The ARKANSAS FAMILY PHYSICIAN
Volume 21 • Number 4

AR AFP Office Has Moved!!!!

AR AFP 71st Annual Scientific Assembly
August 2-4, Embassy Suites, Little Rock
Pre Assembly, August 1

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The Arkansas Family Physician

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

Managing Editor
Carla Coleman

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EDITION 83

Dear Academy Member,

So far 2018 has started very busy! Along with our year end elections/re-elections; dues payments, taxes and beginning the program planning for our Annual Meeting August 1-4, we are also moving our office! Dr. Charles Smith , a member of the Board of Directors and I participated in the Annual Multi State Meeting in Dallas February 10 and 11 to share ideas and gain information from 12 other participating chapters.

We have been at our current location on Pleasant Valley for six years and of course we love it – the building, the area , the quietness and the close proximity to banks, the post office and everything we need; however, the space was too large since our conference room was not big enough to accommodate our board and in reviewing our budget, our long range plans and what we really felt was needed for the future, we began looking. We found , leased and by the time you receive this publication, we will have moved to our new location on Rahling Circle in West Little Rock. Again we will be close to the post office, banks and people we do business with . We will have considerably less space with 1100 compared to the 2152 we have had at Pleasant Valley but we also know that it is adequate space for our needs and the cost savings will be considerably less.

Please do note however that we will now be using a Post Office Box – not a physical address; to ensure we receive our mail. Our address is now: P. O. Box 242404, Little Rock, Ar 72223-9998. Our phone number and email will remain the same.

The financial statement for year end 2017 revealed total assets of $695,005,: Income for the year was in the amount of $338,945, and $343180 in expenses resulting in a net loss for the year of $4,236. Last year's net loss was $28,400. Our current assets which include checking , money market and CD accounts total $695,005. The Board of Directors approved a $25.00 increase in Active and Supporting Members dues beginning 2019 subject to approval by the membership at the Business meeting of the membership August 2.

The Academy also joined UAMS, and other medical related organizations in an Opiod Addiction Consultation Service that will kick off very soon . It will be a consultation service CME for physicians to use weekly at no charge for better pain medications for patients.

We hope you will plan on joining us August 1-4 in Little Rock at the Embassy Suites in Little Rock for our annual meeting! Any questions or any way we can assist all us at 501 223 2272.

Carla Coleman

On the cover:
Location of the AR AFP's New Office

pcipublishing.com
Created by Publishing Concepts, Inc.
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The Arkansas AFP Office has Moved!!!

As of 2/28/18, the AR AFP Office will have moved to 27 Rahling Road, Suite C, The Village at Rahling Road which is on the SE Corner of Chenal Parkway and Rahling Road. The office is 1100 square feet and includes a foyer, two offices, a private restroom, a large storage room with built in cabinets and a very large room for an office, for our break room and parking at the door with a nice view of Rahling Road. It was built in 2001.

After much thought and as much as we loved our space on Pleasant Valley Drive, the decision was made basically from a financial perspective to downsize the office so the search began several months ago and this move will ultimately save us over $1,000, per month in rent from what we were paying in 2017. We will have half the space we had on Pleasant Valley but although much smaller, it is more suitable for us. There of course will be start up costs involved with the moving company, deposits for electricity and gas but we believe the savings will begin to show in three months.

Due to the area and difficulty in obtaining mail in a timely fashion, we were advised by the post office to obtain a box for mail rather than delivery to the complex we are in. **Our new address is : P.O. Box 242404, Little Rock, Arkansas 72223-9998. The email and phone will remain the same.**

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From AAFP NEWS NOW:

Sharing Our Legislative, Regulatory Priorities for 2018

Shawn Martin, AAFP Senior Vice President of Advocacy, Practice Advancement and Policy

Congratulations to the Philadelphia Eagles on their Super Bowl victory. Now that Super Bowl LII is over, that can only mean one thing for sports fans -- spring training. Yes, that's right. One week from today, pitchers and catchers report, marking the beginning of the 2018 Major League Baseball season. Opening Day is March 29, and, for the first time since 1968, every team will play on Opening Day 2018. My beloved Washington Nationals open in Cincinnati and will host the New York Mets in their home opener on April 5.

The Second Session of the 115th Congress is well underway, and last week President Trump delivered his first State of the Union (SOTU) address(www.c-span.org) to a Joint Session of Congress. The SOTU is the traditional opportunity for presidents to frame their domestic and foreign policy priorities for the year. President Trump touched on a couple of health care issues in his address -- opioid epidemic, prescription drug prices and the repeal of the individual mandate -- but his speech largely focused on economics, national security and foreign affairs.

This post seems like a good time for me to outline some of the AAFP's legislative and regulatory priorities for the year. Due to limited word count, I will do this in two posts. These posts will provide an overview of our top-tier priorities, and by no means will they be an exhaustive list of all the issues and topics we will be working on in 2018. Additionally, this does not account for new issues that might emerge during the course of the year. As you know, the legislative and regulatory process always produce a few surprises.

Finally, these are not necessarily in a prioritized order. I have aligned the issues with the AAFP's strategic objectives under six topics: payment reform; practice transformation; workforce; clinical expertise; health care coverage and financing; and advocacy operations. This week, I will discuss payment reform and practice transformation.

Payment Reform

- **Advanced Primary Care Alternative Payment Model**(38 page PDF) **(APC-APM)** -- On Dec. 19, 2017, the Physician-Focused Payment Models Technical Advisory Committee (PTAC) approved the AAFP's APC-APM proposal for testing. https://www.aafp.org/media-center/releases-statements/all/2017/aafp-applauds-green-light-for-alternative-payment-model.html The next step is to work with HHS, CMS and the Center for Medicare and Medicaid Innovation (CMMI) to further refine the model and recruit physicians to participate in the testing phase.

  The AAFP is extremely excited about the opportunities the APC-APM presents to fundamentally change the primary care payment model and provide family physicians a more equitable and predictable revenue stream that is unencumbered by excessive administrative requirements. Lots more to come on this issue, so stay tuned.

MACRA implementation -- First, a gentle reminder that you have until March 31 to report data for the 2017 performance period(qpp.cms.gov). That is just over 50 days remaining. The 2018 performance period is underway, and eligible physicians are required to participate in one of the two payment pathways (MIPS or Advanced APM). The AAFP continues to advocate for improvements to the program. Our top priority is ensuring the availability of a greater number of Advanced APMs for family physicians. Implementation of the APC-APM is a central part of this strategy.

Our second priority is to dramatically simplify the MIPS program, starting with a reduction in the quality reporting requirements and simplification of the EHR usability requirements under the advancing care information (ACI) component.

Our third priority is to continue the low-volume threshold exemption for small practices but create a voluntary opt-in option for these practices. Many practices that are currently exempted have expressed a desire to participate in the program and we are exploring ways to make that possible on a voluntary basis. If you are participating in

the MIPS program, I encourage you to consult the AAFP's 2018 MIPS Playbook, an excellent step-by-step guide on how you can be successful in MIPS. This is one of many resources you will find on our MACRAReady pages.

- **Medicaid to Medicare parity** -- The Affordable Care Act required that state Medicaid programs compensate qualifying primary care physicians at Medicare rates for a defined set of primary care services (primarily E&M and prevention codes). This program was extremely popular and beneficial to family physicians participating in the Medicaid program, but it has expired. A handful of states have continued the program independent of federal support, but it is our goal to once again extend the program to all states.

Practice Transformation

- **Administrative and regulatory reform** -- The issue(s) of reducing the administrative and regulatory burden on family physicians is a major priority for the AAFP, and we are pursuing this objective with public and private payers. I wrote about this issue a couple of times during the past year -- here and here.

