measure Specifications guidelines.

This resource includes an explanation of definitions, reporting requirements, scoring information and more.

Improvement Activities

Do some improvement activities look like they would work well for you, but you need to know what documentation CMS suggests for that activity? Download the MIPS Data Validation Criteria to help. Filter by your selected improvement activities and find the description, activity weight, validation and suggested documentation. Remember to save all documentation in case of an audit.

If you need help getting started with your improvement activities, find out how working with the TMF QIN-QIO can count for several activities under the Improvement Activities category. This document includes QPP fact sheets to help you select the improvement activities that are right for your practice. They cover several areas of quality improvement which TMF can assist with.

Just for SURS

CMS has created a page specifically to guide small, underserved and rural clinicians and practices as they navigate MIPS. Find information specific to small and rural practices on this support page.

Looking into Next Year

Read the 2018 Proposed Rule for the 2018 Performance Period Fact Sheet for an overview of what’s staying the same, what’s changing and what’s new so you can start now to prepare for the future.

Get Free Support for QPP

To learn more about free MIPS support, visit www.tmfqin.org/qpp. To request free technical assistance with MIPS for practices or systems with 16 or more eligible clinicians, contact QualityReporting@tmf.org. To request free technical assistance with MIPS for small and rural practices, contact QPP-SURS@tmf.org.
Six Arkansas AFP members received the Degree of Fellow during a special convocation ceremony by AAFP Past President Robert Wergin on Thursday, August 3. Receiving recognition pins and certificates for their accomplishments were:

**Appathurai Balamurugan, M.D., DrPH, MPH, Little Rock**

**Randall Bowlin, M.D., Conway**

**Shashank Kraleti, M.D., Little Rock**

**Rebecca Luper, M.D., Junction City**

**Darrell Over, M.D., Pine Bluff**

**Nawal Singh Shekhawat, M.D., Little Rock**

Recognized for distinguished service to family medicine by their advancement to healthcare to the American people, and by their professional development through medical education and research, Fellows of the AAFP are recognized as champions of family medicine and are the physicians who make family medicine the premier specialty in service to their community and profession.

The American Academy of Family Physicians Degree of Fellow was established in 1971 as a special honor bestowed upon AAFP members who have distinguished themselves among their colleagues by their service to Family Medicine and their commitment to their professional development through medical education and research. The criteria for this honor is a minimum of six years of membership, and points for the application based on experiences and activities in Life Long Learning, Practice Quality and Improvement, Volunteer Teaching, Public Service, Publishing, Research, and Service to the Specialty. If you wish to participate and obtain your degree, please complete the Fellowship application that can be found on the American AFP website at http://www.aafp.org/membership/involves/fellow.html.
Author’s Note: The original intent of this article was to cover the flood of new drugs that entered into the U.S. market in the 20th century and delve into their impact on Arkansas. In the research and writing, I discovered two things: one is how much information there is and two is how little I knew.

Here in the early 21st century, we take for granted the availability of effective medicines for most of the problems we face daily. It’s easy to forget that many of the disease states we deal with on a regular basis such as infectious diseases, hypertension, heart disease, diabetes and cancer were often a death sentence at the beginning of the 20th century.

The 19th century saw the isolation of a few drugs from herbal sources such as digitalis, morphine, cocaine, quinine, colchicine, salicylic acid and aspirin. The use of nitrous oxide, ether and chloroform as anesthesia agents helped to revolutionize surgery.

A variety of mercury salts had been in use since antiquity. They became a major part of the European and American medical regimen for their diuretic and cathartic properties. “Heroic” medicine was a term used to describe the side effect of these treatments. Starting in the 16th century, one of its chief uses of mercury was in the treatment of syphilis; this continued until the beginning of the 20th century. Mercurochrome was first used as a topical antiseptic as early as 1918 and was eventually removed from the U.S. market in the late 1990s. Mercury-based diuretics continued to be used in the U.S. medicine until the late 1950s.

In the early 20th century the roles of physicians as prescribers and pharmacists as dispensers was not as clear as it is today. Almost any drug could be obtained without a prescription. The AMA designated two categories of drug: “ethical” drugs or those listed in the U.S. Pharmacopeia and “patent” medicines made of unknown ingredients and trademarked. Self-medication was common and fraught with danger.

The Pure Food and Drug Act of 1906 was an attempt to force drug manufacturers into accurate labeling of the contents of their products and the Harrison Narcotic Act of 1914 was an attempt at reducing the use and distribution of narcotics and cocaine.

