Scope of Practice Bills

Dominate the Arkansas Legislative Session!!
After more than 40,000 joint replacements, patient outcomes are still the highest priority at our hospital.

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Physician Owned. Patient Focused.
Dear Academy Member,

We have been busy from the beginning of January mainly focusing on legislation not only affecting Family Medicine but the many other scope of practice bills that have been introduced in the legislative session this past year. By the time you receive this publication, the session will be over and many bills will become law that we did not agree with but we thank all of you for your assistance in communicating with your elected representatives and to those of you who traveled to the Capitol to testify. We were honored to have as guests at our February Board Meeting, Arkansas State Representatives Michelle Gray, Dr. Lee Johnson, Dr. Steve Magie and Jeff Wardlaw along with David Wroten and Scott Smith of the AMS to discuss the many bills affecting medicine in this session.

One thing we have learned is that these bills are not won or lost at the time of their debate during the legislative session. It is so important that each of you become involved in the election process in your area and get to know your representatives and senators long before the next session in 2021 so that you have a relationship with him/her. They are more accessible if they know you and what Family Medicine is and are more likely to understand our position on the many bills that came up this year that affect medical doctors.

We are estatic over the news from the recent Match results in Arkansas. We do know that all Arkansas Family Medicine programs filled the first round but at the time of this writing we are unable to obtain how many UAMS Senior Medical Students matched with Arkansas programs. This data will be coming to you as soon as it is received. Congratulations to all of our Family Medicine Residency Programs in Arkansas!

We are looking forward to our Annual Scientific Assembly at the Embassy Suites in Little Rock with a Pre Assembly program the afternoon of July 31 on Office Emergencies, followed by a Resident/Student Fair with all of the Arkansas Family Medicine Residency Programs and medical students from UAMS and our two osteopathic medical schools in Arkansas. The program includes topics you requested at our meeting last year and in a survey done in the fall of 2018. The official program with registration and hotel information at the Embassy will be included. Look for your program in the mail in April!!

A special thanks to Dr. Leslye McGrath and Dr. Tasha Starks for representing the Arkansas AFP at the recent Multi State Meeting in Dallas – a weekend meeting of 15 state chapter officers who discuss topics of mutual interest in a casual setting.

Finally, we are so close to meeting our Active membership goal of 925 with current membership statistics of 890 Active members and total membership of 1491. Help us retain members and recruit your colleagues who are eligible for membership.

We look forward to seeing you at our upcoming annual scientific meeting!

Sincerely,

Carla Coleman
Executive Vice President

On the cover:
Old Mill in North Little Rock, Arkansas
Was 2018 your Re-Election Year? Have you met your CME Requirements?

If you have not reported your hours for re-election in 2018 please do so now. Your membership will be dropped May 2, 2019 if they are not reported!

The AAFP requires that you complete 150 credits of CME during your re-election cycle. Of the 150 credits, at least 75 must be AAFP Prescribed credits, and 25 must be from a live activity.

Please do not delay in reporting your CME. The fastest way is to report it online at www.aafp.org/mycme. You can also contact us at 501-223-2272 or by email at arafp@sbcglobal.net and we will be happy to assist you. If you believe our records are incorrect or you would like to report CME, please contact us immediately to maintain your membership.

Thank you for your prompt attention to this matter. We look forward to your continued membership in the Arkansas AAFP!

August Fellowship Convocation
Deadline is May 15, 2019

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 August 1, 2019 at Embassy Suites. You must have completed the application, earned your Degree of Fellow, and contacted this office by May 15, 2019 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.
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LifePoint Health offers unique opportunities for providers to prosper professionally and personally at 89 hospital campuses nationwide. Quality care is our top priority – we give you access to the tools, resources, and support you need to help you care for your patients and grow your business. In addition, we offer competitive compensation packages, which may include a sign-on bonus, student loan reimbursement, and residency stipends.

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We are an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability or veteran status.
Since the first of January, the Arkansas AFP led by President Scott Dickson has worked tirelessly at the Arkansas State Capitol and behind the scenes contacting legislators not only from the AR AFP Office but from hundreds of members across the state with our position on the APRN Scope of Practice bills primarily of which four were filed in the House Public Health Committee and two were filed in the Senate Public Health Committee today. Our statement is as follows which was sent to all of the representatives and senators as well as to the more than 25 Family Physicians who were in attendance at the Public Health Meetings of the Senate and House to testify.