  In January 2017, the AAFP issued an Agenda for Regulatory and Administrative Reforms. In December of 2017, the AAFP Board of Directors approved the Academy's Principles for Administrative Simplification(4 page PDF), which serve as the foundation of our advocacy efforts on these issues.

  We also have been working closely with CMS Administrator Seema Verma and her team on the Patients Over Paperwork initiative. On Oct. 26, 2017, AAFP President Michael Munger, M.D., joined Verma at the launch of the initiative in Washington, DC. You can read Munger's comments here(280 KB PDF).

  Finally, we have been working closely with America's Health Insurance Plans (AHIP) and the large commercial insurers to identify ways to reduce the administrative burden on family physicians. Our top targets are the development of a uniform prior authorization form for all insurers, the elimination of PAs for generic medications, and the elimination of PAs for diabetic supplies. There is a substantial amount of work to do in this area, but we are devoting substantial attention to reducing burden for you and your practices.

- **Direct Primary Care** -- DPC continues to grow as an alternative to the traditional insurance-based practice model for family physicians. We continue to be excited about the model and its potential. Our advocacy efforts are three-fold. First, we are committed to providing tools, resources, and education to DPC practices. The AAFP's DPC Toolkit is a great resource for those who are in the early stages of starting a DPC practice. In addition, we offer some of the best DPC education programs in the nation. I encourage you to join us at the 2018 DPC Summit(www.dpcsummit.org) or FMX 2018, where you will find a full menu of education offerings on DPC ranging from "let's get started" to "working with employers." Finally, we have a lively and informative DPC Member Interest Group. This resource is a great place to meet other DPC physicians and to engage in discussion on items impacting DPC practices.

  Our second advocacy objective is to improve the regulatory framework to better align DPC practices with patients. A key to achieving this objective is the enactment of the AAFP-supported Primary Care Enhancement Act(www.congress.gov). This legislation would clarify that individuals are allowed to use their HSA accounts to facilitate a relationship with a DPC practice by determining that the monthly membership fee for a DPC practice is an allowable medical expense. The AAFP has worked closely with the bill's sponsors for several years and is committed to seeing this legislation enacted into law during the 115th Congress.

  Finally, the AAFP has been working closely with the Trump Administration, especially Verma, on expanding opportunities for the DPC model in Medicare, Medicaid and the health insurance marketplaces. Many of these efforts are active, but I am confident that we may see some significant activity on these efforts later this year. Stay tuned.

I hope you have found this information informative. Again, this is not an exhaustive list so if you do not see an issue, it does not mean we are not working on it. In two weeks, I will outline our work on workforce; clinical expertise; health care coverage and financing; and advocacy operations.

Medicaid Provider Inactivity Letter

Some providers were incorrectly selected to receive a cancellation notification letter due to Medicaid billing inactivity. Please disregard this letter: providers will not be cancelled for inactivity as stated. The problem is being corrected and letters will be sent only to appropriately inactive providers.

FAMILY PHYSICIAN OPPORTUNITY

The SHARE Foundation in El Dorado, Arkansas is seeking a full time Family Physician to work with its Hospice Program, including a 16 bed hospice house as a collaborating physician for its charitable clinic. The clinic is staffed with two Advance Practice Nurses and the Family Physician would also be a consultant for its aquatics/ health and fitness center.

For questions about this position, please contact Dr. Brian Jones, President/CEO at bjones@sharefoundation.com.

Learn more about the SHARE Foundation and this position at www.sharefoundation.com

For other practice opportunities in Arkansas or to post positions for Family Physicians in our state, please contact our office at arafp@sbcglobal.net.

MIPS 2018 Update: Revised Claim Codes for Quality Measure Reporting

Eligible clinicians participating in the Merit-based Incentive Payment System (MIPS) who plan to report MIPS Quality measures using claims should be aware that some claims codes have changed for the 2018 performance period. Following are answers to common questions about the claims-based reporting.

Question: We noticed some of the 2018 Quality Data Codes (QDCs) for claims submissions have changed. If my practice submits claims using the previous codes, will they count toward our MIPS Quality measure submission for the 2018 period?

Answer: If you have submitted the claim and it has been processed, you cannot resubmit solely to add or correct the QDC. You should switch to the correct codes as soon as possible to ensure you meet the measure's data completeness requirement of 60 percent for the 2018 performance year.

Q: How do I know if my claims submissions count toward my MIPS Quality measure requirements?

A: When the claim is processed and you are credited for the measure, you will receive an N620 follow-up code stating, "This procedure code is for quality reporting/informational purposes only." This code indicates the QDC codes are valid; it does not mean the QDC code was correct or that you met the measure requirement. Keep track of submitted cases so that you can verify QDCs reported against the remittance advice notice sent by the Medicare Administrative Contractor (MAC).

Q: Is it too late to begin MIPS claims submissions for 2018?

A: The most important component of MIPS Quality measure reporting is the 60 percent data completeness requirement. That means 60 percent of a MIPS-eligible clinician's patients who meet the denominator criteria for the measure must be included, regardless of payer, for the 2018 performance period. If you begin billing using the appropriate codes early in the period, you have a good chance of meeting this criteria.

The Centers for Medicare and Medicaid Services (CMS) released updated measure specifications on Dec. 27, 2017. Find these on the CMS QPP Resources webpage.

Free Support from TMF

Contact TMF for resources, tools and assistance for claims-based reporting and other Quality Payment Program topics.

Submit a TMF Request for Support.

Email QualityReporting@tmf.org (practices with 16 or more eligible clinicians) or QPP-SURS@tmf.org (practices with 15 or fewer eligible clinicians).

Call 1-844-317-7609 or live chat with a TMF consultant, Monday - Friday, 8 a.m. - 5 p.m. CT.

CMS Seeking Practices to Participate in Measure Development Testing Opportunity

The Centers for Medicare & Medicaid Services (CMS) is currently seeking primary care practices to help test a potential change to an electronic clinical quality measure (eCQM) related to clinician referrals. The measure is entitled **Closing the Referral Loop: Receipt of Specialist Report (CMS50v5).** The benefit to practices testing this measure is they will directly contribute to the refinement and validation of an eCQM that CMS uses in its quality reporting programs. In addition, **honoraria will range from $2,000-$4,000, depending on practices' level of testing participation.**

Interested practices should be reporting this eCQM under the Merit-Based Incentive Payment System (MIPS) or another CMS quality improvement initiative. Data elements should be documented in structured fields of the electronic health record (EHR) or electronic medical record (EMR), and practices should be able to extract patient-level information about data elements. Under the current measure specification, the denominator includes the **first referral** for each patient who was referred to other clinicians during the measurement period. Under the proposed revisions to the measure, the denominator includes **all referrals** during the measurement period.

The testing activities will involve practice staff—both clinicians and, if applicable, practice managers—speaking with a project team from Mathematica Policy Research, a CMS contractor, about the practices' workflows and the data elements they capture in their EHRs. Practices will be asked to submit an extract of de-identified patient-level data from the EHR, including all of the data elements required to calculate the current and proposed revised versions of the measure. Additionally, practices will be asked to work with the Mathematica project team who will abstract data from a sample of charts to verify the accuracy of the data elements. The de-identified patient-level data will be shared with Mathematica for analysis. Practices will receive feedback from Mathematica about their data, including rates of referrals and the proportion of referrals with follow-up information returned to the referring provider by the specialist. None of the testing activities will involve an audit of the practices' performance scores reported to CMS quality reporting programs.

For more information or if you are interested in assisting with this activity, please contact Shari Glickman at SGlickman@mathematica-mpr.com and Omoniyi Adekanmbi at OAdekanmbi@mathematica-mpr.com

Plant, Animal and Mineral

Changes in the Drug Industry

Part 6

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

This is the last in a series of articles detailing the evolution of drugs and pharmaceutical services in the state of Arkansas over the last two hundred years.

