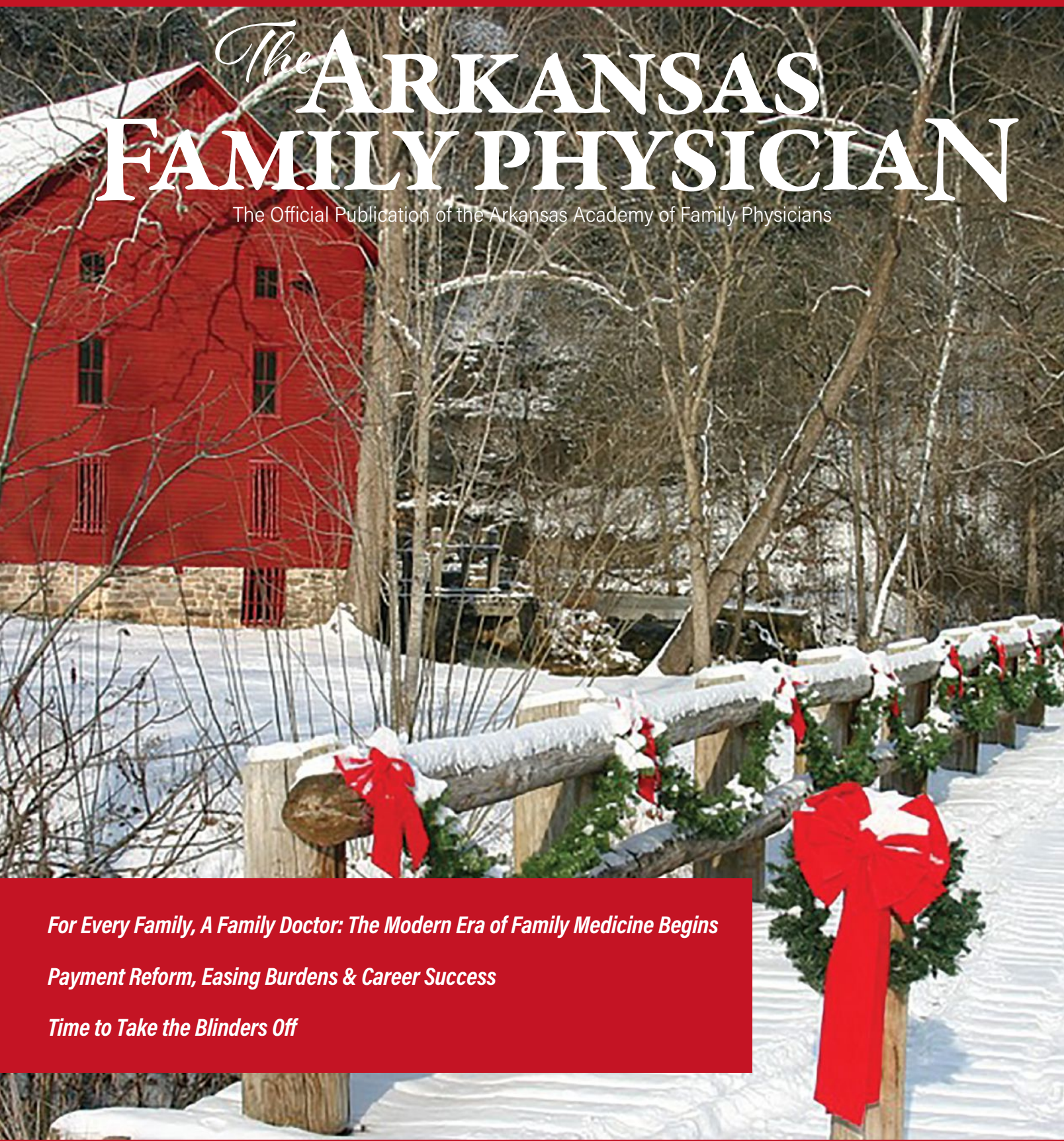
Happy Holidays!

The Arkansas Family Physician

The Official Publication of the Arkansas Academy of Family Physicians



For Every Family, A Family Doctor: The Modern Era of Family Medicine Begins

Payment Reform, Easing Burdens & Career Success

Time to Take the Blinders Off

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

Volume 26 • Number 3 • Winter 2022

MEDICATIONS AND BREAST MILK

There are a few medications that are not safe in breastfeeding, so it's important for providers to be aware of these.

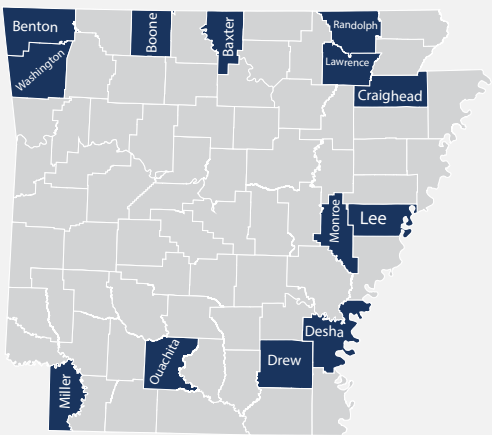
Providers may email **breastfeedingmedicine@uams.edu** to address medication safety concerns for their breastfeeding patients. A second option is to download the app called InfantRisk HCP (App Store for iphone and Google Play for android). The app clearly identifies medications as safe, "use with caution" or dangerous to the baby, based on what mom is taking, what percent might be present in her milk and how readily the baby will absorb it. **Breastfeeding is best.**

UAMS College of Medicine

SPAN
State Physical Activity & Nutrition for Arkansas

bit.ly/SPAN4Arkansas

Family physicians in 13 counties have committed to promoting breastfeeding. Join the Breastfeeding Initiative, and you'll get a copy of Dr. Thomas Hale's book, *Medications & Mother's Milk*, the Breastfeeding and Protocol Guide and earn free CME at the UAMS Family Medicine Spring Review April 25 - 28. Email **wmitchell@uams.edu** for details.



Hear more from Dr. Misty Virmani on medications and breast milk.