"With a membership totaling over 1480 Family Physicians in the State of Arkansas including Family Medicine Residents and medical students at three medical schools in the state interested in Family Medicine, the addition of the two new osteopathic schools will certainly ease the shortage of Family Physicians in the coming years.

We oppose any legislation granting independent practice for Advanced Practice Nurses. Physicians and APRNs are not interchangeable. Primary Care Physicians and APRNs do not share the same levels of expertise, education, training or knowledge. A Family Physician must complete a four year Bachelors degree, four years of an MD/DO education then a minimum of three years of residency including up to 20,000 hours of clinical patient care. Family Physicians are required to complete 150 hours of continuing medical education every three years and if board certified must sit for the certification exam every seven to ten years along with completing annual requirements for maintaining certification. Research shows that APRNs do not move to rural communities in states that have independent practice they are only required to complete a four year Bachelors Degree and 1.5 to 3 years of masters level coursework and complete between 500 to 1500 clinical hours before becoming APRNs.

We recognize that APRNs are an integral part of the medical team led by a physician but this will not solve the issue of access to care in a rural community by removing the collaborative agreement".

Scope of Practice Bills Dominate the Arkansas Legislative Session!!
Below is a recap of some of those bills.

APRN Bills

**HB 1267**
Amends the prescriptive authority of an advanced practice nurse who has completed 2,000 hours of practice to include Schedule II drugs.

This bill was amended after negotiation and compromises, allowing APRNs with a collaborative practice agreement to prescribe opioids for no more than a 5 day supply and stimulants provided the original prescription was initiated by a physician and the physician sees the patient within 6 months of the prescription. This bill was passed by the House Public Health committee as amended.

**HB 1274**
Authorizes advanced practice nurses who have practiced in a community with a population of 5,000 or less for 5 years to practice without a collaborative agreement from a physician.

This bill is still on the House agenda and has not been heard yet.

**HB 1282**
Removes the requirement for a mandatory collaborative practice agreement for an advanced practice registered nurse to have prescriptive authority.

This bill was defeated in the Public Health Committee of the House by a vote of 10-10 but it can be introduced again.

**HB 1284**
Requires the Arkansas Medicaid Program and Arkansas Works (Medicaid expansion) to recognize advanced practice registered nurses as primary care providers and allow them to lead a patient centered medical home. Also grants the Nursing Board sole authority to determine their scope of practice.

The sponsor of this bill, Representative Gonzales has agreed not to run this legislation as part of the negotiations and compromise of HB 1267.

**SB 189**
Removes the requirement for a mandatory collaborative practice agreement for an advanced practice registered nurse to have prescriptive authority.

Similar to House Bill 1282, this bill was defeated in the Senate Public Health Committee by a vote of 4-3 but it can again be introduced again.

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CRNA Bills

**HB 1283**
Amend the definition of “Practice of Certified Registered Nurse Anesthesia” to now include the administration of analgesics and procedures in coordination with (no longer under the supervision of, as current law provides) a licensed physician.

**SB 184**
Amend the definition of a certified registered nurse anesthetist, removing the requirement that a certified nurse anesthetist must serve “under the supervision of” a licensed physician, dentist, etc., but instead “in coordination with” such a professional.

This bill passed in committee and full senate and was referred to the House Public Health committee where it was defeated after hours of testimony. This could also come back up before the end of the session.

Pharmacist Bills

**HB 1164**
Authorizes a pharmacist who has completed a training program to dispense oral contraceptives without a prescription.

**HB 1263**
Authorizes a pharmacist to initiate therapy and administer or dispense or both certain types of tobacco cessation and nicotine replacement therapy products if participating in a pilot program.

This bill passed after amendments were made removing prescription drugs such as Chantix.

**HB 1278**
Amends the definition of “practice of pharmacy” to allow vaccines and immunizations to be administered to a child 7-18 years old under a general written protocol rather than under a patient specific order or prescription.