In this article we will focus our attention on changes in the pharmaceutical industry that had a significant impact on the practice of medicine in the United States and specifically Arkansas.

Drug Effectiveness and Safety

A number of pieces of legislation were passed in the 20th century aimed at protecting the public from fraudulent claims by drug manufactures. The Pure Food and Drug Act of 1906 was designed to give the public more information as to contents of a particular preparation; the law had primarily to do with product labeling. In 1938 the Food, Drug and Cosmetic Act required, for the first time that a drug must be proven to be safe and receive the FDA's approval before it could be marketed. In 1951, the Congress passed the Durham-Humphrey Amendment to the FDCA which created the definition of prescription drugs to include those drugs that because of their toxicity or their potential for abuse were not safe for use except under the supervision of a practitioner, licensed by law to administer such drugs. The driving force behind this law was the number of new barbiturates and amphetamines that were on the market.

It should be noted that neither of the laws and regulations listed above had anything to say with the effectiveness of a drug. In 1957, thalidomide was introduced in West Germany as an over-the-counter aid for anxiety gastritis and tension. In a short time, a large number of babies were born with phocomelia (malformation of the limbs). Ten thousand cases were eventually reported worldwide directly associated with the drug. Dr. Frances Kelsey, FDA medical officer, is credited with refusing to authorize the wide release of the drug in the United. States. Unknown to the FDA, the drug company had released the drug to 1200 physicians on an experimental basis. The agency launched a nationwide campaigning to recover all supplies of the drug, reminiscent of the sulfa scandal in 1938. There was a major outcry in the country that prompted Representative Orin Harris from Arkansas and Senator Estes Kefauver of Tennessee to sponsor the Drug Efficacy Amendment of 1962. This bill required that drug manufacturers prove scientifically that medication was not only safe but was effective. The FDA was granted the power to demand proof of efficacy in the form of adequate and well-controlled investigations. Another part of the law required a review of all of the drugs approved between 1938-1962, looking carefully at their efficacy. By 1970, over 600 of these drugs were found to be ineffective and were withdrawn from the market. These bills were strongly opposed by the AMA arguing that "the only possible final determination as to the efficacy and ultimate use of a drug is the extensive clinical use of that drug by large numbers of medical profession over a long period of time."

The passage of the bill was a long-fought battle but in the end the Kefauver-Harris Bill was passed and signed into law by President Kennedy.

The Double-Edged Sword

Narcotics and opioid addiction

are not a new problem. The pain relief provided from the poppy plant was recognized for several centuries. Morphine was first extracted from the opium plant in 1804 and, by the Civil War, it was in wide use. In 1898, Bayer Drug company began producing heroin commercially. By the 1910s, narcotic abuse and addiction were common and widespread. The Harrison Narcotic Act of 1914 was designed to begin the process of reining in the use of narcotics. In 1924, heroin was outlawed because of its abuse.

The 1960s saw an abrupt increase in the use and abuse of narcotics and other psychotropic drugs. By 1970, the use and abuse of narcotics seemed to be reaching epidemic proportion. The Comprehensive Drug Abuse Prevention and Control Act was passed and signed into law by President Richard Nixon. The law requires the scheduling of controlled substances, divided into five schedules on the basis of their potential for abuse and medical use. Substances in Schedule I have a high potential for abuse, no accredited medical use, and a lack of accepted safety. From Schedules II to V, substances decrease in potential for abuse. Prescriptions for drugs in all schedules must bear the physician's federal Drug Enforcement Administration (DEA) license number.

For the next several decades there was an ongoing argument, played out in the major journals, about whether these drugs could be managed with little risk. Many reputable authors underplayed the risk. As the abuse of hydrocodone, oxycodone and fentanyl increased dramatically, these arguments have been put to rest.

Doctor, don't you think I need?

We are all confronted with the

issue of a patient standing in front of us with a magazine ad or a printout from the Internet extolling the benefits of the latest drug that has just entered the market. The idea of self-diagnosis and self-medication is as old as the practice of medicine. In the 19th century there were few effective medicines and patients usually chose their own medicine purchased through a druggist or grocery store. Patent Medicines seldom labeled the ingredients in their product. In the early 20th century the AMA declared two categories of medicines, "Patent Medicines" that were of questionable use and value and "Ethical" drugs that were prescribed by a physician. The companies that produced Patent Medicines strongly believed in newspaper advertising and these type ads contributed roughly half of most newspaper's advertising income. Often, the advertising took the form of official looking news stories. The AMA urged physicians not to advertise nor to prescribe Patent Medicines. The Pure Food and Drug Act of 1906 prohibited false and misleading statements about the ingredients or identity of a drug; it did not, however, prevent the drug companies from making fraudulent claims about efficacy.

The Durham-Humphrey act of 1952 essentially divided drugs into prescription and over-the-counter (OTC) drugs. Paradoxically, in the 1950s and 1960s, those purchasing an OTC drug got more information about the drug than those purchasing a prescription drug.

Once drugs were provided by physician's prescription, pharmaceutical companies stopped advertising directly to patients and, instead, channeled all their promotions to health professionals. By the 1960s, more than 90 percent of all drug promotion was aimed at doctors and the other 10 percent went to pharmacists and hospitals. Sales representatives or "detail men" became one of the main physician conduits for drug information. A study done in 1965 showed that 45 percent of physicians indicated that a "good" detail man was more like a friend than a salesman. The Arkansas Drug Travelers was an organization that advertised in the Journal of the Arkansas Pharmacists Association, with pictures and names of many of the familiar detail men who served the state of Arkansas.

Slowly during the 1960s, consumer demand began to build for more drug information. The patient's rights movement of the 1970s raised the issue of consumer's awareness of prescription drugs, their uses and their risks.

By the mid-1980s, Direct-To-Consumer-Advertising had taken on a life of its own. In 1991, DTCA was a $55 million/year, by 1995 it rose to $363 million dollars. Few would argue that DTCA has created a dramatic transformation of the consumer's role in health care. The debate continues as to whether this transformation is positive or negative.

For questions or remarks
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DEGREE OF FELLOW CONVOCATIONS
To Be Held at AR AFP Assembly

The American Academy of Family Physicians Degree of Fellow was established in 1971 is 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.

You may be eligible for this honor if you are an Active, Life or Inactive member of the AAFP and have been for at least six years or have held a combination of Resident and Active membership for at least six years.

The Arkansas Chapter will recognize Arkansas Family Physicians who have earned the Degree of Fellow by the American Academy of Family Physicians at the Annual Scientific Assembly at Embassy Suites. You must have completed the application and earned your Degree of Fellow by May 1, 2018 in order to be conferred at the August Assembly.

The requirements and application can be found at: https://nf.aafp.org/DegreeOfFellow

Please let us know if you wish to be conferred in August or need assistance in applying for the Degree of Fellow by calling 800-592-1093 or 501-223-2272 or email us at arafp@sbcglobal.net.

Have you met your CME Requirements for 2018??

Members due for re-election this year have until December 31, 2018 to earn your CME!

CME Requirements for Membership

ACTIVE and SUPPORTING (FP) MEMBERS must accrue at least 150 hours of approved continuing education within each three-year reporting period to retain membership. These credits must include at least 75 Prescribed credits and at least 25 group activity hours.

Reporting Your CME

The Academy offers several easy and convenient ways to report CME credit:

- Online at www.aafp.org/cme
- Complete quizzes for AAFP programs such as American Family Physician, Family Practice Management, Home Study Self Assessment, Video CME, and Proficiency Testing.
- Call a CME representative 1-800-274-2237 between the hours of 8:30 a.m. – 5:00 p.m. Central Time.
- Or call the Arkansas Chapter Office at 1-800-592-1093 or 501-223-2272 and we will be happy to assist you and report your hours for you!