A night with Venus, a lifetime with Mercury

One of the first major breakthroughs in the new century was an effective treatment for an old and dreaded disease, syphilis. Statistics prior to the 1930s (especially in Arkansas) are notoriously inaccurate but estimates are that 6-8 percent of the population in the U.S. was infected, with higher rates in the South. A blood test for syphilis became available in 1906. Large numbers of young men were turned away from military service during WWI because of positive tests. In 1909 Paul Ehrlich tested and began using intravenous arsphenamine (an organoarsenic compound) marketed under the name of Salversan and then a refinement called Neosalversan in the treatment of syphilis. He was the first to coin the phrases chemotherapy and magic bullet. Because of the presence of the Army-Navy Hospital in Hot Springs, an active program of syphilis evaluation and treatment was created under the leadership of Dr. Oliver Clarence Wenger. Between 1920 and 1936, 80,000 men and women came through the Hot Springs facility and 36,000 received treatment for syphilis.

Adrenalin, Ephedrine and Amphetamine

The sympathomimetic amines were introduced to the U.S. market near the turn of the 20th century. Adrenalin was isolated in the 1890s and first used in eye surgery in 1896. A close cousin, ephedrine, derived from the Ephedra plant, has been in use in traditional Chinese medicine for 2000 years. In the 1920s China began exporting the drug to the United States. In 1928, they shipped 216 tons to the Untied States. Merck marketed the drug under the name Ephetonin. Amphetamine was first synthesized in 1887 but had no medical use until the mid-1934s when Smith-Kline-French began selling it as a decongestant inhaler for children under the trade name of Benzadrine. It was advertised in 1934 in the Arkansas Medical Journal. By WWII, oral amphetamines were being used extensively by the Armed Services for its stimulant properties and performance-enhancing effects. As its use became more
widespread, the abuse potential became obvious and by the 1970s it became a Schedule II controlled substance.

**Barbiturates**

Barbituric acid was synthesized in 1864 but first found a medical use by Bayer Drug Company in 1903 with the observation that it caused sedation in lab dogs. Bayer marketed barbital under the name Veronal. During the 20th century over 2500 barbiturates were synthesized and about 50 were eventually used clinically. In 1912, phenobarbital (Luminal) was marketed as a sedative-hypnotic and would go on to become one of the mainstays in seizure treatment during the 20th century. It was not until the 1950s that the problems with physical dependence and behavioral disturbances began to be recognized with this class of drugs.

**Insulin**

On January 11, 1922, Dr. Fredrick Banting, a Canadian Physician, gave a seriously ill 14-year old diabetic the first human injection of insulin. The original injection was quite impure and caused dreadful allergic reactions. Eli Lilly Drug Company joined the fray and soon had a far more refined product. In January of 1925 the lead article in the Arkansas Medical Journal declared insulin the standard of care in diabetes; the report went on to detail the use and precautions of this new and miraculous product. The face of diabetes had changed.

Despite these notable exceptions, what began as a trickle of new drugs in the last half of the 19th century and the first part of the 20th turned into a flood of new drugs during and after the 1930s.

**Sulfa**

The first of these drugs to stake their claim were the sulfa drugs: Sulfonamide (Prontosil) was the first of these antibiotics. In 1932, a chemist for the Bayer Drug Company, found that a red coal-tar dye could bind preferentially to bacteria and stop infections in mice. Because of the peculiarity of the way the drug was metabolized to sulfanilamide, they were unable to patent the final product. As a result, several hundred companies began producing products that hit the market in the late 1930s.

Roosevelt’s New Deal had been pushing for stronger drug regulations in the American market place but had made very little progress, that changed in 1937. Sulfanilamide was used to treat streptococcal throat and skin infections. It had been shown to have dramatic curative effects and had been used safely in tablet and powder form. In June 1937, a salesman for the S.E. Massengill Co., in Bristol, Tenn., reported a demand in the southern states for the drug in liquid form to be used in children. The company’s chief chemist and pharmacist, experimented and found that sulfanilamide would dissolve in diethylene glycol (antifreeze). The company control lab tested the mixture for flavor, appearance, and fragrance and found it satisfactory. Immediately, the company compounded a quantity of the elixir and sent shipments all over the country. The drug had not been tested for toxicity.

Ruth Jeanell Long of Blevins, Ar. in Hempstead County had developed a severe skin infection. On Oct 8th, 1937, she was taken to her family doctor, Dr. James E. Gentry, who prescribed Elixir Sulfanilamide. She died on October the 24th. An investigator for the Federal Drug Program exhumed the body and determined that she had died of renal failure from the medicine she had consumed.