It was requested that this bill be delayed to hear testimony from the Arkansas Chapter of the Academy of Pediatrics, but with no one present, the bill was passed out of committee.

**HB 1290**
Amend the provisions of the Arkansas code concerning the practice of pharmacy, and to authorize a pharmacist to provide access to and administration of oral contraceptives.

This bill passed out of the Public Health Committee of the House.
Optometrist Bill

HB 1251
Amends the definition of “Practice of Optometry to expand the types of ophthalmic surgery that may be performed by optometrists; and to modernize the practice of optometry. This bill passed the House Public Health Committee and also passed the full House with 70 votes. The bill will be heard before the Senate Public Health Committee very soon.

Telemedicine Bill

HB 1220
Amends the telemedicine act, to ensure that telemedicine is the least restrictive method to deliver healthcare services remotely, and to expand the definition of “Professional Relationship”. Bill defeated in committee.

Maintenance of Certification

SB 339
Prohibits the requirement of, barring of and discrimination against a physician for his or her decision to not participate in maintenance of certification.

This bill passed with amendments deferring to medical staff bylaws, i.e., only a medical staff can adopt bylaws requiring some or all staff to maintain board certification.

Any bills which are defeated in committee are subject to being brought back prior to the end of the legislative session. We will continue to follow the House and Senate agendas and inform you of any bills through email that are relevant to medicine.

A special thank you to the physicians that traveled to the State Capitol over the past few weeks to testify or just to support our position: Doctor Scott Dickson of Jonesboro, Doctor Dan Knight of Little Rock, Dr. Julea Garner, Little Rock, Dr. JP Wornock, Searcy, Dr. Scott Erwin, Hot Springs, Dr. Mark Lefler, Hot Springs, Dr. Nicole Lawson Rounds, Newport, Dr. Thad Hardin, Conway, Dr. Brian Bowlin, Vilonia, Dr. Garry Stewart, Conway, Dr. Siobahn Hruby, Little Rock, NYIT medical student Tim Baty of Jonesboro.

Work where you vacation!

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IMPORTANT UPDATE!

We continue to optimize the Arkansas Medicaid Prior Authorization Process to ensure the best possible experience for providers and beneficiaries. Prior Authorization requests reviewed by AFMC should continue to be submitted in the AFMC ReviewPoint Portal at ReviewPoint.afmc.org until further notice. Although you can enter the DXC portal now and familiarize yourself with the interface, the DXC Provider Portal will formally launch at a later time and you will be informed when to start using the system for actual submission of prior authorization requests and documents. Until then, please continue to use the ReviewPoint.afmc.org portal for all prior authorization submissions reviewed by AFMC.

IN MEMORY

Benny Jay Kriesel, M.D. of Russellville passed away Friday, November 23, 2018. He was 55 years old.

Dr. Kriesel served on the Board of Directors of the Arkansas AFP Chapter for many years before serving as President in 2006-2007. He was a Fellow of the Academy of Family Physicians and practiced for 18 years in Russellville. He graduated from the University of Arkansas College of Medicine with Honors in 1989 and completed his residency at the University of Wyoming in 1992.

Dr. Kriesel is survived by his wife of 35 years, Jennifer; his son Kristopher (Kayla); daughter Jessica Jarman (Corey); two grandchildren, Adian Kriesel and Oliver Kriesel; and two brothers.

Our condolences are extended to Dr. Kriesel’s family and friends.

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Q&A: MIPS for Newly Eligible Clinician Types

As the third year of the Merit-based Incentive Payment System (MIPS) begins, the definition of MIPS-eligible clinicians has expanded to include new clinician types. In 2017 and 2018, MIPS-eligible clinicians included physician (MD, DO, DDS, podiatrist, chiropractor and optometrist), physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS) and certified registered nurse anesthetist (CRNA). In 2019, seven new MIPS-eligible clinician types were added: physical therapist, occupational therapist, speech-language pathologist, audiologist, clinical psychologist, and registered dietitian or nutritional professional.

Eligible clinicians should begin collecting data and adjusting workflows for 2019 as soon as possible. Below are common questions about MIPS from newly eligible clinician types, with a specific focus on preparing for the Quality category.