Scan to view

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

MANAGING EDITOR
Mary Beth Rogers

EDITION 102

The **Arkansas Family Physician** is the official publication of the Arkansas Academy of Family Physicians

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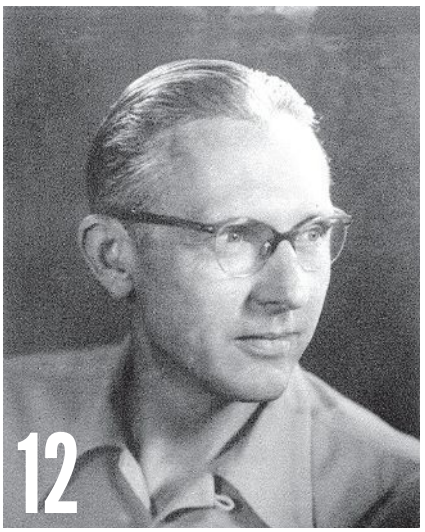

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PRESIDENT'S MESSAGE

Tasha Starks, M.D.
President

Greetings Arkansas AFP,

We are off to a great start following our scientific assembly. The Legislative Committee has been working very hard to prepare for the upcoming legislative session. Several items of discussion involve Medicaid reimbursement that incentivizes pre-natal care in rural areas, methods to simplify or remove pre-authorization requirements, ways to increase primary care spend, and scope of practice. I understand as a membership organization, that we have members who are passionate on a variety of issues. We want to carefully choose our advocacy messages to focus on our ability to care for our patients. To this end, we welcome your input! Please reach out to the academy and share your thoughts and voice. We need members to share stories and testimony during the legislative session for the issues we value and certainly for issues that will impose on or impede our ability to practice. We will continue to advocate for the health of our patient and communities, but again We Need You!

Along the lines of needing our members for advocacy, we need Mentors. We want to continue to increase the number of medical students who choose Family Medicine as a specialty. The 2022 NRMP Match had the most family medicine positions available in history – 4,935, and an all-time high for osteopathic medical students matching in family medicine. 4,470 medical students and graduates matched to family medicine residency programs. In Arkansas, the NRMP reports there were 86 positions available, but only 77 filled. We need every position filled, and the "pace needs to accelerate in order to meet the demand for family medicine in the U.S." Why? The American Academy of Family Physicians predicts Arkansas will need a 23% increase in the number of Family Physicians in the state by 2030. "This is due to an aging, growing, and increasingly insured population in Arkansas". We Need You! If you are interested in serving as mentor, please contact the academy at info@arkansasafp.org or (501) 316-4011.

The Academy is preparing for our 2023 Scientific Assembly. We appreciate those who attended the conference this year, and look forward to seeing new and old faces again in 2023. Thank you to those who filled out the evaluations at the last assembly. We would like to hear from all members on what you want and need from the meeting. We are planning to offer a potpourri of topics from Behavioral Health, Finance, Women's Health, ABFM Updates and much more. We want to offer relevant and innovative continuing education to meet the needs of our membership. But We Need You!

I value the commitment of the Arkansas Academy of Family Physicians to serve you through advocacy, personal and professional growth. As we move into the season of Thanksgiving, I want each and every one of you to know that you are Valued, Appreciated, Resilient, and the health of Arkansans improves each and every day because of the work you do. The Academy is Thankful for You!

1. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/the_match/AAFP-2022-Match-Results-for-Family-Medicine.pdf.

2. www.aafp.org

Another resource to help patients stay well.

Be Well Arkansas is a free program that helps Arkansans quit nicotine and tobacco with personalized counseling sessions and local resources to support them every step of the way.

Call: **1-833-283-WELL** (9355)

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be well


Mary Beth Rogers,
ArAFP Executive Director

Getting Ready for 2023

A brand-new year is just around the corner and a fresh start is just what the doctor ordered. When we held our first in person meeting after the pandemic (is it safe to say that yet?) our message was "Stronger Together", and that message has never been truer as we head into the new year. The legislative session starts in January and already promises to be a busy one. Our legislative team has been engaged with our partners to determine our game plan. It's a lot like playing 20 games of chess, Monopoly and Battleship all at the same time. The good news is that the voice of family physicians is growing in influence and respect as we continue to build relationships. This is a prime example of how we are truly stronger together.

One of the hot topics you will hear about this session is behavioral health. According to a report by the Robert Graham Center, 93.8% of physicians surveyed believe providing integrated behavioral health improves patient care. At the same time, fewer than 50% of those with a mental illness report receiving care in the past year. Check out the article by Dr. Patty Gibson in this issue and be on the lookout for more information as we explore ways to collaborate.

We are working on primary care investment and prior authorization with our partners. There will be more issues as we go along but know that we are tuned in and ready to work on your behalf. The best way to stay one top of these issues to is watch for our "Membership Matters" emails.

There are sweeping changes on the national level too. As the PHE is winding down in early 2023 it will cause some changes that we may not remember were part of the PHE three years ago. When the PHE concludes, provider enrollment will roll back to pre-pandemic procedures (no expedited processing), practitioners will be required to resume reporting their home address on Medicare enrollment and the state will oversee where a provider can practice. The government is accepting applications to waive these impending changes. We will host a meeting with the Arkansas Department of Human Services in December to update you on what to expect. Watch your email for more information.

And now for a little good news! We are planning some new things for 2023. Our chapter has been awarded an OUD/SUD educational grant. We will be working with the Opioid Response Network (ORN) to develop a training program specifically for our chapter.

We have also been awarded an AAFP FMPC Chapter Engagement Grant to build out the Learning on Demand portal on the website. The Learning on Demand section will offer our members a way to access CME anytime, anywhere.

Currently, we have received enduring credit for the 2022 Scientific Assembly sessions. For a nominal fee you can view the sessions and complete an evaluation form for credit. You can access great topics like drug interactions, wilderness medicine, culinary medicine, hospice care, urology and much more. Just contact us at the office for more information.

Mark your calendar for August 9-12 for the 2023 Scientific Assembly to bet held at the Little Embassy Suites. Planning for the Scientific Assembly is underway with more workshops and hands-on experiences. The Foundation will be hosting a bike ride as a fundraiser so plan to bring your bike and enjoy some exercise and fellowship all while supporting the future of family medicine.

This summer your board embarked on creating a new strategic plan for our organization. It was a great meeting of the minds and was a productive time to set our priorities and goals to keep working towards meeting our member's needs. We created several task forces to address areas of concerns. I am so thankful for our board members and their hard work to make us the best we can be.

I am always happy to hear from members about anything that is on your mind to help us navigate the changing healthcare landscape. It will take us all working together to make 2023 a productive year where we take two steps forward and no steps back. We can do it because we are truly stronger together!

I hope you take some time to relax, enjoy your family and do the things that bring you peace and joy this holiday season. May the new year be the best chapter in your book of life!