In September reports had begun to circulate of unexpected deaths after taking the new formulation. One hundred and seven patients, mostly children, died from the ingestion of the Elixir Sulfanilamide in the United States before the investigators

continued on page 12
for the Federal Agency could track down and confiscate the unused medicine. With pressure from the Roosevelt Administration, the 1938 Food, Drug, and Cosmetic Act was passed. That act forms the primary statutory basis for federal regulation of all foods, drugs, biological products, cosmetics, medical devices, tobacco, and radiation-emitting devices by the U.S. Food and Drug Administration.

It is beyond the scope of this brief essay to list every drug derived from these original sulfa-based compounds. There are multiple sulfa antibiotics formulations still on the market today. Several oral anti-diabetic agents such as glipizide, glimepiride, glyburide are still in use. Most of the commonly used diuretics such as furosemide, hydrochlorothiazide, metolazone, and indapamide can all be traced back to research begun back in the 1930s. In addition, several commonly used anticonvulsants, anti-retrovirals and Hepatitis C anti-virals and some of the anti-inflammatory drugs such as apricoxib and celecoxib find their lineage in the earlier work. The anti-migraine meds such as sumatriptan, several anti-glaucoma drugs, a number of the anti-arrhythmic drugs plus the B-blocker, sotalol, and, last but not least, sildenafil are all great-grandchildren to the original sulfa drugs.

It seems fair to say that the chemists who worked on the Bayer lab in the early thirties could not have predicted the flood gate they were opening.

Penicillin

As the popularization of sulfa antibiotics was taking flight in the 1930s, Dr. Alexander Fleming was working away in his lab with a different product but he was having trouble getting anyone interested. On Friday 28th, 1928, Dr. Fleming noticed that a penicillin mold had contaminated one of his petri dishes and created a halo of inhibited bacterial growth. He persisted with his research and in 1939, Australian scientist, Howard Florey showed that penicillin effectively cured bacterial infections in mice. In 1941, Florey and his team at Oxford began human treatments with remarkable results. The biggest problem they faced was producing enough penicillin. By 1943 they began using deep-tank fermentation methods for producing large quantities of pharmaceutical-grade penicillin. In July 1943, the United States War Production Board drew up a plan for large scale distribution of penicillin stocks to Allied troops fighting in Europe. As a direct result of the war and the War Production Board, by 1945, over 646 billion units were being produced per year. On March 15th, 1945, the American government removed all restrictions on its availability to the public. It may well be apocryphal but tradition has it that by 1949 sixty-percent of all physician office visits ended with an injection of penicillin; clearly, it changed the face of medicine.

Streptomycin, erythromycin and tetracycline

In the mid-1930s Rene Dubois and Selman Waksman were hard at work at their lab at Rutgers studying a number of species of the soil bacterium Streptomyces. By the late 1940’s their work resulted in the discovery and production of many new families of antibiotics including streptomycin, tetracycline, chloromycetin and neomycin. Erythromycin was isolated and derived from a similar species of soil bacterium in about the same timeframe. Streptomycin would be the first effective drug in the battle with tuberculosis. Tetracycline, chloromycetin and erythromycin were heavily advertised in the Arkansas Medical Journal during the 1950s.

By the early 1950s, the tidal wave of new medicines could be seen from the shore and it wasn’t just antibiotics; hormonal preparations, vitamins for long standing nutritional deficiency, anti-cancer drugs, new vaccines and increasing numbers of psychiatric drugs would change the practice of medicine in a very short time.

In 1952, Representative Carl Dunham of North Carolina and Senator Hubert Humphrey of South Dakota, both pharmacists before they became legislators, introduced the Dunham-Humphrey Act that created two specific categories for medications, legend (prescription only) and over-the-counter (OTC) drugs. The act required that any drug that is habit forming or potentially harmful be dispensed under the supervision of a health professional as a prescription drug. In Arkansas the Arkansas Druggist, quarterly for the Arkansas Pharmaceutical Association listed 50 barbiturates that would now need a prescription.

Next issue we will continue this saga as the tidal wave hits the shore.

Sam Taggart M. D.
Any questions and comments: samtaggart@att.net
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The Federal Bureau of Prisons is an Equal Opportunity Employer.
An important focus of the family medicine for America’s Health, which is led by AAFP Past President Ed Epperley has been to engage a broad group of stockholders to consider development of a set of shared principles to collectively advance person centered, team based primary care. To further advance this notion of patient engagement the Patient Centered Medical Home Collaborative was consulted; the PCPCC Board of Directors agreed to lead this effort and appointed a steering committee to convene the appropriate stakeholders (physician specialty societies, other provider groups, consumer groups, employers, payers, etc) to discuss and seek agreement on such principles. In addition the eight national family medicine organizations have had significant input in this process and evolving drafts of these principles.