**Question:** What is the low-volume threshold for 2019?

**Answer:** You must meet all criteria to be considered a MIPS-eligible clinician:

- Bill more than $90,000 for Medicare Part B covered professional services and
- See more than 200 Part B patients and
- Provide 200 or more covered professional services to Part B patients

If you are not required to participate as an individual due to not meeting one of the low-volume thresholds, you may still be required to participate if the following applies:

- Your practice chooses to participate as a group
- You are part of an approved virtual group
- You participate in a type of Alternative Payment Model (APM) called a MIPS APM

MIPS-eligible clinicians reporting as a group will receive a payment adjustment based on the aggregate score of the group. Additional information is available in CMS’ 2019 Merit-based Incentive Payment System (MIPS) Participation and Eligibility Overview.

**Q:** How can I find whether I am an eligible clinician for 2019?

**A:** CMS updates the QPP Participation Status tool at the beginning of each performance year. Enter the clinician’s National Provider Identifier (NPI) to identify his or her status for 2019 and previous years of MIPS. Remember to note whether the clinician is eligible as an individual or group, and whether he or she is a member of an Alternative Payment Model (APM).

**Q:** What is opt-in for MIPS 2019?

**A:** The opt-in option gives eligible clinicians or groups who do not meet all three of the low-volume threshold criteria, but do meet one or two elements, the choice to participate in MIPS. You can report and receive a payment adjustment if you opt in and meet one of the three low-volume threshold criteria. Once you opt in, you will be scored and this choice is irrevocable.

**Q:** If we are deemed not eligible in 2019, should we report anyway?

**A:** If you are not eligible, you have two options to report. You can opt in if you qualify to do so, and you must indicate this choice in the QPP Portal. You may also voluntarily participate. Voluntary participation means submission will be scored, but no payment adjustment will be applied. As you ponder your options, review your performance on the measures you are considering submitting in 2019. If your performance is positive and you think you will score well on those measures, you may want to opt in. If MIPS is new to you, you may want to work through measures and submit voluntarily to figure it out.

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TMF’s QPP team suggests that you do not make the choice to do nothing, even if you are not eligible this year. The rules change year to year and reporting in 2019 prepares you for the future. At the very least, work on data collection, electronic health record (EHR) or registry improvement, and improvement activities to prepare you for when you do become eligible.

Q: How does practice size affect MIPS requirements?

A: Bonuses and measure scoring may differ between small and large practices. A small practice has 15 or fewer eligible clinicians who report under one Tax Identification Number (TIN). A large practice has 16 or more eligible clinicians who report under one TIN. CMS identifies clinicians by their individual National Provider Identifier (NPI) and their associated TIN.

Q: What are the category weights for 2019 MIPS?

A: The Quality category weight has decreased in 2019 to 45 points, and the Cost category has increased to 15 percent. The Promoting Interoperability category is worth 25 points and the Improvement Activities category is worth 15 points. If you are a part of an Alternative Payment Model (APM), the scoring standard used for accountable care organizations (ACOs) is different. The APM scoring standard for 2019 is Quality at 50 percent, Improvement Activities at 20 percent and Promoting Interoperability at 30 percent. The APM standard assigns zero weight to Cost.

Q: What is the 2019 MIPS performance threshold?

A: The performance threshold for 2019 is 30 points. You must obtain 30 points to avoid a negative payment adjustment. This may be reached by a number of submission methods: completing improvement activities is worth 15 points, submitting Quality measures will add up to 45 points, successfully submitting data for PI will add up to 25 points (you must have data or an exclusion for all measures that are required), Cost may add points (unable to calculate in advance), and a small practice bonus is six points (you must submit data on at least one Quality measure to get the bonus).

Q: What are the 2019 MIPS performance periods?

A: The performance period is the amount of time the clinician or group must collect data for that measure or activity. The Quality and Cost categories are a 12-month period. The Promoting Interoperability and Improvement Activities categories must have data for at least a consecutive 90-day period.

Q: What is Quality data completeness?

A: Data completeness is required to reach full scoring potential on Quality measures. If not reached, only one point will be scored on the measure for large practices and three points for small practices. See table below for data completeness thresholds.