The AAFP offers members over 200 credits of free online CME. For a complete listing, log-on to www.aafp.org/onlinecme.xml.

Questions About CME

If you have questions about your reelection or need a current copy of your CME record, please call Michelle at 1-501-223-2272 or 1-800-592-1093.

Dr. Jeffrey Mayfield Appointed to AAFP Commission

Dr. Jeffrey Mayfield , a family physician in Bryant, Ar. was appointed to the Commission on Continuing Professional Development of the American Academy of Family Physicians.

Dr. Mayfield's term of office began December 15, 2017 and ends December 14, 2021.

He was nominated by the Arkansas Chapter, American Academy of Family Physicians Board of Directors as a candidate for this commission and has served the Arkansas Chapter, AAFP for over 20 years having served in every elective office including President in 2011-12 and currently serves as Alternate Delegate to the AAFP Congress of Delegates and on the Executive and Nominating Committee of the AR AFP. He is a Diplomate of the American Board of Family Physicians.

The Commission on COCPD works directly to support the AAFP's Strategic Objective on Clinical Expertise (education) by supporting the lifelong learning of family physician members and other health care professionals. The Commission's priority areas of attention include;

AAFP CME Accreditation: Guidance and Perspective on AAFP's Accreditation or provision of CME/CPD Delivery methods, such as live group activities, interactive lectures, problem based learning discussion, procedural workshops, self study learning activities, and other innovative methods for teaching, learning assessment or improvement: CME aspects of Maintenance of Certification and Licensure: Performance Improvement Continuing Medical Education: Oversight of the planning provision and evaluation of all AAFP provided CME activities.

The American Academy of Family Physicians is the nation's second largest medical specialty organization with over 129,000 members nationwide with chapters in every state as well as Uniformed Services, Virgin Islands, Guam, Puerto Rico with the mission to improve the health of patients, families and communities by serving the needs of members with professionalism and creativity. The four objectives of the AAFP is Advocacy, Practice Enhancement, Education and Health of the Public.

ARKANSAS ACADEMY OF FAMILY PHYSICIANS
71ST ANNUAL SCIENTIFIC ASSEMBLY
AUGUST 2-4, 2018 Pre Assembly August 1
EMBASSY SUITES, LITTLE ROCK, ARKANSAS

Please plan to be with us at the 71st Annual Scientific Assembly of the Arkansas Academy of Family Physicians. We begin on Wednesday at 1:15 with three and half hour Pre Assembly on Pediatrics with the Annual Assembly kicking off at 8:30 a.m. on Thursday, August 2 and concluding Saturday, August 4 at approximately 11 a.m.

We will be making many changes this year to our program format as attendees requested at last year's meeting such as more TED Talks, less lunch meetings with speakers to allow for networking with colleagues. Our special Academy guest will be Dr. Reid Blackwelder of Tennessee, Past President of the American Academy who will not only provide an update from the AAFP but will also install our officers.

The Fellowship Convocation will be held during the Assembly - the date and time is not yet scheduled.

The Pre Assembly Program on Wednesday afternoon will be a variety of Pediatric Topics of interest to family physicians.

Although the program committee is still working on the program, we do have some topics booked as follows: "Value Based Compensation": "Changes in Prostate Screening": "Integrated Mental Health": "Opoid Prescribing": "Clostridium Difficile": "Travel Medicine": "DVT Treatments, A Fib and Anticoagulants." We will be finalizing the program very soon and contacting speakers.

There will also be 33 exhibits displaying during our meeting on Thursday August 2 and Friday, August 3.

We hope you will plan on being with us. Hotel reservation information along with the complete program and registration information will be coming in May!

ADH Announces Opening of The Arkansas Lifeline Call Center

Little Rock, Ark. – The Arkansas Department of Health (ADH) has officially opened the Arkansas Lifeline Call Center, which is now answering calls made in Arkansas to the National Suicide Prevention Lifeline at 1-800-273-8255.

The opening of the call center was mandated by Act 811 of the 2017 legislative session. This is the first call center for the national line to be operated by a state health department in the nation. Previously, Arkansas was one of two states without an in-state call center, which meant that calls were being answered out of the state.

"We are pleased to offer this important in-state service for Arkansans," said Dr. Nathaniel Smith, ADH Director and State Health Officer. "Callers in crisis will be able to speak to someone here in Arkansas who has a strong understanding of the resources available in the state. This number is available for many reasons - whether a person is contemplating suicide or is having feelings of anxiousness, depression, hopelessness, or they just want to talk."

Suicide is the leading cause of violent death in Arkansas. In 2016, there were 546 suicide deaths, which is more than double the amount of homicides that year. Sixty-seven of those deaths were youth ages 10-24.

Veterans can access the Veteran Crisis Line by calling the national line at 1-800-273-8255 and pressing 1. Anyone can also text the crisis line by sending TALK to 741741, or chat online at www.chat.suicidepreventionlifeline.org

The ADH Injury and Violence Prevention Section works to prevent suicides through education, resources, and awareness. To learn more about the trainings and resources that are available for your group, business, or school, visit http://www.healthy.arkansas.gov/programs-services/topics/suicide-prevention.

IN MEMORY

Patrick Harrison of Irving, Texas formerly from Little Rock passed away suddenly Wednesday, February 7 at his home. He was 51 years old.

Those of you who attended our annual meeting from 1987 through 2011 will remember Patrick who was our Audiovisual and Sound Technician at our annual meeting for all of those years and was a very good friend to not only us but to many of you he became acquainted with through the years. He was certainly a professional and we will miss him very much.

Our sympathy is extended to Patrick's family and friends.

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Demographic Characteristics By Membership Type
Chapter: Arkansas AFP

Demographic	Active		Inactive		Life		Resident		Student		Supporting		Totals	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Gender														
Male	624	71.81	2	50.00	89	89.00	92	58.23	125	47.89	3	75.00	935	66.98
Female	245	28.19	2	50.00	11	11.00	63	39.87	123	47.13	1	25.00	445	31.88
No response	0	0.00	0	0.00	0	0.00	3	1.90	13	4.98	0	0.00	16	1.15
Gender Totals	869	100.00	4	100.00	100	100.00	158	100.00	261	100.00	4	100.00	1396	100.00
AAFP Fellow														
Yes	154	17.72	1	25.00	72	72.00	0	0.00	0	0.00	0	0.00	227	16.26
No	715	82.28	3	75.00	28	28.00	158	100.00	261	100.00	4	100.00	1169	83.74
AAFP Fellow Totals	869	100.00	4	100.00	100	100.00	158	100.00	261	100.00	4	100.00	1396	100.00
Med. School Grad														
US Med. Sch.	710	81.70	4	100.00	97	97.00	69	43.67	261	100.00	4	100.00	1145	82.02
Int. Med. Sch.	159	18.30	0	0.00	3	3.00	88	55.70	0	0.00	0	0.00	250	17.91
No response	0	0.00	0	0.00	0	0.00	1	0.63	0	0.00	0	0.00	1	0.07
Med. School Grad Totals	869	100.00	4	100.00	100	100.00	158	100.00	261	100.00	4	100.00	1396	100.00
FP Residency Grad														
Yes	835	96.09	2	50.00	28	28.00	158	100.00	0	0.00	0	0.00	1023	73.28
No	34	3.91	2	50.00	72	72.00	0	0.00	261	100.00	4	100.00	373	26.72
FP Residency Grad Totals	869	100.00	4	100.00	100	100.00	158	100.00	261	100.00	4	100.00	1396	100.00
Ages														