These principles are not meant to replace or compete with but be complimentary to the 2007 Joint Principles of the Patient Centered Medical Home. Additionally, in developing these principles, the steering committee effectively avoided several potential areas of controversy, such as the expansion of scope of practice and payment for non physician providers.

The annual meeting of the PCPCC this October will be focused on announcing and promoting these shared principles including a listing of all supporting organizations. Several AAFP chapters have indicated their support.
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PROSTATE HEALTH MATTERS

When you see blue ribbon decals on your local high school’s helmets, remember PROSTATE HEALTH.

A recent report published in JAMA Oncology links the decline in PSA testing to the rising number of men being diagnosed with advanced prostate cancer.

USPSTF has reversed course with new draft recommendations on PSA screening.

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Remember that September is PROSTATE CANCER AWARENESS MONTH!
2017-2018 Officers and Directors Installed at Annual Assembly

The following Officers and Directors were installed on Friday, August 4, 2017 by AAFP Past President, Dr. Robert Wergin of Milford, Nebraska.

2017-18 Elected Officers

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

Directors Elected for coming year:

Hunter Carrington, M.D., Hot Springs
Marissa DeLaPaz, Little Rock
Caleb Dickson, M.D., Jonesboro
Leslye McGrath, M.D., Paragould
Joseph Shotts, M.D., Cabot

Dr. Wagner presents engraved Arkansas Duck Call to Dr. Wergin

Dr. Yelvington, Dr. Nix, Dr. Daniel, Dr McGrath, Dr. Dickson, Marissa DeLaPaz, Dr. Carrington, Dr. Caleb Dickson with Dr. Wergin and Dr. Mayfield.
The ABFM has announced that it is offering the PRIME Registry **FREE for the first three years** to the first 2,000 board-certified family physicians who sign up!

The PRIME Registry is currently helping nearly 3,000 primary care clinicians use the data from their EHRs to view any performance gaps and reduce their reporting burden. In fact, more than 1,100 clinicians used PRIME to report for PQRS this year! Additionally, many have been able to use the PRIME registry to identify gaps in care at the individual patient level. PRIME is also supporting hundreds of family physicians in reporting data for several federal practice transformation demonstrations including TCPI and CPC Plus. The Registry also automates data submission for Performance Improvement Activities for diplomates, simplifying continuous certification activities. Already enrolled in the PRIME Registry? Great news! The ABFM is also offering **3 additional free years** to any Family Medicine Diplomates who have already signed up.

After the initial 3 years, PRIME cost is only $295/ABFM Diplomate/year. For all other family physicians, primary care colleagues, and mid-level providers, the cost is only $360/clinician/year.

For more information or to take advantage of this offer visit:

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The Centers for Medicare & Medicaid Services (CMS) has spent the last three years experimenting with how it and Medicare administrative contractors (MACs) review physicians’ clinical documentation to prevent improper payments and use that experience to help physicians and practices avoid future errors.

Apparently, the experiment was a success. CMS says it is expanding its medical review strategy, called “Targeted Probe and Educate” (TPE), to all MACs later this year. This actually appears to offer some advantages to physicians.

CMS, recognizing that medical record review is a burden to physicians, began in 2014 a program that combined a review of a sample of submitted claims with education to help reduce mistakes in the claims submission process. CMS called this medical review strategy Probe and Educate. The agency then began phasing in TPE, a more targeted program where the MACs focused on specific providers or suppliers within the service instead of looking at all providers and suppliers billing a service.

TPE involves up to three rounds of review. Each round, called a probe, reviews 20-40 claims per provider, per item or service. After each round, providers are offered individualized education based on the results of their reviews. TPE began as a pilot in one MAC jurisdiction in June 2016 and expanded to three additional MAC jurisdictions in July 2017. CMS has decided to expand it to all MAC jurisdictions later in 2017.

TPE offers physicians some advantages over the original program:

- Rather than reviewing claims from all providers for a specific service, the MACs will focus only on claims from providers or suppliers who have the highest claim error rates or who use billing practices that vary significantly from their peers.
- The number of claims reviewed for an individual provider is likely to be smaller than under the previous process.
- Physicians who successfully improve after a given round are not subject to additional rounds and appear to earn a 12-month reprieve from TPE.
- Additional actions, including 100 percent prepay review, extrapolation, and referral to a Recovery Auditor, occur only after a provider or supplier fails three rounds of TPE with high error rates.

Additional information on TPE(www.cms.gov), including a flow chart(www.cms.gov), is available on the CMS web site.