<table>
<thead>
<tr>
<th>Category</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>60 percent of Medicare Part B patients for the performance period</td>
</tr>
<tr>
<td>QCDR/Registry/EHR</td>
<td>60 percent of the clinician’s or group’s patients across all payers for the performance period</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>Sampling requirements for Medicare Part B patients</td>
</tr>
<tr>
<td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey</td>
<td>Sampling requirements for Medicare Part B patients</td>
</tr>
</tbody>
</table>

For groups that submit five or fewer Quality measures and do not meet the CAHPS for MIPS sampling requirements, the Quality denominator will be reduced by 10 and the measure will receive zero points.

Q: How can a clinician or group earn bonuses in the Quality category?

A: Bonus points are awarded for measures submitted in addition to the first required outcome or high-priority measure. An extra outcome or patient experience measure is worth two points and another high-priority measure is one point. These measures must meet the data completeness and case minimum requirements as well as have a performance rate of greater than zero. This does not
apply to measures submitted using the CMS Web Interface. These bonus points are capped at 10 percent of the denominator for the total Quality category.

Bonus points may also be earned for end-to-end reporting, which earns one point for each Quality measure that is submitted using end-to-end electronic reporting and is capped at 10 percent of the denominator of the total Quality category.

Clinicians and groups may also earn up to 10 additional percentage points based on their improvement in the Quality performance category from the previous year. These points will be incorporated into the overall Quality category score. You must completely participate in the Quality category (submit all required measures and meet data completeness and case minimums) for improvement scoring to apply.

A small practice bonus will be added to the Quality category for MIPS-eligible clinicians in small practices who submit data on at least one Quality measure. Six bonus points are added to the numerator of the Quality performance category.

Q: What do I need to know about topped-out measures?

A: Topped-out measures are measures in which the performance is so high and unvarying that meaningful distinctions and improvement in the performance can no longer be made. Scoring is capped at seven points for these measures. QCDR measures are excluded from topped-out and special scoring. A topped-out measure becomes an extremely topped-out measure when the average mean performance is within the 98th to 100th percentile range, and these measures may be removed sooner than the defined cycle.

Q: What do we need to know about the reporting methods for Quality?

A: In 2019, new terminology was defined:

- Collection type – a set of Quality measures with comparable specifications and data completeness criteria
- Submitter type – MIPS-eligible clinician, group or third-part intermediary
- Submission type – mechanism by which the submitter type submits data to CMS

### 2019 Quality Reporting for Individuals

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct</td>
<td>Individual</td>
<td>eCQMs, MIPS CQMs, QCDR measures</td>
</tr>
<tr>
<td></td>
<td>Log in and upload to the QPP Portal</td>
<td>Third-party intermediary</td>
<td>Medicare Part B claims (small practices only)</td>
</tr>
</tbody>
</table>

### 2019 Quality Reporting for Groups

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Submission Type</th>
<th>Submitter Type</th>
<th>Collection Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Direct</td>
<td>Group</td>
<td>eCQMs, MIPS CQMs, QCDR measures, CMS Web Interface measures, CMS-approved Survey Vendor measure</td>
</tr>
<tr>
<td></td>
<td>Log in and upload to the QPP Portal</td>
<td>Third-party intermediary</td>
<td>Administrative claims, Medicare Part B claims (small practices only)</td>
</tr>
<tr>
<td></td>
<td>CMS Web Interface (groups of 25 or more)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Part B claims (small practices only)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q: Can we submit using multiple collection types for the Quality category in 2019?

A: Yes, individuals and groups may use multiple collection types. This includes MIPS CQM (formerly registry measures), eCQM, QCDR measures and Medicare Part B claims for small practices only. Measures submitted via CMS Web Interface and facility-based measures may not be combined with any other collection type. There is a specific set of measures that must be submitted for those collection types.

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Q: If I submit data using two different collection types, will CMS aggregate my data for a total Quality score?

A: CMS will not aggregate two collection types of the same measure to achieve measure completeness. If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring. If you submit different measures using two collection types, those individual measure scores will be added together for a full score. Appendix B in the 2019 MIPS Quality Performance Category Fact Sheet (Page 25) contains an example of scoring.

Q: How have the Quality measures changed from 2018 in consideration of the newly eligible clinician types?