Demographic	Active		Inactive		Life		Resident		Student		Supporting		Totals	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
0-20	0	0.00	0	0.00	0	0.00	0	0.00	1	0.38	0	0.00	1	0.07
20-24	0	0.00	0	0.00	0	0.00	0	0.00	89	34.10	0	0.00	89	6.38
25-29	9	1.04	0	0.00	0	0.00	46	29.11	128	49.04	0	0.00	183	13.11
30-34	75	8.63	0	0.00	0	0.00	83	52.53	18	6.90	0	0.00	176	12.61
35-39	107	12.31	0	0.00	0	0.00	18	11.39	2	0.77	1	25.00	128	9.17
40-44	95	10.93	0	0.00	0	0.00	2	1.27	0	0.00	0	0.00	97	6.95
45-49	143	16.46	0	0.00	0	0.00	5	3.16	1	0.38	0	0.00	149	10.67
50-54	103	11.85	2	50.00	0	0.00	1	0.63	0	0.00	0	0.00	106	7.59
55-59	105	12.08	0	0.00	2	2.00	1	0.63	0	0.00	1	25.00	109	7.81
60-64	121	13.92	0	0.00	4	4.00	0	0.00	0	0.00	2	50.00	127	9.10
65-69	65	7.48	0	0.00	12	12.00	0	0.00	0	0.00	0	0.00	77	5.52
70-74	24	2.76	1	25.00	15	15.00	0	0.00	0	0.00	0	0.00	40	2.87
75->	6	0.69	1	25.00	67	67.00	0	0.00	0	0.00	0	0.00	74	5.30
Unknown	16	1.84	0	0.00	0	0.00	2	1.27	22	8.43	0	0.00	40	2.87
Ages Totals	869	100.00	4	100.00	100	100.00	158	100.00	261	100.00	4	100.00	1396	100.00
Average Ages		50.11		63.25		77.63		32.10		25.72		56.50		45.83
Urbanization Code														

Demographic	Active		Inactive		Life		Resident		Student		Supporting		Totals	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent
1	13	1.50	0	0.00	2	2.00	5	3.16	2	0.77	0	0.00	22	1.58
2	421	48.45	1	25.00	47	47.00	67	42.41	227	86.97	4	100.00	767	54.94
3	122	14.04	1	25.00	14	14.00	45	28.48	4	1.53	0	0.00	186	13.32
4	24	2.76	0	0.00	6	6.00	0	0.00	2	0.77	0	0.00	32	2.29
5	24	2.76	1	25.00	4	4.00	0	0.00	1	0.38	0	0.00	30	2.15
6	77	8.86	1	25.00	11	11.00	2	1.27	0	0.00	0	0.00	91	6.52
7	98	11.28	0	0.00	9	9.00	8	5.06	1	0.38	0	0.00	116	8.31
9	9	1.04	0	0.00	3	3.00	0	0.00	1	0.38	0	0.00	13	0.93
Unknown	79	9.09	0	0.00	4	4.00	31	19.62	23	8.81	0	0.00	137	9.81
8	2	0.23	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	2	0.14
Urbanization Code Totals	869	100.00	4	100.00	100	100.00	158	100.00	261	100.00	4	100.00	1396	100.00

Printed: 02/01/2018

For a description of Urbanization codes see http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx#.U6BkLhCXJA8 and then select the 2013 Rural-Urban Continuum Codes link.

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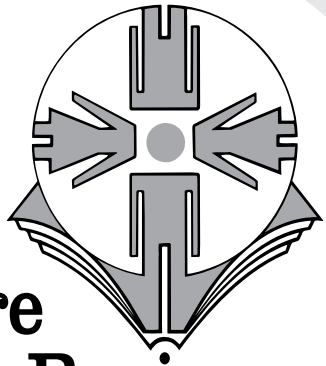

The Core Content Review of Family Medicine

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From AAFP NEWS NOW:

Value-based Payment Modifier Initiative Winds Down

■ CMS Releases 2018 Results

January 23, 2018 12:15 pm

News Staff

CMS recently released outcomes data on the value-based payment modifier(www.cms.gov) for 2018 -- the final year for the initiative -- and noted some high points.

For instance, more than 20,000 physicians and other clinicians will receive increases in their Medicare payments based on quality and cost measures data reported in 2016.

That means CMS will make good on pay increases that range from 6.6 percent to 19.9 percent.

Physicians and other clinicians who met the minimum quality reporting requirements will see positive or neutral payment adjustments; those who did not meet minimum requirements will see their Medicare payment decreased.

Based on details made public in CMS' Jan. 12 fact sheet,(www.cms.gov) the percentage of physicians who will receive a negative payment adjustment in 2018 decreased compared with percentages for the past two years.

Furthermore, CMS noted that because of rule changes in the 2018 Medicare physician fee schedule, practices that reported quality data that would have landed them a penalty based on previous value modifier policies would instead be held harmless.

As noted by CMS, in 2018

- 3,478 total practices (1.7 percent) representing 20,48l total clinicians will receive an upward payment adjustment,
- 74,024 practices (35.7 percent) representing 746,556 clinicians can plan on a neutral payment adjustment based on their performance,
- 8,007 practices (3.9 percent) representing 87,841 clinicians were held harmless and will see a neutral payment adjustment, and
- 121,642 practices (58.7 percent) representing 296,475 clinicians will get a downward adjustment in their Medicare payment because they failed to report quality measures.

The percentage of the negative adjustment is based on practice size. Solo physicians and those in practices with nine or fewer clinicians will see a 1 percent penalty, and physicians in groups with 10 or more clinicians will receive a 2 percent penalty.

A total of 207,151 practices were included in the 2018 value modifier program, accounting for 1,151,353 total clinicians.

Moving forward, physicians will participate in the Quality Payment Program, which rewards value and outcomes via two pathways -- the Merit-based Incentive Payment System (which effectively replaces the value-based modifier) and advanced alternative payment models.

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Thank you for maintaining your membership in the AAFP!

From AAFP NEWS NOW:

CDC, AAFP Release 2018 Immunization Schedules

■ Updates Include Preferential Shingrix Recommendation, Third MMR Dose for Some

February 06, 2018 02:53 pm

Chris Crawford

The CDC and its Advisory Committee on Immunization Practices (ACIP), together with the AAFP and other medical professional organizations, have released the 2018 adult and childhood immunization schedules.

Changes in this year's schedule include recommending preferential use of the new herpes zoster subunit vaccine (HZ/su; Shingrix), which is approved for use in adults 50 and older, over the currently available herpes zoster live vaccine (Zostavax).

Adult Schedule Highlights

Recent Academy liaison to the ACIP Margot Savoy, M.D., M.P.H., told *AAFP News* that the biggest update to the adult immunization schedule was the herpes zoster vaccine preferential recommendation. That recommendation came out of the ACIP's October 2017 meeting.(www.cdc.gov)

"Both are safe vaccines," she said. "The new subunit vaccine, Shingrix, appears to be significantly more effective at preventing herpes zoster in immunocompetent adults ages 50 and older. So, if you have an adult who has never been vaccinated for shingles, give them Shingrix. If you have an adult who was vaccinated with Zostavax, give them Shingrix too."

Story Highlights

- Changes to the newly released 2018 immunization schedules include recommending preferential use of the new, FDA-approved herpes zoster subunit (HZ/su; Shingrix) vaccine over the currently available herpes zoster live (Zostavax) vaccine for adults 50 and older.
- A third dose of measles, mumps and rubella vaccine now is recommended for patients considered to be at-risk during outbreaks.
- The 2018 childhood immunization schedule has been revised to be easier to read, with increased white space and a larger font size in the footnotes section.

Next, for mumps-containing vaccines, Savoy said that although the current two-dose series has been effective in controlling mumps in the United States for decades, recent evidence shows waning immunity has contributed to an increase in outbreaks. Therefore, a third dose of measles, mumps and rubella vaccine is recommended for at-risk patients during outbreaks.

"Hopefully, most of us will not be involved in needing to give the third dose of mumps-containing vaccine because we will not be managing an outbreak," Savoy said. "Unfortunately, we are seeing ongoing outbreaks of mumps in the U.S., particularly in settings where people have close, prolonged contact, such as universities and close-knit communities."