Kent Moore, Senior Strategist for Physician Payment for the American Academy of Family Physicians

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Ar AFP 70th Annual Scientific Assembly Photos

Stone Robinson, Michelle Hegwood, Carla Coleman, Margie Northcutt

Dr. Kerry Pennington and Karen Richardson, APRN

Ar State Representative Jeff Wardlaw

Dr. Tommy Wagner, 2016-17 President with plaque of appreciation

Lecture Hall
Over 140 members attend Lunch Meeting

Dr. Ross Halsted with Charlotte Downs
Dr. Erin Large

Dr. Richard Hayes visiting Ar. Children’s Hospital exhibit
Carla Coleman with Dr. Tommy Wagner

Arkansas Army National Guard presents colors while Timia Starks, sings National Anthem
AMA Opioid Task Force Issues Updated Naloxone Guidance

Physicians are increasingly prescribing naloxone in the fight against the opioid abuse crisis. During the first eight weeks of this year, the number of naloxone prescriptions written by physicians increased 340 percent compared with the same period in 2016. Also during that time, the number of physicians prescribing naloxone increased 475 percent compared with the previous year.

To aid in the response to this public health scourge, the AMA Opioid Task Force -- to which the AAFP belongs -- has released an updated resource (520 KB PDF) family physicians can use for guidance when co-prescribing overdose drug naloxone with opioid medications.

“The opioid epidemic continues to take thousands of lives in this country,” said Jennifer Frost, M.D., medical director for the AAFP Health of the Public and Science Division. “While family physicians work with their patients to prevent opioid misuse and overdose, naloxone is potentially life-saving for those patients who remain at risk. This opioid task force resource encourages clinicians to consider co-prescription of naloxone and offers guidance about when this is most appropriate.”

The updated resource recommends family physicians and other clinicians consider these factors when determining whether to co-prescribe naloxone to a patient and/or their caregivers:

**STORY HIGHLIGHTS**
- On Aug. 24, the AMA Opioid Task Force released an updated resource family physicians can use for guidance when co-prescribing overdose drug naloxone with opioid medications.
- During the first eight weeks of this year, the number of naloxone prescriptions written by physicians increased 340 percent compared to the same period in 2016.
- The AAFP remains committed to providing family physicians with timely, relevant resources to help them combat the opioid abuse epidemic.
- Does the patient’s history or a state’s prescription drug...
monitoring program (PDMP) show that my patient is on a high opioid dose?

- Is my patient on a concomitant benzodiazepine prescription?
- Does my patient have a history of substance use disorder?
- Does my patient have an underlying mental health condition that might make him or her more susceptible to overdose?
- Does my patient have a medical condition, such as a respiratory disease, sleep apnea or other comorbidities, that might make him or her susceptible to opioid toxicity, respiratory distress or overdose?
- Would my patient be able to aid someone who is at risk for opioid overdose?

In the AMA’s Aug. 24 “Advocacy Update,”(assets.ama-assn.org) Patrice Harris, M.D., M.A., chair of the AMA Opioid Task Force, said: “We know that naloxone -- by itself -- will not reverse the nation’s opioid epidemic, but it is a critical component that saves lives and provides a second chance.”

The AMA also hosts an End the Epidemic microsite that features additional naloxone resources(www.end-opioid-epidemic.org).

More Naloxone Co-prescribing Considerations

According to the task force’s newly updated naloxone resource, family physicians who are trying to determine whether to co-prescribe naloxone should also consider discussing with patients

- the risk for and symptoms of opioid overdose,
- the potential stigma associated with opioid use disorder,
- the broader issue of treating substance use disorder, and
- appropriate training to deal with an overdose.

Additional benefits that co-prescribing naloxone offers include reducing emergency department visits and helping patients become more aware of the potential hazards of opioid misuse.

The task force document also referenced a study published online Sept. 20, 2016, in the journal Substance Abuse that found that co-prescribing naloxone for patients at risk for overdose doesn’t increase the liability risk for practices. Specifically, the study stated that the legal risk associated with prescribing naloxone is no higher than that associated with prescribing any other medication and, in many cases, is lower.

“Additionally, laws in a majority of states provide explicit legal protections for providers who prescribe or dispense naloxone, in many cases extending this protection to prescriptions issued to friends, family members and others,” the study said.
USPSTF Draft Recommendation

Don’t Screen Average-risk Women for Ovarian Cancer

July 25, 2017 03:06 pm Chris Crawford

On July 18, the U.S. Preventive Services Task Force (USPSTF) released a draft recommendation statement (www.uspreventiveservicestaskforce.org) and draft evidence review (www.uspreventiveservicestaskforce.org) assessing the benefits and harms of screening ovarian cancer. Based on its review of the evidence, the task force reiterated its 2012 final recommendation that the potential harms of screening outweigh the benefits, and asymptomatic women shouldn’t be screened.