Mary Beth Rogers

Mary Beth Rogers
Executive Director

NEW FROM CDC

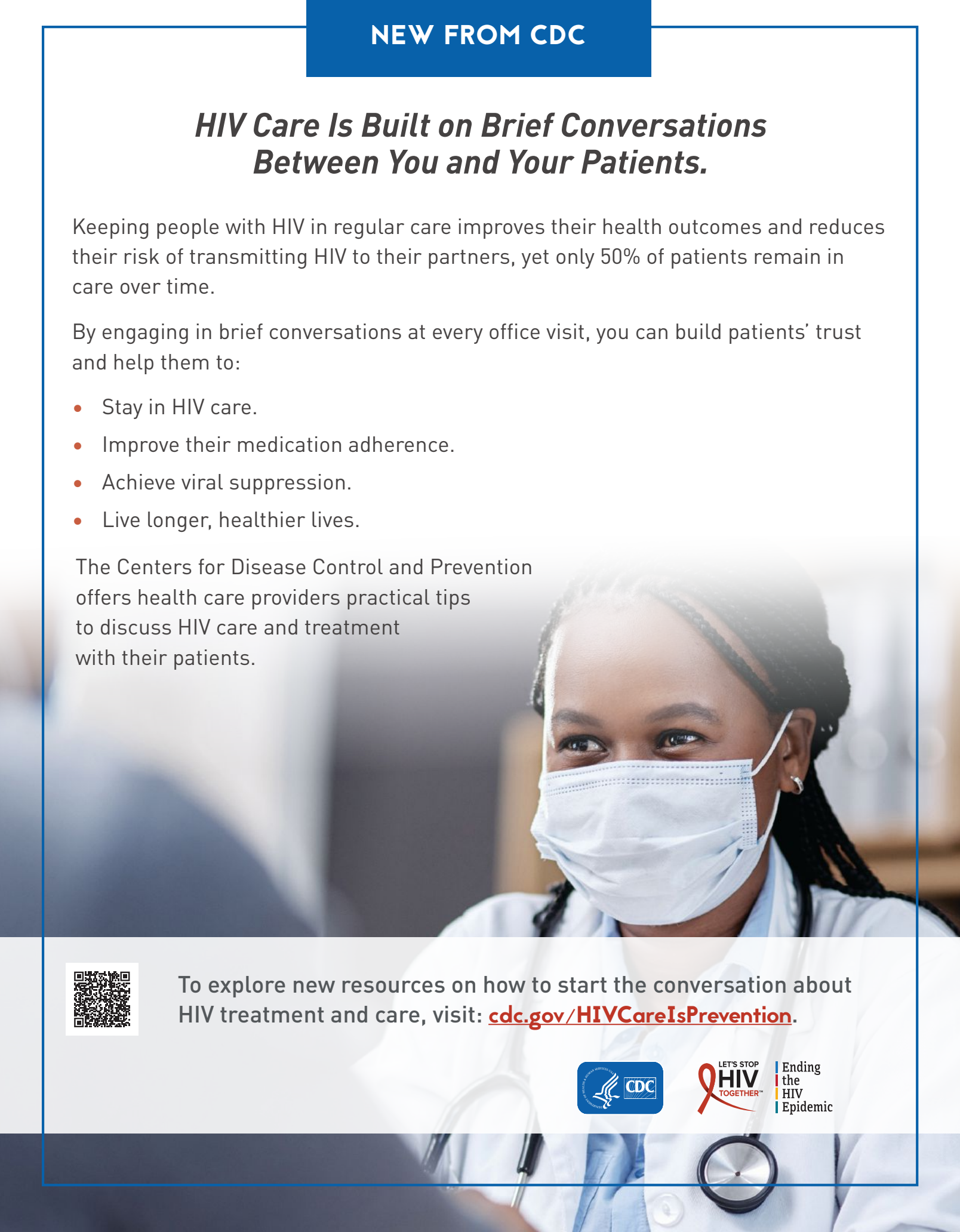
HIV Care Is Built on Brief Conversations Between You and Your Patients.

Keeping people with HIV in regular care improves their health outcomes and reduces their risk of transmitting HIV to their partners, yet only 50% of patients remain in care over time.

By engaging in brief conversations at every office visit, you can build patients' trust and help them to:

- Stay in HIV care.
- Improve their medication adherence.
- Achieve viral suppression.
- Live longer, healthier lives.

The Centers for Disease Control and Prevention offers health care providers practical tips to discuss HIV care and treatment with their patients.



To explore new resources on how to start the conversation about HIV treatment and care, visit: cdc.gov/HIVCareIsPrevention.

CDC

LET'S STOP HIV TOGETHER™ Ending the HIV Epidemic

Patty Gibson, MD
Patty.Gibson@ABHINetwork.org
www.ABHINetwork.org

Time to Take Our Blinders Off – But What Can We Do?

- There is a mental health crisis. More Overdose deaths. More suicides.
- Shortage of psychiatrist and psychotherapists
- Primary Care is the De-facto Mental Health System

It's no longer news that that there is a mental health crisis or that we have more suicides and more overdoses than ever before.

The President of the Arkansas Medical Society, Dr. Seth Barnes, recently expressed his concerns in an editorial in the AMS Journal saying, "it happens in every office and hospital every day. No specialty is immune to matters of mental health. No doubt the recent social issues associated with the pandemic have brought a lot of these diagnoses to the forefront... and isolation and social interruptions have destabilized otherwise stable medical conditions." https://joom.ag/mj1d

The harder reality is that the shortage of psychiatrists and mental health clinicians is getting worse, which means that ***Primary Care will continue to be the "Defacto Mental Health System"*** where 75% of patients will get their mental health care and psychotropic medications will be prescribed by primary care physicians. https://tinyurl.com/2p953b2w

Behavioral Health Integration is the ideal solution, and many family physicians in Arkansas have begun to add components of these models to their practices. Some practices have hired therapists to work on their teams as primary care behaviorists and others have begun to use a psychiatric collaborative care management model.

In that recent AMS Journal several family physicians described their positive experiences with behavioral health integration which was implemented as part of the Comprehensive Primary Care (CPC+) program. Unfortunately, many practices are struggling to continue, or expand, their BHI programs due to difficulty with payment for these services after CPC+ payments ended. https://joom.ag/mj1d

Although AR Behavioral Health Integration Network (ABHIN) has been working to bring more training and awareness of BHI to the state, there are still significant financial and operational barriers to be able to add this type of care to primary care. ABHIN is available as a resource to help practices, but we also wanted to share some recommendations and resources. www.ABHINetwork.org

Action steps for family physicians (see links below):

1. **Accept and embrace the reality** that your patients want and need you as their physician to provide "whole person care." This is a change of culture and paradigm in our traditional healthcare approach that artificially separates the brain from the body.
2. **Educate yourself**, your clinic manager/leadership, your staff, and your patients about the importance of including mental and behavioral health care along with physical health care.
3. **Implement and bill for systematic screening** of depression, anxiety, and substance use for all patients, at least annually and as indicated for patients with symptoms or to monitor response to treatment. The PHQ9, GAD7, and one question substance use screen are commonly used and widely available.
4. **Develop office processes** in advance to be able to manage patients who are actively suicidal, psychotic or in withdrawal from substances.
5. Get your staff to **create a local resource list for social services** and/or access services in the state such as "Find Help," "211," "HARK," or "Unite Us."
6. Renew old friendships or make new **relationships with psychiatrists and therapists** that you can call when you have mental health questions or have patients to refer. Develop formal referral relationships that include your sharing information prior to referral and your getting records back from them in a timely fashion (like from other specialists).
7. **Hire a therapist, psychiatric nurse practitioner, and/or psychiatrist** who has training in behavioral health integration to work with you. Or consider consulting with a Behavioral Health agency/specialist or independent vendor to provide psychiatric collaborative care management (CoCM).
8. **Develop a plan for financial sustainability,** including billing for behavioral health screens and behavioral health interventions by embedded therapists and/or CoCM codes.