According to Savoy, during a local outbreak of mumps, the state or local public health department will provide guidance about which contacts are at greatest risk and would benefit from the additional dose.

"In general, people at increased risk for acquiring mumps are those who are more likely to have prolonged or intense exposure to droplets or saliva from a person infected with mumps, such as through close contact or sharing of drinks or utensils," she said.

As for the influenza vaccine, Savoy said not much has changed, even given this year's flu season, which has proven quite deadly.

"While the vaccine hasn't been as effective at preventing influenza infections this year, those who were vaccinated appear to have a much lower risk of death," she noted. "And that alone is reason to continue encouraging your unvaccinated patients to get their flu shot even during the season."

The ACIP will choose and announce the new strains for the 2018-19 season flu shot at its June meeting. It's currently unclear whether live attenuated influenza vaccine (LAIV; FluMist) will return in the upcoming season, said Savoy.

Childhood and Catch-up Schedule Highlights

Like its adult vaccine schedule counterpart last year, the 2018 childhood immunization schedule has been revised to be easier to read, with increased white space and a larger font size in the footnotes section.

Formatting changes include

using bulleted lists instead of complete sentences and removing redundant language. Additionally, the title page was updated to include a table listing vaccine abbreviations and product names.

"The ACIP continues to work on clarifying the language and presentation of the vaccine schedules using feedback from clinicians across the country," Savoy explained.

One long-standing source of confusion among physicians that the current schedule aims to address, she said, has been whether the dashes used in ranges meant "between" or "through."

"So, for example, if there is an age range saying '12-18 years,' it means 12 years through 18 years," Savoy said. "In other words, a patient who is age 18 and two days should still get the vaccine because that patient is still in their eighteenth year."

The updated recommendation on mumps-containing vaccine mentioned above also applies to younger patients; a third dose is warranted for at-risk patients when public health departments deem it necessary.

And finally, the recommendation against using LAIV remains in effect for children and adolescents during the current flu season.

Coding Cards and Other Resources

For the first time, the AAFP is offering members an option to buy childhood vaccine coding reference cards.

The card package, which costs $25 for members, includes five desk-reference and five pocket-size versions of the childhood schedule that can be shared with other physicians and practice team members. The quick-reference cards are intended to facilitate payment for administration of 15 vaccinations, with one side of each card supporting ancillary staff administration, and the other side supporting physician counseling with administration.

In addition, Savoy said the Academy offers a variety of resources to support family physicians' work with immunizations, including the AAFP Foundation's recently launched Highlight on VACCINATIONS 4 TEENS(www.aafpfoundation.org) program.

And this isn't the only news about vaccines that AAFP members can expect to hear in the coming months, according to Savoy. "Be on the lookout for exciting new announcements from the Commission on the Health of the Public and Science this spring around vaccine tools," she said.

AAFP PRESIDENT'S MESSAGE

"Fighting for Family Medicine is More Important than Ever"

By: Michael Munger, M.D.,President, AAFP, Leawood, Kansas

As we enter 2018, we face a remarkable and unpredictable time for our country, our patients and our profession. Lawmakers are weighing important decisions that impact access to health care for all Americans, while physicians are coping with more administrative burden than we've ever seen before.

The AAFP strives to provide value to its members by advancing our specialty, strengthening our collective voice, and providing solutions to enhance the care we give our patients. Now more than ever, it is critical that the AAFP meets your needs. To that end, I want to share some of the key issues the Academy plans to focus on in the new year.

Back in September, I shared results of the AAFP's Member Satisfaction Survey, including some of the top priorities members asked us to address. Two of those issues, increasing physician payment and reducing administrative burden, will factor into much of our work to fight for today's family physicians and help fill the family physician pipeline.

Payment Reform

The AAFP has developed and proposed an important alternative payment model for family medicine and primary care that includes risk-adjusted prospective monthly payments to cover evaluation and management visits, a separate risk-adjusted prospective monthly payment for care management services for non-face-to-face patient care and coordination, quarterly performance-based incentive payments, and fee-for-service payments as needed. In addition to enhancing overall payment, the upfront bundled monthly payments are expected to reduce claims-related administrative burden by eliminating the need for billing documentation requirements. Such alternative payment models also are important to another AAFP goal of increasing the overall annual spend on primary care -- which now stands at about 6 percent of total spend -- to as much as 15 percent.

Last month, the AAFP achieved a major success when a special CMS technical advisory committee recommended that HHS test the payment model, and we will be advocating that HHS accept that recommendation in the coming months.

In addition to our efforts to implement this alternative payment model, the AAFP is working to help prepare members for success in new payment models, including the Merit-based Incentive Payment System (MIPS). We have developed resources such as the MIPS Playbook, which is free for members and provides a step-by-step guide to MIPS participation. Also, educational supplements have been, and will continue to be, published in *FPM* (formerly *Family Practice Management*) to highlight specific aspects of the Quality Payment Program and explain how members can realize payment now and be successful in these new models going forward.

Shaping Legislation and Regulation

Administrative burdens, such as prior authorizations, not only are a source of great frustration, they reduce patients' ability to access our care in the current fee-for-service environment and adversely impact our practice margins and ability to deliver comprehensive care. The Academy meets regularly with regulators, legislators and public and private payers to discuss issues related to payment and administrative burden. This month, for example, I was on Capitol Hill with representatives from five other primary care organizations advocating on a wide range of issues that are important to our members' practices and patients. Representatives from the AAFP also attended a meeting with the Office of the National Coordinator for Health Information Technology to discuss issues related to electronic health records.

We'll also be keeping a close eye on two initiatives CMS launched late last year that are intended to reduce administrative burden.

Affordable Health Care for All

Another issue members asked us to prioritize in our 2017 survey was affordable health coverage for all. This remains consistent with AAFP policy first adopted in 1989. Coverage not only affects patient outcomes, it also impacts physician payment. Just before the end of the year, Congress included funding for the Children's Health Insurance Program (CHIP) in a short-term spending bill intended to keep the program going through March. The reality is that some states will run out of CHIP funding this month. Consistent with our policy, the AAFP will continue to fight for this vital program, which covers roughly 9 million children and must have stable, long-term support.

Protecting Physician Well-being

Regulatory and administrative burdens are also major contributors to physician burnout. Although the Academy is working on long-term strategies to address these issues, we also are developing tools to help provide more immediate relief. In September, the Academy launched its Physician Health First initiative. A web portal includes free resources to help physicians develop individual practices that address burnout and improve well-being, including content related to physician health, financial tools and practice tips. The site also offers free CME for members, as well as access to the Maslach Burnout Inventory.

New content is being added to the portal each month, and a well-being planner will launch in the spring before the Family Physician Health and Well-being Conference, which is scheduled for April 18-21 in Naples, Fla. That meeting will allow attendees to earn up to 18 AAFP Prescribed credits and develop an individualized plan to address their well-being.

The AAFP also is one of more than 50 organizations supporting the Action Collaborative on Clinician Well-Being and Resilience. The initiative, which was launched by the National Academy of Medicine, plans to introduce new resources this month.

Building the Future

While the AAFP is working on a myriad of fronts to help our members in daily practice, we also are working to build our specialty's pipeline for the future. The AAFP and other stakeholders are working on a new, long-term goal to increase student choice of family medicine to 25 percent of all U.S. medical graduates by 2030.

We will work toward that goal by

- expanding the influence of the AAFP National Conference of Family Medicine Residents and Medical Students,
- supporting family medicine interest groups to be active champions for family medicine,
- working with medical school faculty and staff to better understand the most effective strategies to increase student choice, and
- building relationships and new partners in pipeline workforce development to help strengthen pathways to family medicine for students from groups that are underrepresented in medicine.