This draft recommendation doesn’t apply to women who are at high risk for ovarian cancer, such as women known to have certain BRCA1 or BRCA2 genetic mutations. The task force has a separate recommendation (www.uspreventiveservicestaskforce.org) on risk assessment and genetic counseling and testing for BRCA-related cancer, which is currently being updated.

Evidence Review

The USPSTF commissioned an updated review of the evidence on ovarian cancer screening that evaluated the benefits and harms of screening in asymptomatic, average-risk women. Outcomes of interest included ovarian cancer mortality, quality of life, false-positive test result rates, surgery and surgical complication rates, and psychological effects of screening. Any screening approach that was evaluated in clinical trials reviewed was included.

The task force identified three good-quality studies that examined how annual screening affected asymptomatic women not at high risk for ovarian cancer, and none of them found that screening significantly reduced ovarian cancer mortality.

The largest and most recent trial, the United Kingdom Collaborative Trial of Ovarian Cancer Screening (UKCTOCS), was a randomized, controlled trial involving 202,638 postmenopausal women ages 50-74. The trial evaluated screening using one of two methods -- transvaginal ultrasound or CA-125 testing with the risk of ovarian cancer algorithm (ROCA), which assesses changes in CA-125 values over time -- after a baseline age-adjusted measurement.

Women randomized to the transvaginal ultrasound arm, as well as those randomized to the CA-125 ROCA arm, received annual testing. Participants found to be at increased risk for ovarian cancer based on their ROCA score were then screened with transvaginal ultrasound.

After a median follow-up of 11.1 years, ovarian cancer mortality was similar in the control and intervention groups (0.35 percent, 0.32 percent and 0.32 percent in the control, transvaginal ultrasound and CA-125 ROCA groups, respectively).

The pilot trial for UKCTOCS, known as UK Pilot, was much smaller (n=21,955 randomized) and evaluated the use of a single cutpoint value for CA-125 testing. Finding no significant difference in ovarian cancer mortality between screened and unscreened women.

The Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial randomized 78,216 U.S. women to either annual screening (CA-125 testing and transvaginal ultrasound for the first four rounds of screening, then CA-125 testing only for an additional two rounds) or usual care. The median follow-up period was 12.4 years. No difference in ovarian cancer mortality was seen among the two groups.

The USPSTF reviewed evidence on harms of screening for ovarian cancer from these and a fourth fair-quality study that reported on quality of life and psychological harms of screening.

False-positive rates calculated for the various screening methods were

- 4.2 percent in the UK Pilot trial (excluding peritoneal cancer);
- 11.9 percent in the UKCTOCS trial in the first round of screening with transvaginal ultrasound (excluding peritoneal cancer);
- 9 percent in the UKCTOCS trial in the first round of screening with CA-125 ROCA (excluding peritoneal cancer);
- 44.2 percent in the UKCTOCS
trial in all subsequent rounds of screening with CA-125 ROCA; and 9.6 percent in the intervention arm of the PLCO trial.

Across all the trials reviewed, the percentage of women randomized to screening who had surgery because of false-positive test results ranged from 0.2 percent to 3.2 percent. Of this group, 0 percent to 15 percent of participants experienced major surgical complications.

“The current screening tests do not do a good job identifying whether a woman does or does not have ovarian cancer,” said USPSTF Chair David Grossman, M.D., M.P.H., in the release. “The task force hopes that in the future, better screening tests for ovarian cancer will be developed.”

A Family Physician’s Perspective

Jennifer Frost, M.D., medical director for the AAFP Health of the Public and Science Division, told AAFP News the studies reviewed show that screening for ovarian cancer using transvaginal ultrasound and/or CA-125 testing does not reduce mortality from ovarian cancer but is associated with a high false-positive rate.

“This means that a significant number of women undergo further testing, including diagnostic surgery, when they do not have ovarian cancer,” she said. “These women are exposed to potential surgical complications and may undergo unnecessary salpingo-oophorectomy.”

Frost reiterated that there currently isn’t an effective screening strategy for ovarian cancer.

“Many clinicians perform a bimanual pelvic exam for this purpose, but the positive predictive value of the pelvic exam is zero to 3.6 percent,” she said.

And although the USPSTF said there is insufficient evidence to recommend against the bimanual exam, the AAFP and the American College of Physicians recommend against this exam given its low positive predictive value and the risk of harms, Frost added.

“Family physicians should remember that these recommendations are for women at average risk,” she said. “Although there is not an effective screening strategy for screening women at high risk, some of these women may be appropriate for BRCA testing.”