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9. **Actively advocate for changes in reimbursement** models by speaking with state and federal policy makers, insurance payers, and health system leadership. Consider participation in Value-Based Care programs, such as ACOs, CINs, MSSPs, Primary Care First, and ask partners and administrators to include rewarding behavioral health integration.

Resources/links:

- AMA
  - BHI Module: https://edhub.ama-assn.org/steps-forward/module/2782794
  - https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-physician-practices
  - https://www.ama-assn.org/system/files/bhi-compendium.pdf

- Education for Physicians managing mental health issues in primary care
  - Reach Institute: https://thereachinstitute.org/
  - UCSD course; https://www.psychiatry.uci.edu/fellowship/train-new-trainers-primary-care-psychiatry.asp

- Addressing Suicide in Primary Care:
  - https://tinyurl.com/46pzv7vn
  - https://www.ama-assn.org/system/files/overcoming-obstactles-addressing-suicidal-ideation-webinar-slides.pdf

- Substance Use disorder Guide:
  - https://www.ama-assn.org/delivering-care/overdose-epidemic/substance-use-disorder-treatment-guide
  - https://www.ama-assn.org/system/files/bhi-sud-how-to-guide.pdf

- Social Services Resources in Arkansas
  - Find Help: https://www.findhelp.org/
  - 211: https://arkansas211.org/
  - HARK: https://www.harknwa.com/
  - Unite Us: https://uniteus.com/solutions/providers/

- Mental Health Resources in Arkansas
  - UAMS AR Connect Now; https://uamshealth.com/ar-connectnow/
  - Youth UAMS AR Connect Now: https://www.faceyourfeelings.org/
  - Mental Health Resources: https://uamshealth.com/ar-connectnow/resources/
  - Substance Use Treatment Assistance: https://psychiatry.uams.edu/clinical-care/ar-connectnow/substance-abuse-facilities/
  - Resources for Veterans: https://www.campconnect.com/

- BHI jobs
  - CFHA Job site: https://jobs.cfha.net/
  - Hiring BHC: https://aims.uw.edu/resource-library/care-manager-role-and-job-description
  - Hiring Psychiatric Consultant: https://aims.uw.edu/resource-library/psychiatric-consultant-role-and-job-description

- CoCM Vendors
  - Concert Health: https://concerthealth.com/
  - Mindoula: https://www.mindoula.com/
  - Neuroflow: https://www.neuroflow.com/

- Psychotropic Medication Guides
  - https://wacoguide.org/
  - https://www.ama-assn.org/system/files/bhi-psychopharmacology-how-to-guide.pdf

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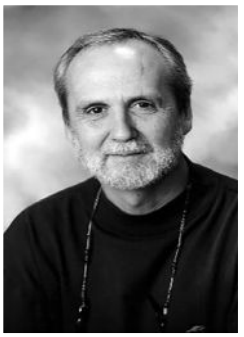
For Every Family, A Family Doctor

The Modern Era of Family Medicine Begins



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

The Family Doctor
by Edward Albert Guest

I've tried the high-toned specialists, who doctor folks to-day;
I've heard the throat man whisper low "Come on now let us spray";
I've sat in fancy offices and waited long my turn,
And paid for fifteen minutes what it took a week to earn;
But while these scientific men are kindly, one and all,
I miss the good old doctor that my mother used to call.
The old-time family doctor! Oh, I am sorry that he's gone,
He ushered us into the world and knew us every one;
He didn't have to ask a lot of questions, for he knew
Our histories from birth and all the ailments we'd been through.
And though as children small we feared the medicines he'd send,
The old-time family doctor grew to be our dearest friend.
No hour too late, no night too rough for him to heed our call;
He knew exactly where to hang his coat up in the hall;
He knew exactly where to go, which room upstairs to find
The patient he'd been called to see, and saying: "Never mind,
I'll run up there myself and see what's causing all the fuss."
It seems we grew to look and lean on him as one of us.
He had a big and kindly heart, a fine and tender way,
And more than once I've wished that I could call him in to-day.
The specialists are clever men and busy men, I know,
And haven't time to doctor as they did long years ago;
But some day he may come again, the friend that we can call,
The good old family doctor who will love us one and all.

In 1946, despite its official repeated opposition to a board specialty of general practice, the American Medical Association created a Section on General Practice of the Society that would meet at each convention and have a scientific meeting. The first meeting of the section was held in San Francisco on July 3rd,1946 in the Masonic Hall. The room was large enough to accommodate 500 physicians but was, at most, 1/2 to 2/3 full. The leadership of the AMA hadn't known a general practitioner who they felt could chair the session, so they chose an internist (Dr. Wingate Johnson) to organize and preside over the meeting. By all accounts, the scientific session was mediocre. Near the end of the session, the group began discussing having a business meeting the next day and electing a set of officers for the Section. They decided to create a nominating committee to recommend a slate of officers and establish an agenda for the next day's meeting. Near the end of the meeting, a general discussion began about the nearly universal problems being faced by all general practitioners in the United States. During this meeting, Dr. Stanley Truman of Oakland California made an impromptu presentation on how the General Practice community of Oakland had handled their situation with restricted privileges.

Dr. Stanley Truman, of Oakland, Ca.

In the Army, during WW II, specialists and members of academic colleges received higher rank/pay; general physicians, regardless of their skill level, were of lower rank. Near the end of the war, the trustees of Merritt Hospital of Oakland divided the membership of its staff into three classes: A, AA, and AAA. All the A ranked physicians, regardless of their training or skill level, were required to have a AAA (specialist) physician supervise the care of their patients. All general practice physicians regardless of training or skill level were ranked as A physicians. In December of 1945, Truman and 10 other general physicians met in his home; they created and incorporated the General Practitioners Association. The stated purpose of the Association was: *"To Promote and maintain high standards of general practice of medicine and surgery; to encourage and assist in providing postgraduate study for general practitioners of medicine and surgery; to perpetuate the relationship between the family doctor and his patient; and to protect the right of the general practitioner to engage in medial and surgical procedures for which he is qualified by training or experience."* This organization and its purposes were published in the local newspapers. This resulted in a meeting between the group and the County Medical Association who offered their services and their office space to be used to help solve the problem with the hospital. Soon they met with the trustees of the Merritt Hospital who subsequently abandoned the A, AA, AAA system and agreed to grant privileges based on the individual doctor's training, ability, and experience.