Increasing student choice by itself will not be enough to address the projected shortage of primary care physicians. The Academy will continue to advocate for graduate medical education reform that leads to more residency slots for family medicine.

Spotlight on Health Equity

The Academy is committed to taking a leadership role in addressing diversity and social determinants of health and striving for health equity. The AAFP launched its Center for Diversity and Health Equity last year, and the center is working on many fronts to assist our members in their practices and communities in this important area by

- raising awareness of the effect of social determinants of health and establishing best practices for screening;
- developing strategies for coordinating with social services and behavioral health resources;
- developing workflows that incorporate the primary care practice team;
- advocating for initiatives that support relevant policy at the local, state and federal levels;
- supporting CME; and
- producing topic issue briefs to engage multisector stakeholders.

It's clear that the AAFP has important priorities in the coming year, which is a direct reflection of the vital importance of the work we do as family physicians. As I said, we live in remarkable times. Our membership, much like our country, has differing views on the current status of our health care system. But I assure you that the AAFP, its Board of Directors and its staff are constantly and passionately working on behalf of *all* our members and our specialty. We are committed to delivering results that create a better health care system based on foundational family medicine and primary care while ensuring it is a system that pays our members differently and better.

I am proud to serve as president for the AAFP in the coming year. I am also proud of our members and the work we do for our communities. But most importantly, I am proud of the common ground we share as family physicians. We are called to heal. We must fight to protect our ability to answer that call.

Arkansas' Strategy to Reduce Maternal Mortality and Morbidity

By Michelle Murtha, RN, Arkansas Foundation for Medical Care

Unlike women in the rest of the developed world, American women are far more likely to die from childbirth or pregnancy-related causes, according to the Centers for Disease Control and Prevention (CDC). More than 700 women die each year in the United States due to pregnancy and childbirth-related complications. The CDC's National Vital Statistics System ranks the United States 46th in the world for maternal mortality. Arkansas' maternal death rate is the third-highest in the nation with 35 maternal deaths per 100,000 live births annually. The national average is 20 deaths per 100,000 live births.

While maternal deaths are increasing in the United States, serious maternal morbidity is increasing even faster. The CDC reports more than 60,000 new mothers experience serious or life-threatening complications every year. From 1993 to 2014, the serious-complication rate more than doubled. New mothers needing resuscitation from heart failure increased by 175 percent; the need for endotracheal tubes and sepsis treatment both increased by 75 percent. Cesarean births have increased from less than 5 percent in the 1960s to 33 percent in 2016 – about twice the rate in European countries. Cesarean-sections increase the risk for hemorrhages, blood clots, infections and uterine ruptures in subsequent pregnancies. During the past 20 years, the number of women with induced labor more than doubled. Induction leads to more prolonged labor, increasing the risk of hemorrhage.

The cost of caring for severe maternal morbidity costs billions of dollars a year. Treating preeclampsia alone costs more than $1 billion annually, according to the *American Journal of Obstetrics and Gynecology.*

A combination of factors causes high mortality and morbidity rates, including:

- Access to care
- Pre-existing chronic conditions including obesity, hypertension, diabetes or cardiovascular disease
- Increase in maternal age
- Increase in drug addiction
- Use of tobacco and alcohol

The risk of pregnancy-related deaths for black women is three to four times higher than for white or Hispanic women. Even healthy women who give birth are at risk for complications.

The leading causes of maternal death are:

- Hemorrhage
- Hypertensive disorder
- Cardiovascular diseases
- Pulmonary embolism
- Amniotic fluid embolism
- Infections

The most common preventable errors that lead to maternal mortality and morbidity include:

- Failure to adequately control hypertension
- Failure to diagnose and treat pulmonary edema in women with preeclampsia
- Insufficient attention to vital signs or hemorrhage following Cesarean birth.

Arkansas' strategy to decrease maternal deaths

Arkansas' efforts to reduce maternal mortality and morbidity focuses on hospitals and the implementation of maternal safety bundles that were developed and endorsed by national multidisciplinary organizations.

Maternal safety bundles include action measures for:

- Obstetrical hemorrhage
- Severe hypertension/preeclampsia
- Cardiovascular diseases in pregnancy
- Prevention of venous thromboembolism
- Reduction of low-risk primary Cesarean births and support for intended vaginal births
- Reduction of peripartum racial disparities
- Postpartum care access and standards

The University of Arkansas for Medical Sciences' Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) and Center for Distance Health hosted the *Perinatal Outcomes*

continued on page 28

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continued from page 26

Workgroup by Education and Research (POWER) networking event in April 2017 for every Arkansas facility that provides obstetric services.

The training focused on implementing patient safety bundles for two leading causes of maternal mortality: Postpartum hemorrhage and hypertensive emergencies in pregnancy. Each facility received components of both bundles, supporting literature and hyperlinks to other resources.

POWER works with participating facilities to adopt the safety bundles. The goal is for every facility to implement these two safety bundles and assign a staff mentor to facilitate the process. The facilities identified aspects of each bundle that were already in place, aspects that needed development and potential barriers to implementation. Regular virtual meetings are held to assess progress and identify areas needing support.

Under the direction of Arkansas Medicaid, AFMC's Medicaid Quality Improvement team is focusing on educating new mothers about post-birth warning signs. The focus groups will include hospital emergency and obstetric departments, hospital prenatal classes, OB/GYN providers, nurses and clinic staff, home visitors and community health units.

The postpartum period is a critical time to ensure women and their newborns are healthy. It is important for women and their family members to be educated about the warning signs that can potentially cause maternal death. Education is vital to successfully reduce and prevent maternal mortality and morbidity.

Moms need to be aware of the many changes their body goes through during pregnancy and delivery. While there will be discomfort, soreness and fatigue, they must understand that some conditions need medical attention. New mothers should be encouraged to trust their instincts about their bodies and pay attention to these **warning signs**:

- Bleeding that's heavier than during normal menstrual period or gets worse
- Discharge, pain or redness that does not go away or worsens
- Feelings of sadness lasting longer than 10 days after birth
- Fever over 100.4 F
- Pain or burning when urinating
- Pain, swelling and tenderness in legs, especially calves
- Red streaks on breasts or painful lumps in a breast
- Headache that does not lessen after taking medicine; headache with vision changes
- Severe pain in lower stomach, feeling nauseous or vomiting
- Foul-smelling vaginal discharge

Critical warning signs include:

- Bleeding that can't be controlled
- Chest pain
- Trouble breathing or shortness of breath
- Seizures
- Signs of shock
- Mother has thoughts of hurting herself, the baby or others

References

Centers for Disease Control and Prevention. *Meeting the Challenges of Measuring and Preventing Maternal Mortality in the United States*. Retrieved from https://www.cdc.gov/cdcgrandrounds/archives/2017/november2017.html

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Postpartum Discharge Education Program. (2017) *POST-BIRTH Warning Signs: The Nurse's Role in Preventing Maternal Morbidity and Mortality.* Retrieved from http://www.awhonn.org/?page=POSTBIRTH

Building U.S. Capacity to Review and Prevent Maternal Deaths. (2017). *Report from maternal mortality review committees: a view into their critical role.* Retrieved from https://www.cdcfoundation.org/sites/default/files/upload/pdf/MMRIAReport.pdf

Centers for Disease Control and Prevention. *At A Glance 2016: Maternal Health: Advancing the Health of Mothers in the 21st Century.* Atlanta, GA: CDC, Div. of Reproductive Health; 2016. https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-maternal-health.pdf

Centers for Disease Control and Prevention. *Saving Mothers, Giving Life: Maternal Mortality. Phase 1 Monitoring and Evaluation Report.* Atlanta, GA: CDC, U.S. Dept. of Health and Human Services; 2014. https://www.savingmothersgivinglife.org/docs/Maternal_Perinatal_Outcomes.pdf

American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine*, Kilpatrick SK, Ecker JL. Severe maternal morbidity: screening and review . Am J Obstet Gynecol. 2016;215(3):B17–B22. https://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Severe-Maternal-Morbidity-Screening-and-Review*

American College of Obstetricians and Gynecologists, Association of Women's Health, Obstetric and Neonatal Nurses, The Joint Commission, Society for Maternal-Fetal Medicine. *Severe maternal morbidity: clarification of the new Joint Commission sentinel event policy.* Washington, DC: American College of Obstetricians and Gynecologists, AWHONN, SMFM; Oakbrook Terrace (IL): Joint Commission; 2015. Available at: http://www.acog.org/About-ACOG/News-Room/Statements/2015/Severe-Maternal-Morbidity-Clarification-of-the-New-Joint-Commission-Sentinel-Event-Policy

Mrs. Murtha is a quality manager with AFMC.