A: CMS has added new measures and removed some, as well as has changed some topped-out measures. Some specialty measure sets have also changed, with additions and deletions. Details on these measures are in Appendix 1, Table B, on Page 2,180 of the QPP 2019 Final Rule.

Q: What are facility-based Quality and Cost measures?

A: Facility-based scoring will be used for your Quality and Cost performance category scores when the following apply:

- You are identified as a facility-based clinician.
- You are attributed to a facility with a Hospital VBP program score for the 2019 performance period.
- The Hospital VBP score results in a higher score than MIPS Quality measure data you submit and the MIPS Cost measure data CMS calculates for you.

Additional details are available by reviewing CMS’ 2019 Facility-based Measurement Fact Sheet (PDF).

Q: How can we evaluate Quality measures for potential best method of submission?

A: The first place to search for measures that may apply to the practice is to look at the 2019 Clinical Quality Measure Specifications and Supporting Documents (ZIP) from CMS. This ZIP file contains multiple documents, including the 2019 MIPS Quality Measures List that allows you to filter for the measures applicable to your specialty. Once you identify measures, look at the measure specification sheets also included in the file to understand the reporting requirements for each measure.

Q: How do benchmarks impact my score?

A: CMS uses the 2019 Quality Measure Benchmarks (ZIP) to score Quality measures. Each collection type has its own benchmark. When you are able to submit a measure using different collection types, choose the measure submission method that provides the best score.

Q: What first steps should new eligible clinician types do to prepare for 2019 MIPS?

A: Review the resources available on each category to educate you and your practice. In CMS’ QPP Resource Library, you can filter to find materials pertinent to 2019 in whatever category you choose to research.

Prepare to access the QPP Portal. You will need a HCQIS Authorized Roles and Profile (HARP) account for this (formerly an Enterprise Identity Management account). If you do not have a HARP account, register at QPP.CMS.gov on the Sign-in tab. The QPP Access User Guide (ZIP) provides you direction on setting up your account. Contact the CMS QPP support desk at 1-866-288-8292 if you need to reset your HARP or EIDM password or need additional help setting up your account.

Join the TMF Learning and Action Network. This free website provides MIPS fact sheets, Q&As, webinars and other resources to help you. Review TMF’s MIPS fact sheet for each MIPS category, which will provide a foundation for your work. Spanish versions are also available at https://tmfqin.org/app:

- Quality 2019
- Cost 2019
Finally, if not yet completed, select the Quality measures you plan to report. Review available measures for your specialty and select those you will report on. Your next step would be to look at the available improvement activities that will help you improve on those measures. If using an EHR and reporting for the Promoting Interoperability category, consider improvement activities that will benefit those scores as well.

**Get Free Support for QPP**

To learn more about free MIPS support, visit www.tmfqin.org/qpp. To request technical assistance with MIPS for practices or systems with 16 or more eligible clinicians, contact QualityReporting@tmf.org. To request support for small and rural practices, contact QPP-SURS@tmf.org. Call us at 1-844-317-7609 Monday to Friday, 8 a.m. to 5 p.m., or you can submit a [Request for Support form](#) at any time.
During the flu season the Arkansas Department of Health (ADH) produces a Weekly Influenza Report for clinicians. The report provides information on flu activity in the state. The report also compares influenza like illness (ILI) in Arkansas to activity in the U.S. ADH receives reports of only a fraction of flu cases. Therefore, it is important to understand that the information in the weekly update is representative of the timing and location of activity, but it does not reflect the overall burden of disease. It is presumed that there are many more people actually affected than the report shows. Clinicians and policy makers may find the report helpful in terms of communicating to colleagues and patients about the current status of the flu season.

Report Key Points:

- For Week 9, Arkansas reported “Widespread” activity to the Centers for Disease Control and Prevention (CDC) for geographic spread of influenza, and “High” or 10/10 for ILI intensity.

- Since September 30, 2018, over 22,400 positive influenza tests have been reported to the ADH online database by health care providers. In Week 9, 72 counties reported influenza cases. The majority of reports came from Pulaski, Benton, Lonoke, Sebastian, Saline, Washington, White, Garland, Franklin, Faulkner, Pope, Scott, Yell, and Lawrence.