As the Oakland Association began formalizing its membership requirements, one of the tenets was that membership should not be on a permanent basis but contingent on continued post-graduated study. In a somewhat arbitrary way, the decision was made that membership would be on a three-year basis with 100 hours of postgraduate work required to continue as a member.

It should be noted: at this time adequate, meaningful postgraduate medical courses were hard to come by. Some continuing education was carried on by national and state journals as well as yearly meetings. (In Arkansas, the Arkansas Medical Society and the Southern Medical Association played a role in providing ongoing education especially to the isolated rural physician. In many rural states such as Arkansas, the County Medical Societies played a significant role in regularly updating its members.)

continued on page 14

Extending Our **Body of Work**

Arkansas Children's pediatric rheumatology specialists are specifically trained to care for children suffering from inflammatory diseases that impact their muscles, joints and connective tissues, that often begin with bone and joint pain. The specialists provide expert care in a wide range of common and rare conditions for newborns to young adults, including:

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- Autoimmune diseases
- Lupus
- Vasculitis

The clinic now includes four physicians and two certified nurse practitioners committed to seeing patients quickly at both Arkansas Children's Hospital in Little Rock and Arkansas Children's Northwest in Springdale.

Arkansas Children's

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There are several specialty clinics within Arkansas Children's rheumatology care to treat patients with unique needs.

archildrens.org/rheumatology | 501-214-4081

continued from page 12

A second meeting occurred in Oakland at Hunter Hall on February 24th, 1946. One hundred-plus general practitioners attended that meeting and by the time of the next meeting seventy-six had signed up as dues paying members.

After Dr. Truman had finished his history of the Oakland Organization, he was met with a vigorous round of standing applause and Dr. Holland Jackson of Fort Worth, Texas jumped to his feet and shouted, *"Gentlemen, this is what we need! This is the kind of organization we need on a national basis. I move that we form a national organization like the one from Oakland."* Multiple members in the room seconded his proposal.

There are only a few times in history where an era can be dated to a specific time and place but clearly the modern era of Family Medicine began around noon, on July 3rd, 1946, at the Masonic Hall in downtown San Francisco.

At the meeting then next day, Dr. Paul Davis of Ohio was elected to the Chairmanship of the General Practice Section. He and the other officers of the section were directed to craft a national organization of general practitioners. A Membership and Organization Committee as well as a Constitution, By-Laws and Name committee were created and charged with looking carefully at these two sets of issues. They were tasked with creating the bones of what would become the American Academy of General Practice. The two committees were to report back to the group at the June meeting of the AMA in Atlantic City in 1947. Four major items were accomplished in the intervening time (1.) A letter was sent to the secretary of every county medical society in the United States announcing that there would be a meeting in Atlantic City in June 1947 for the purpose of organizing the general practitioners into a national organization. (2.) The decision was made to call the organization the *American Academy of General Practice*. (3.) To avoid the "government by old men" that had come to dominate the AMA, they made the decision that the governing body of the organization would be composed of two representatives from each state. (4.) The membership committee embraced the principle of continued education for the maintenance of membership. The only difference was that they made the requirement 150 hours every three years instead of the 100 hours required by the Oakland Organization. Dr. Emil Leland of Oakland felt the national organization should have a higher standard than those required by the local organization. It should be noted that this would be the first professional organization

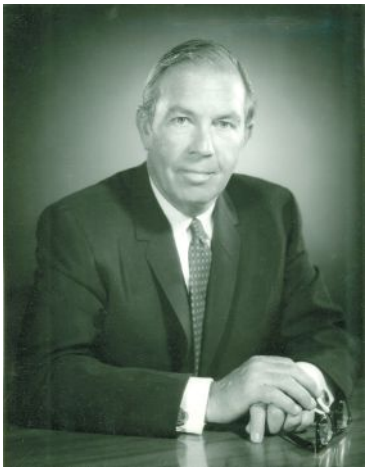
Dr. Paul Davis, First President of American Academy of General Practice

to require continuing education to maintain membership.

At 8:25 PM on June 10th, 1947, at the Solarium of the Claridge Hotel in Atlantic City, New Jersey, 200 general practitioners representing 33 states and Hawaii were present. The net result was the creation of the American Academy of General Practice by a vote of 194 to 6. The constitution and the by-laws were passed with little discussion. The first discussion of creating a journal for the group which would ultimately be called *American Family Physician/GP* occurred at this meeting. The largest concern for the leadership was establishing national membership. The decision was to recruit on a state-by-state level with the establishment of Chapters in each state. A Kansas City Star reporter was at the meeting and requested an interview with Dr. Truman. The next day the Star ran an editorial to the effect that out of the Centennial Meeting of the AMA the only significant event was the forthcoming American Academy of General Practitioners. There was some thought later that this most positive article may have played a role in Kansas City being chosen as the headquarters of the Academy.

The next meeting was scheduled for November 8th and 9th, 1947 at the Palmer House in Chicago.

In the first six months, the membership grew from zero to 2000 scattered across the country. The first state Chapter was Missouri, with Arkansas as the 11th State charter on April 20th, 1948.



Mac Cahal, First Executive Secretary of American Academy of General Pracitice

The next chore for the national organization was to hire an executive secretary. Three men were considered. On October 15th, 1947, one of the candidates. Mac Cahal wrote to Dr. Truman, "*My excitement over the prospect of taking up the work of the American Academy of General Practice has constantly increased since your call last week. It offers a tremendous challenge and a real opportunity to do something fundamentally valuable for medicine. My enthusiasm and eagerness to take up the work are enormous.*"

On Dec 1st, 1947, Mac Cahal was hired as the executive secretary of the organization. Before coming to the Academy, Mr. Cahal had served as the Executive Secretary for the American College of Radiology for 10 years. He was also formerly a newspaper man and a lawyer. Stanley Truman described him as, "*a master organizer, a perfect writer and a smooth personality.*" One of Cahal's ideas was to create a top-notch scientific publication. Within the next 18 months, Cahal and Dr. Walter Alvarez, the first editor of the journal fashioned the editorial board of the Academy's new journal, *American Family Physician/ GP.* The first issue of the journal appeared in April 1950.

In the next few months, Arkansas was getting ready to enter the fray.

Members due for Re-Election in 2022- Have you met your CME Requirements??

You have until December 31, 2022 to earn your CME!