Voice Response System (VRS) Update

Providers may use the Voice Response System (VRS) to assign a primary care provider (PCP) if the patient doesn't have a PCP already assigned. This system can be reached by calling 1-800-805-1512.

It is important to follow the process provided in section 173.200 of the Arkansas Medicaid manual. Be sure to have on file a copy of the PCP change form signed by the beneficiary. The PCP change form is in section V of the Arkansas Medicaid manual.

Download PCP change form from: http://go.afmc.org/e/130061/mxr-130061-121326-DMS-2609-doc/2s9ctp/420606190

Caseload information has also been updated on the Provider Portal. This allows providers to update their caseload information. Job aids are available to assist providers with this process.

Download job aid: http://go.afmc.org/e/130061/JobAid-UpdatingPCPCaseload-pdf/2s9ctr/420606190

If you have questions, please contact your AFMC Provider Relations representative.

ARMedicaid

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ADH adopts new guidelines for high blood pressure

Hypertension (high blood pressure) is one of the primary causes of heart attack and stroke. Arkansas leads the nation for the highest heart attack death rates and is number five for the highest stroke death rates.

To combat this, the Arkansas Department of Health (ADH) and other healthcare providers are adopting new hypertension (high blood pressure) guidelines developed by the American Heart Association, the American College of Cardiology, and nine other health professional organizations. These guidelines indicate that some patients who were not thought to have high blood pressure may now be considered hypertensive. Hypertension leads to illness and death–but it can be prevented.

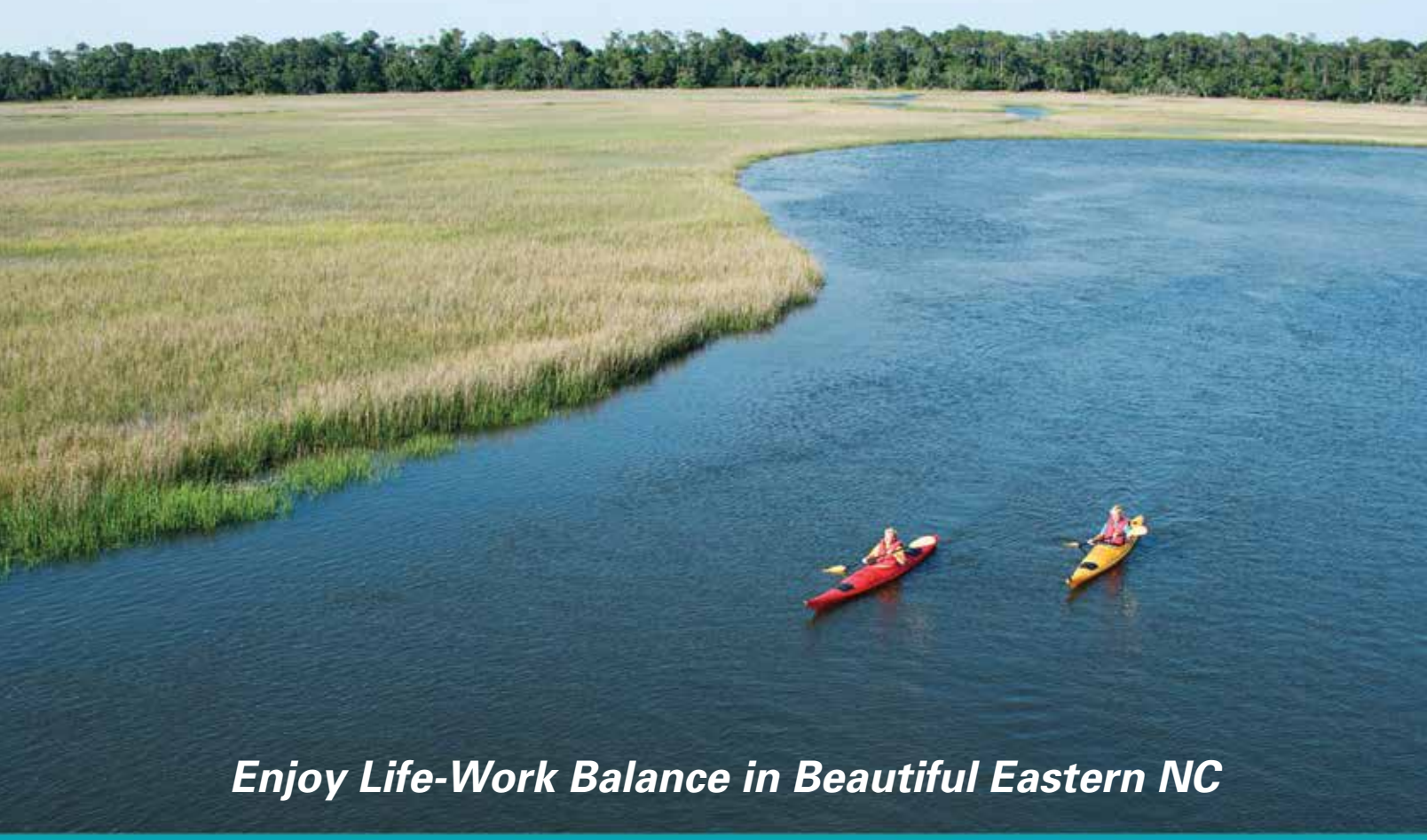
The new guidelines redefine high blood pressure, treatment thresholds, goals, and medications in the management of hypertension in adults. This is the first update to the United States guidelines on blood pressure detection and treatment since 2003. **High blood pressure is now defined as readings of 130 and higher for the systolic blood pressure measurement (top number), or readings of 80 and higher for the diastolic measurement (bottom number).** That is a change from the old definition of 140/90 and higher, and reflects the health impact that can occur at those lower numbers.

"By changing the definition of high blood pressure, the guidelines recommend earlier steps for care to prevent the illness and death that can occur as a result of uncontrolled hypertension," said Dr. Appathurai Balamurugan, ADH State Chronic Disease Director. "People should know their blood pressure numbers, and make important lifestyle choices, like quitting smoking, getting physically active, and eating a healthy diet that will help lower blood pressure."

Legislative Fiscal Session Begins in Arkansas

The Fiscal Session that began on February 12 included Governor Hutchinson's explanation of his new budget to lawmakers wich had been cut $100 million for the FY beginning July 1. He stated the budget shows a slower growth in Medicaid spending and meets requirements of education adequacy. It increases funding for public safety and reduces on surpluses to fund ongoing budget needs.

The Governor highlighted a new report from the Department of Human Sources that the state's Medicaid program now has 117,620 fewer enrollees than a year ago. The new number of 931,000 Arkansans on Medicaid includes 285,564 who receive expanded healthcare coverage through the Arkansas Works Program under the Affordable Care Act also known as Obamacare. The Governor's new budget calls for an increase in Medicaid spending of only 2.17% compared to the nation's average and earlier budget recommendation of 4.5%.



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