Up Next

The USPSTF is inviting comments on its draft recommendation statement (www.uspreventiveservicestaskforce.org) and draft evidence review (www.uspreventiveservicestaskforce.org).

The public comment window is open until 8 p.m. EDT on Aug. 14. All comments received will be considered as the task force prepares its final recommendation.

The AAFP will review the USPSTF’s draft recommendation statement and supporting evidence and provide comments to the task force. The Academy will release its own recommendation on the topic after the task force finalizes its guidance.

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The nation’s opioid abuse epidemic has been especially costly in Arkansas, in both lives lost, and the social and psychological costs of substance abuse. In 2015, Arkansas ranked 34th in the country for deaths due to drug overdose. In 2015, 392 Arkansans died of drug overdoses, a 10 percent increase from 2014. Death from prescription drug overdose is nearly double the death rate from illicit drugs.

Opioids are involved in 61 percent of all drug overdose deaths, according to the Centers for Disease Control and Prevention (CDC). Opioids are involved in about 40 percent of all emergency department visits for nonmedical drug use. The prescription opioids most often linked to overdose deaths include oxycodone, oxymorphone, hydrocodone, fentanyl and methadone. Heroin use is also driving the 200 percent increase in the rate of opioid-related overdose deaths since 2000.

Prescription drug monitoring programs (PMPs) are state-controlled databases that track prescriptions for controlled substances and identify overprescribing problems. They help providers identify patients who may be seeking prescriptions from multiple providers (“doctor shopping”), a behavior that greatly increases the risk of overdose death.

The Arkansas Department of Health implemented Arkansas’ PMP (AR-PMP) in 2013 after the Arkansas Legislature authorized it in Act 304 of 2011. By law, all licensed pharmacies and other licensed dispensers are required to report dispensing data to the AR-PMP for every controlled substance. Effective July 31, 2017, all prescribers must check the AR-PMP each time a prescription is written for a Schedule II and III opioid, and the first benzodiazepine prescription.

Originally, access to AR-PMP was granted to physicians, pharmacists, authorized prescribers, law enforcement, regulatory boards and the state medical examiner. Beginning in 2016, access was expanded to allow prescribers to delegate access of PMP data to designated staff members (licensed or unlicensed) whom they supervise. There is no limit to a prescribers’ number of delegates. All users must be approved for access according to statutory requirements. Delegates must create their own account. Once they register, the prescriber must link his/her account to delegates’ accounts. Access occurs through a secure website requiring authorized users to log in with a password.

AR-PMP benefits include the ability to:

- Determine when drug abuse or drug diversion occurs

- Collect data on Schedule II through V controlled substances
Arkansas has the HIGHEST teen birth rate in the nation.

Unplanned pregnancies occur when birth control is not used or not used correctly. Long-acting reversible contraception (LARC) methods, which include intrauterine devices (IUDs) and hormonal implants, are the most successful in preventing unplanned pregnancies.

Educate and encourage your patients to consider LARC.

LARC is recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) as the first-line contraceptive method, given its efficacy and safety.

Visit afmc.org/LARC for more information.
substances and these state-controlled drugs when dispensed to an individual: nalbuphine, ephedrine, pseudoephedrine and phenylpropanolamine

- Access controlled-substance data 24/7
- Access interstate data
- Help providers work together to improve patient care

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Click on the practitioner/pharmacist registration and enter the temporary user name newacct and temporary password of welcome. Fill out the form that appears. In response, you will receive two emails for your permanent user name and a password that you will be prompted to change.


At the end of the second quarter 2017, there were 7,440 prescribers (4,619 physicians) and 2,119 prescriber delegates registered with the AR-PMP. Physicians made 277,612 queries of the program in the first half of 2017.

In 2016, a new component was added to the patient history report that calculates the morphine equivalent dose (MED) for each opioid. Narcotic pain reliever doses greater than 100 MED have been shown to increase the risk of overdose and death. The MED calculation is: Dose x QTY x Conversion Factor / Day Supply = MED.

The MED for each opioid is displayed in the report’s last column; the MED Summary is at the bottom. The MED Summary provides an “MED Max” value, which is the maximum occurrence of cumulative MED sustained for any three consecutive days. This value is calculated based on the number of prescriptions dispensed during the date range requested.

The number of individuals receiving daily doses of narcotic pain relievers greater than 100 MED has steadily decreased, reflecting a positive change in opioid prescribing.

AR-PMP is a valuable tool for you and your practice to utilize in combating opioid misuse, abuse, overdose and death, but only if you use it.

The AR-PMP has greatly reduced the extreme instances of “doctor shopping.” The number of individuals visiting seven or more prescribers and seven or more pharmacies in a 90-day period (7/7/90) has decreased by 74 percent since AR-PMP implementation.