- Among flu antigen tests that can distinguish between influenza A and B virus types, 93 percent were influenza A, and 7 percent were influenza B.

- There are 419 positive PCR flu tests this week from private labs: 409 tested positive for influenza A, 9 tested positive for influenza B, and 1 positive for influenza A subtype H3N2. At the ADH lab, 10 tested positive for influenza A subtype H1N1, 8 positive for influenza A subtype H3N2, and 2 tested negative for influenza this week.

- About 5.5 percent of patients visiting emergency rooms this week were there for ILI. About 7.5 percent of outpatient visits were for ILI.

- The average school absenteeism rate last week was 6.9 percent among public schools. As of 03/02/2019, ADH is aware that 17 schools closed briefly due to the flu.

- To date, 57 influenza-related deaths have been reported in Arkansas this flu season, including one pediatric death; 70% were unvaccinated or had an unknown vaccine history. CDC has reported a total of 56 pediatric deaths nationwide this season.

- Since September 31, 2018, 5 nursing homes in Arkansas have reported influenza outbreaks.

- The proportion of deaths reported to the National Center for Health Statistics attributed to pneumonia and influenza (P&I) was below the system-specific epidemic threshold.

- For Week 8, the geographic spread of influenza was reported as widespread in Puerto Rico and 49 states; the District of Columbia and 1 state reported local activities; the U.S. Virgin Islands reported sporadic activities, and Guam did not report.

- You can report flu year-round and view the weekly influenza report during the influenza season at: http://www.healthy.arkansas.gov/programs-services/topics/influenza.

You can also access the reporting website directly at: https://FluReport.ADH.Arkansas.gov

For Additional National and International Influenza Surveillance Information:


CDC - Seasonal Influenza (Flu) - Weekly Report: http://www.cdc.gov/flu/weekly/
2018-2019 Influenza Outbreak Response/Epi Report (Week 9: 02/24/19 – 03/02/19)

Death Report for Week 9
- Deaths from all causes: 729
- Deaths due to Pneumonia: 68
- PCR confirmed Flu Deaths: 4
- Death Certificate or Flu Antigen only: 15

Cumulative Flu Deaths since 09/30/2018
- PCR confirmed Flu deaths: 11
- Death Certificate or Antigen only: 46
- Cumulative Flu deaths: 57

ER Visits
- Week Ending: 03/02/2019
  Weighted Average: 5.5%
  - Total Visits: 22,846
  - Visits with ILI: 1,258
- Previous Week
  Weighted Average: 5.6%
  - Total Visits: 22,551
  - Visits with ILI: 1,260

Total Flu-Related Hospital Admissions
- PCR Confirmed:
  - Cumulative: 303
  - Week ending 02/02/2019: 34
- Antigen Positive:
  - Cumulative: 610
  - Week ending 03/02/2019: 55

Weekly Arkansas ILI Intensity Level
Reported by Sentinel Providers

PCR Lab Confirmed Influenza Cases
- Total Cases since 09/30/2018: 2,651
- Week ending 03/02/2019: 437

<table>
<thead>
<tr>
<th>PCR Tests</th>
<th>ADH Lab Week 9</th>
<th>Other Labs Week 9</th>
<th>Cumulative Cases since 09/30/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+</td>
<td>0</td>
<td>409</td>
<td>2,403</td>
</tr>
<tr>
<td>B+</td>
<td>0</td>
<td>9</td>
<td>125</td>
</tr>
<tr>
<td>B/Victoria</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>B/Yamagata</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>H1N1+</td>
<td>10</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>H3+</td>
<td>8</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>Unsubtypeable</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>419</td>
<td>2,651</td>
</tr>
<tr>
<td>Negative</td>
<td>2</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

PCR Confirmed Influenza Cases since 09/30/2018

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>PCR+</th>
<th>Hospitalized</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 yr.</td>
<td>547</td>
<td>33</td>
<td>1</td>
</tr>
<tr>
<td>5-18 yr.</td>
<td>1110</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>19-24 yr.</td>
<td>55</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>25-44 yr.</td>
<td>278</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>45-64 yr.</td>
<td>363</td>
<td>99</td>
<td>5</td>
</tr>
<tr>
<td>&gt;= 65 yr.</td>
<td>283</td>
<td>131</td>
<td>4</td>
</tr>
<tr>
<td>Unknown</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>2,651</td>
<td>303</td>
<td>11</td>
</tr>
</tbody>
</table>

School Absenteeism*

Week Ending: 03/02/2019
- Percent Absent: 6.88
- Previous Week: 7.79
- Average daily absenteeism for all public schools during this reporting week.