Active 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. AAFP Prescribed credit is designated for activities that are designed primarily for physicians and related to direct patient care or patient care delivery. Examples include:

- CME activities approved by the AAFP
- Instruction of health professionals in a formal individual preceptorships or live educational format. (limit of 20 hours per year)
- Most life support courses such as ALSO, ACLS, ATLS, BLS, NALS and PALS.
- American Family Physician and FPM journal quizzes
- Most activities produced by AAFP
- Scholarly activities

If an activity is not considered Prescribed, it can be reported as AAFP Elective credits such as professional enrichment.

Reporting Your CME

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

- Online at www.aafp.org/cme
- Call the Arkansas chapter office and we will be happy to assist you and report your hours for you!

Questions About CME

If you have questions about your re-election or need a current copy of your CME record, please call Michelle at 501-316-4011 or email michelle@arkansasafp.org

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EQUAL HOUSING LENDER

CLINICAL GUIDANCE SHEET: Influenza Vaccination

Influenza vaccination is one of the best preventive health tools we have available to help reduce serious illness and hospitalization from the flu. **The American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC) recommend annual flu shots for patients six months and older who do not have contraindications.**

This clinical guidance sheet outlines key information for family physicians and team members from the CDC's Standards for Adult Immunization Practice. You can use this guidance to recommend influenza vaccination to your patients during any office visit throughout the flu season and promote increased patient acceptance and adherence.

Assess Immunization Status

- Ask about your patients' immunization status at every visit. Vaccination needs change over time, so be sure to include the patient's age, health conditions, lifestyle, travel, and occupation in your assessment.
- Stay up to date with CDC recommendations for immunization of adults and children.
- Generate immunization reminders for clinical staff and patients in the electronic health record (EHR).

Make a Clear and Strong Recommendation

- Strongly recommend that all patients six months and older who do not have contraindications receive the influenza vaccine each year.
- Identify the best influenza vaccine for each patient based on age, health conditions, lifestyle, travel, and occupation. Explain to your patient the reasons that you have tailored your recommendation to them.
- Highlight the benefits of vaccines, and remind patients that vaccines protect them and their loved ones.
- Describe the potential health effects and financial costs of becoming infected with the flu.

Educate Patients Early and Often

- Explain to your patients that the flu is a very common illness in the United States that infects millions of people, hospitalizes hundreds of thousands of people, and even kills tens of thousands of people each flu season.
- Discuss the safety and efficacy of the influenza vaccine with your patients. Tell them that getting a flu shot will protect them from the four strains of flu virus included in all influenza vaccines for the 2022-2023 flu season.
- Distribute the Vaccine Information Statement (VIS) for the influenza vaccine to your patients through your online portal or by mail, and offer a copy to read during the immunization visit, as a reminder.

Address Misinformation and Patient Concerns

- Prompt patients to ask any questions they have about the influenza vaccine, including its safety, side effects, and efficacy.
- Ask probing questions so you can better understand and address your patients' concerns and any reasons for vaccine hesitancy.
- Reassure patients that vaccines are required to go through rigorous research and testing to ensure that they are safe and effective.
- Emphasize that people cannot get the flu from the influenza vaccine.

Administer or Refer

- Educate your team members about proper influenza vaccine administration.
- Employ standing orders to empower nurses to administer the influenza vaccine for patients six months and older who do not have contraindications.
- Store vaccines appropriately, and use clear labels to differentiate between different brands and formulas.
- When you discuss the influenza vaccine with a patient who has not had a flu shot, recommend that they receive it during that visit. If you do not have the vaccine that your patient needs, refer them to another health care professional who can administer it.
- Report any adverse events after vaccination to the Vaccine Adverse Events Reporting System (VAERS).

Document

- Complete three key steps to accurately document the influenza vaccine given to your patient:
  1) Record administration of the influenza vaccine in the patient's record.
  2) Give influenza vaccine administration documentation to the patient for their personal medical records.
  3) Submit influenza vaccine administration records to an immunization information system (IIS) as required by your state.

 HOPS22091207

By: Rhelinda McFadden and Angie Hughes Walker

Modern House Calls: Improving the Health of Two Rural Arkansas Communities

In De Queen, connecting marginalized populations with health care access and community resources is a top priority for Dr. Randy Walker and his team. They are upending the traditional model of care to improve patients' and the community's social determinants of health.

The De Queen community, like many rural Arkansas communities, experiences high rates of chronic disease rooted in social determinants of health (SDOH). SDOH are non-medical factors that have an affect overall health and well-being. They include the conditions in which we live, grow, learn, work, play, and worship.

The population of De Queen is 6,077, with a poverty rate of 25.8%. Its diverse population is 51.4% Hispanic or Latino, 40.6% White, 3.8% African American, 2.3% American Indian and 1.3% Native Hawaiian or Other Pacific Islander (Marshallese).

Dr. Walker and his team know their community and the needs that patients face. Their active patient base includes more than 11,000 patients.

Angie Walker, office manager for the practice and Dr. Walker's spouse, has monitored their patient population and quality outcomes for over a decade. Combining this data with the known community needs, the Walker Clinic built its foundation on the patient-centered medical home model. This model contains five key functions: access and continuity, care management, patient and caregiver engagement, comprehensiveness and coordination, and planned care and population health. This model has transformed how The Walker Clinic practices medicine.

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"Quality Team Based Healthcare must be delivered to the right person, by the right person, at the right place, and at the right time every time."

Planting Seeds

In 2003, Randy Walker, MD, selected De Queen to put down roots and open his medical practice. He could not predict the future of his community or guess that a future pandemic would completely change how he practiced medicine.

The COVID-19 pandemic exposed the realities of the community's SDOH. With the nearest hospital more than 30 miles away, as COVID struck, community members struggled.

The onset of COVID gave the Walkers a clear view of their patients' need for better health care access. They set out to identify ways of delivering total population health care while addressing SDOH.

Expanding access to care was an immediate need. The Walker Clinic added locations, open seven days a week, from 7 a.m. to 7 p.m. For after-hours needs, they established a triage line where patients can speak directly with a provider.

The Walkers also have a clinic in the De Queen public schools. The newest location is in Dierks, a community in neighboring Howard County.

When COVID arrived, the medical team also began making house calls. They have a fleet of lime green vehicles used to make these calls. The clinical team found they needed to monitor high-risk COVID-positive patients to achieve the best possible outcomes. Today, a health care provider internally refers patients for monitoring when identified as potentially "at risk" or homebound status.

"Quality, team-based health care must be delivered to the right person, by the right person, at the right place, and at the right time every time," Dr. Walker says. The care team consists of Randy D. Walker, MD, and Phillip Glasgow, MD, advanced practice registered nurses (APRN) board certified in Family Practice, one psychiatric APRN, a dietician, three longitudinal care managers, and one episodic care manager in addition to 33 other care team members spread across the practice's three locations.