AR-PMP has implemented unsolicited reporting, a CDC best practice recommendation. Unsolicited reporting is a proactive dissemination of PMP information to prescribers alerting them to questionable patient activity. The initial parameter set to trigger an alert is set at 7/7/90. Each prescriber and pharmacy listed on a report will receive questionable patient activity alerts. If registered with the PMP, they will receive an email that a patient report is awaiting review. It is extremely important that contact information is current. Those not registered with AR-PMP will receive an alert letter directing them to register in order to view patient reports. In addition to questionable patient activity, the alert letter will also address several “what to do next” options. This information may be kept with patient history reports in the patient file or chart. It should be marked as confidential and not copied or forwarded to other parties.

In the website’s Reports section www.arkansaspmp.com, quarterly reports provide statistical data detailing registered users, queries and interstate data-sharing information. You will also find color-coded state opioid maps showing existing variations in the number of opioid recipients and the number of doses dispensed by county. The data are reported using rates to better compare larger and smaller populated counties.

Under the Resources tab, you will find links to prescribing guidelines, opioid prescribing continuing education opportunities and other information. The Substance Abuse Resources tab includes contacts for national and local addiction programs. To expand access to drug treatment, the limit has been increased on the number of patients to whom a physician can prescribe the maintenance drug buprenorphine. Unlike methadone for drug treatment, buprenorphine can be prescribed and dispensed from conventional medical practices. Arkansas can benefit from this change if physicians seek buprenorphine education and consider prescribing it when appropriate.

The AR-PMP actively shares data with 21 other states and our goal is to share data with our border states. According to several national articles published this year, PMP programs have been successful and Arkansas shares in that success. An article published by Health Affairs credited PMPs with sustained reduction in opioid prescribing by physicians nationwide. Another article credited PMP implementation with a reduction in opioid deaths nationwide.

AR-PMP is a valuable tool for you and your practice to utilize in combating opioid misuse, abuse, overdose and death, but only if you use it. Prescribers who use the PMP report higher confidence levels in prescribing opioids. AR-PMP technical assistance is available at arpmp-info@apprishealth.com by calling the Help Desk at 855-729-8917, weekdays 8 a.m.-5 p.m.

Dr. Robertson is Arkansas’ Prescription Monitoring Program administrator.
References

3. www.cdc.gov/mmwr 1-1-2-16
5. Health Affairs Vol. 35, No. 6, P. 1045 Bao, Yuhua; Pan, Yinjun; Taylor, Aryn; et al

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In early 2017, nearly 900 children in Ocean County, New Jersey faced possible revaccination when state health officials discovered that a pediatrician administered mumps, measles, chicken pox and other vaccines that had been improperly stored. The New Jersey example gives a glimpse into an important question among practices and clinics: how best to store vaccines.

Many vaccines, including those provided for by the Vaccines for Children (VFC) program, are monitored by state officials to help providers manage their supplies and ensure medications are safe and properly stored. A 2012 report from the Office of the Inspector General (OIG) at the Department of Health and Human Services revealed that improper refrigeration of vaccines could lead to practices losing a significant amount of money each year. As a result, the OIG recommended that the CDC continue to promote proper administration, storage and handling of vaccines, as well as educate providers in the VFC program.

Exposing vaccines to temperatures outside of designated ranges can compromise the integrity of the vaccines and contribute to wasted resources, as demonstrated in the OIG report. There is also a risk that the vaccines are rendered ineffective, as seen in the New Jersey case. The Advisory Committee on Immunization Practices (ACIP) recommends that potentially-compromised vaccines not be administered to patients and instead be properly discarded.

Managing vaccines can be a time-consuming process for clinicians, particularly given their many other responsibilities. Keeping vaccines in safe temperature ranges requires that teams of people follow the cold chain from the manufacturer to the provider, and also continuously monitor and control the temperature. For example, the Centers for Disease Control (CDC) recommends that MMR vaccines be kept in freezers below 5 degrees Fahrenheit, while HPV and hepatitis vaccines are kept in ranges of 36 to 46 degrees Fahrenheit.

One solution that practices have deployed is the use of digital thermometers with automatic alerts that constantly monitor vaccine storage equipment. In the case of the New Jersey pediatric practice, the digital thermometers were an immediate and effective solution, acceptable by the courts to help get the practice back on track, according to settlement documents.

For providers, remaining compliant with vaccine storage and management practices takes both commitment to continuing education and use of the latest technology. To stay updated on CDC guidelines for proper vaccine management practices, visit the You Call the Shots continuing education resource page.
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