House calls are completed by a licensed health care professional and include an interpreter when needed for Hispanic and Marshallese populations. During these visits, they can provide electrocardiogram and spirometry (pulmonary) testing. They can deploy remote patient monitoring technology for patients needing constant monitoring. At any point during a house call, the health care professional onsite can connect directly with an MD using the clinic's telehealth technology.

The team also connects patients or families needing additional services (i.e., home health, Meals on Wheels, childcare, etc.) at the point of care.

The Walker Clinic has an easy-to-use community resource guide to share with patients and their families or caregivers. The guide connects patients to resources that help improve social determinants of health.

"Our communities are everything to us," the Walkers say. Their reconfigured practice offers De Queen and its neighboring area a team of forward-thinking visionaries looking at how to meet tomorrow's health care needs today.

Rhelinda McFadden, BSN, RN, CPHIMS, PCMH-CCE, serves as Manager of Practice Transformation and a Quality Consultant with the Arkansas Foundation for Medical Care. **Angie Hughes Walker** serves as office manager for The Walker Clinic, the family medicine practice of her husband, Dr. Randy Walker, in De Queen, Arkansas.

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Dr. James Stewart Reeves Receives Honorary Fellowship Degree!

James Stewart Reeves, MD, FAAFP of Beebe has achieved and was presented the Degree of Fellow of the American Academy of Family Physicians. Dr. Reeves joins more than 18,000 physicians around the county with this honorary distinction. Criteria for receiving the AAFP Degree of Fellow consist of a minimum of six years of membership in the organization, extensive continuing medical education, participation in public service programs outside medical practice, conducting original research and serving as a teacher in family medicine.

James Stewart Reeves, MD, FAAFP

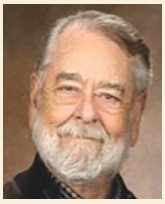
The Degree of Fellow was established in 1971 as a special honor bestowed upon AAFP members who have distinguished themselves among their colleagues by their service to Family Medicine and their commitment to their professional development through medical education and research. If you wish to learn more, please complete the Fellowship application that can be found on the American AFP website at www.aafp.org/fellow or contact our office at 501-316-4011 and we will be happy to help!

Congratulations Dr. Stewart!

Jim Citty, M.D., Searcy

James L. Jones, M.D., Fayetteville

Katie Youngblood, M.D., Rogers



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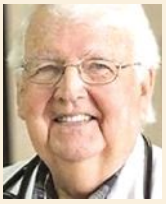


Forrest Miller, M.D., Little Rock

Payment Reform, Easing Burdens, and Career Success:

How the AAFP Helps Its Members

KAREN JOHNSON, PHD,
VICE PRESIDENT OF THE DIVISION OF PRACTICE ENHANCEMENT,
AMERICAN ACADEMY OF FAMILY PHYSICIANS, LEAWOOD, KS

Founded in 1947, the American Academy of Family Physicians (AAFP) represents 127,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care, with more Americans receiving care from family physicians than any other medical specialty. The most important role of the AAFP is to ensure members voices are heard by all health care stakeholders.

Each AAFP member also belongs to one of 55 state chapters — one in each state and the District of Columbia, as well as chapters for the uniformed services, Guam, Puerto Rico, and the US Virgin Islands. Members lead the AAFP by participating in the Congress of Delegates, serving on the Board of Directors or one of eight commissions (**Figure 1**).

AAFP policies, positions, and related activities are set at the annual Congress of Delegates (COD), where delegates present resolutions from their chapters asking the AAFP to adopt policies or take other action on important issues. Board members and other leaders are also elected during COD, making it one of the most important ways to contribute your voice to the governance of the AAFP. Participating in one of the eight AAFP commissions is another way to contribute your voice, knowledge, and expertise to the work of the AAFP.

About AAFP Members

The strong history of family medicine is built on the foundation of a continuous physician-patient relationship that serves as the first point of contact for comprehensive and coordinated whole-person care.[1] Family physicians conduct approximately one in five office visits — that's 192 million visits annually, or 48 percent more than the next most visited medical specialty. Family physicians also provide more care for America's underserved and rural populations than any other medical specialty, making their efforts particularly important to achieving equitable care for all.

The vast majority of AAFP members spend some or all their time in clinical practice. Where and how they practice varies widely, with 73 percent reporting being employed in the most recent AAFP Practice Profile survey (**Figure 2**). The majority of employed physicians practice in hospital or health system settings. However, it is important to note that 24 percent of members are in independent practice as a sole or partial owners.

Giving members what they need to thrive in all these different practice settings is an important priority of the AAFP! We do this in many ways, including with important work to

- Strengthen primary care payment,
- Reduce your administrative burdens, and
- Equip you for career success.

Strengthening Primary Care Payment

It is essential that we change primary care payment to sustainably fund the kind of comprehensive, whole-person care that is the hallmark of family medicine. Without both an increased investment and a fundamental shift in the underlying payment approach, primary care practices will not have the human and financial resources needed to provide high-quality primary care. In May 2021, a consensus report from the National Academies of Sciences, Engineering, and Medicine titled Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care provided specific recommendations for reaching five key objectives. The first objective is, "Pay for primary care teams to care for people, not doctors to deliver services." This will require moving from the undervalued and overly burdensome fee-for-service approach to health care payment that reimburses individual clinicians for providing specific services.

While fee-for-service may continue to work for very discrete services common in highly specialized care, prospective payment models are necessary to sustainably support physician-led teams and the broad range of services that comprehensive, whole-person primary care requires — much of it not visit-based and not reimbursable under fee-for-service. It is estimated that more than 60 percent of a primary care practice's revenue needs to be prospective, or "capitated," to sustainably support the comprehensive, team-based, whole-person care that is unique to primary care.[2]

The AAFP makes sure you are heard on payment issues. Our advocacy targets the existing fee-for-service system with action that includes pressing for changes to the proposed 2023 Medicare physician fee schedule at the same time that we're working with the Center for Medicare and Medicaid Innovation to accelerate innovative new payment models that

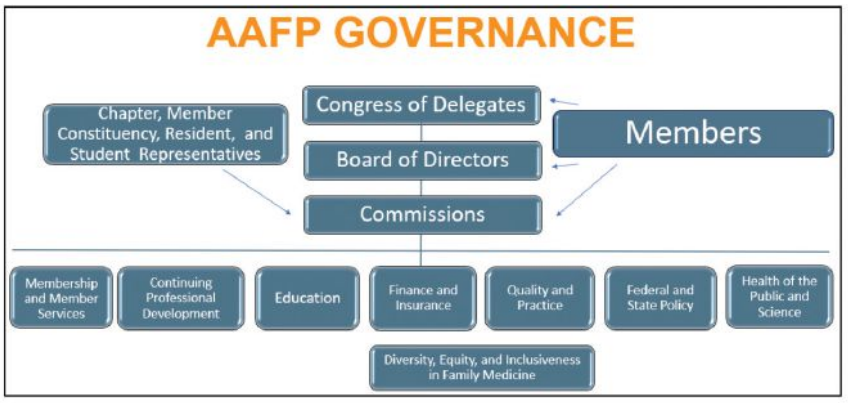
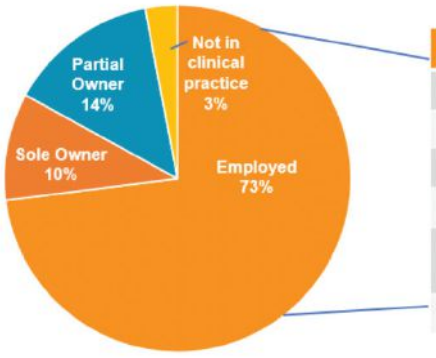


Figure 1



Employer	
Hospital or health system	53%
Physician Group	16%
Government	15%
University-owned	10%
Managed Care Organization	2%
Other	4%

Figure 2

are robust and accessible to all family physicians.

We are also forging new paths and engaging large public and private purchasers who share the belief that a strong primary care foundation is essential to an affordable, high-quality health system. Most recently, AAFP staff ensured family medicine had a voice at the Purchaser Business Group on Health's (PBGH) Primary Care Implementation Summit, which featured a broad range of stakeholders, including large employers, union leaders, health plans, and primary care organizations. More than half of all Americans receive insurance coverage through their employers, and employers are recognizing that they have shouldered an outsized share of the ever-increasing health care expenditure. In a recent survey of Fortune 500 C-suite executives, 87 percent said health care costs will reach unsustainable levels in the next five to 10 years. The employers assembled by PBGH believes that strengthening primary care is central to their success.

Reducing Administrative Burdens

Your voices are consistent and clear: unnecessary administrative burdens are leading to untenable

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levels of burnout and fatigue. You reported working an average of 59 hours per week with less than 60 percent of your time spent on patient care.[3] Too much of your time is spent on electronic health record documentation, prior authorization requests, and other non-clinical tasks. The AAFP is working hard to eliminate these burdens.

We do this through advocacy directed toward the legislative and regulatory levers that affect public and private payers, as well as by engaging and advocating directly with the largest national health insurance companies. We are working to reduce the documentation required by fee-for-service payment and associated quality reporting while also seeking to eliminate unnecessary prior authorization requests in the long run and streamlining the process in the near term.

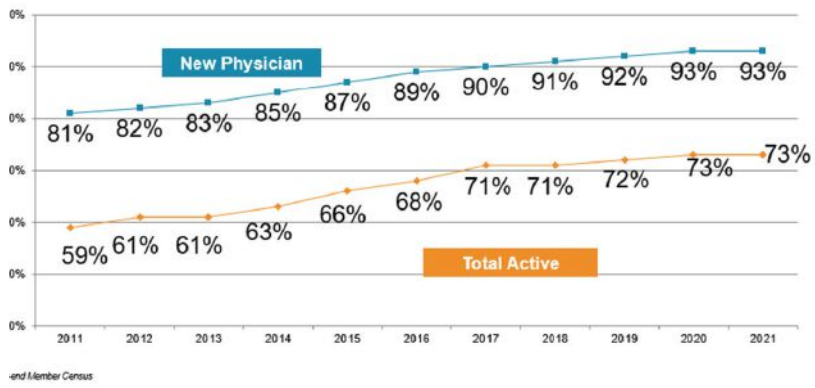

Figure 3

We are also working hard to equip you with the knowledge, skills, and resources to tackle the burdens you face each day. As an example, the July/August 2022 issue of *FPM* featured articles describing how more efficient notes and technological advances could reduce your administrative burden. They include straightforward steps you can take individually or as a team, along with templates and checklists to get you started. The AAFP also recently formed the Center for Practice Experience and Innovation to deliver resources you can use now to ease the unnecessary burdens you face while we continue working to eliminate them entirely.

Equipping You for Career Success

The AAFP has always worked hard to support the careers of family physicians. Many decades ago, when family physicians were mostly in private practice, the distinction between "career" and "practice" support was not as clear as it is today. Based on 2021 membership data, 73 percent of members are employed. When you look only at new physicians (up to seven years post residency), 93 percent are employed. These percentages are up significantly from 10 years ago, when 59 percent of active physicians overall and 81 percent of new physicians were employed (**Figure 3**).

While many family physicians work in physician-owned practices, an increasing number work for large, hospital-led health systems. The AAFP's data is corroborated by an AMA Policy Research Perspective that uses data from its biannual Practice Benchmark Surveys to report on shifts between 2012 and 2020. They note a shift to larger practices, with the percentage of physicians in practices that have 50 or more employees increasing from 14.7 percent in 2018 to 17.2 percent in 2020. They also observed generational differences, with more than 60 percent of physicians age 55 and older in practices that have 10 or fewer physicians. In contrast, only 40.9 percent of physicians under age 40 worked in similarly sized practices.

As the landscape of family physician employment evolves, so do the AAFP's efforts to support your career success. New resources address the specific needs of employed physicians as well as broader topics such as leadership and well-being. The most recent issue of *FPM* is focused on supporting you on your career path with helpful information, tips, and resources across all these topics, including the cover feature, How to Be Employed "Well": Optimizing Your Professional Satisfaction.

Additionally, you will find a host of career resources on the AAFP website at "Managing Your Career" under the Family Physician tab. And did you know that whether you're filling or looking for positions, you can get what you need at AAFP CareerLink? Then once you find the perfect job, you can learn everything you need about employment contracting at **www.aafp.org/careers**.

The last two-plus years have been hard on everyone, but no one has carried the burden more than those on the front lines of health care. The AAFP is proud to stand for and with the family physicians who are the first contact and connection point to comprehensive, coordinated, and continuous primary care for most Americans. We will continue to listen for the things you care most about and press forward to ensure that your voices are heard.

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3. AAFP 2020 Practice Profile Survey

Welcome 2022 New Members to the Arkansas Academy of Family Physicians!

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HPV Vaccine is Cancer Prevention

The American Cancer Society and the National HPV Roundtable recommends starting the HPV vaccine series at age 9.

There are many benefits to starting the HPV vaccine series at age 9. These include :

- Offers more time to complete the series by age 13
- Decreases concerns by parents/guardians about sexual activity
- School required vaccines are administered at a different visit
- Increases the likelihood of vaccinating prior to first HPV exposure

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