Geographic ILI Activity Level Reported for Week 9:
Dr. C. E. Nash was a truly erudite gentleman whose life encompasses this era. Born in St. Louis, Missouri, in 1824. His early years were spent with his brother-in-law, Dr. Robert A. Watkins of Little Rock. In addition to being a physician Dr. Watkins was Arkansas’s first Secretary of the State. Early on, Dr. Nash expressed a desire become a physician. He apprenticed in the drug store of R. L. Dodge and, ultimately, entered the University of St. Louis Medical School, graduating in 1849 as a regularly qualified physician. After finishing medical school, he moved to Helena, where he practiced for the next thirty-five years. While practicing in Helena he managed a plantation across the river in Mississippi. During the Civil War he served in the Confederate Army and oversaw the Confederate marine hospital at Salem, Alabama. After the war he returned and re-built his plantation and resumed his practice. In 1884, he removed to Little Rock where he lived until his death in 1903.

Dr. Nash was a prolific writer and several pieces of his work are of importance. In 1855 the town of Helena had 1500 inhabitants. With the advent of the steamboat in the early nineteenth century, towns on the Mississippi had begun to experience epidemics of yellow fever. Probably because of the limited population of Arkansas, it was spared until 1855. In that year yellow fever struck in Helena and Napoleon. Dr. Nash wrote eloquently of the outbreak in his biographical sketches of Confederate Generals Pat Cleburne and General T. C. Hindman.

William Barnett, a young newspaper boy, boarded a docked steamer which had just arrived in Helena from down river, to sell his newspapers. Unknown to the city fathers of the town the steamer carried passengers who were ill
with yellow fever, several had already died. Since there had never been a case of yellow fever in Helena there was no board of health or any other precautions. In a short time, the boy was ill as were his two brothers and two sisters. Eventually one of his sisters died. Most of those who boarded the steamer became ill. As word spread the citizens of Helena voted with their feet and abandoned the town, soon the town of 1500 was reduced to a ghost town. Only a few people were left and it fell to them to minister to the sick and dying. Dr. Nash and two other physicians made their rounds daily; soon, one of them became ill. Nash speaks in glowing terms of the three men who helped him as nurses: Pat Cleburne, T. C. Hindman (both went on to become Generals in the Confederate Army) and a young minister named Rice. These three men agreed to cook, clean and perform nursing duties for the ill. The siege lasted for two months and when it was over many had died; there were no exact numbers. The young newsboy did survive and went on to be one of the leading journalists in the state. This was the first documented outbreak of yellow fever in the state of Arkansas.

In 1900 Dr. Nash stood before the Arkansas Medical Society and read a poem he had composed called: On The Anniversary of my Seventy-Sixth Birthday. Much of the poem is used to discuss the work he performed over the years including cataract surgery, difficult deliveries and wrong diagnosis. In the middle of the poem he pauses to reflect on the changing nature of medicine.

“When the old man must bemoan his fate,  
To call all he knows out of date.  
’Tis sad to think of one’s out date  
When he recalls the things of late,  
Which are so much out of time  
They would not make a decent rhyme.  
Of theories many we have in state,  
To tell of the wonderful things of late;  
To tell; you must a pessimist be,  
For they look after things much less than a flea.  
A germ is found for everything,  
And you must believe it or take the sting  
Of the scientific scourge that comes with the ring.

These theories are of ancient date,  
But have come in these years of late  
To pose as something new, you see;  
But they cannot deceive you and me,  
For we traveled that path in days of yore---”

It seems that this gentleman was speaking for his generation, having watched one era pass away and another take its place

(Baird, David, Medical Education in Arkansas, 1879-1978, Memphis State University Press, 1979), (Anthology of Arkansas Medicine, 1975), (Nash, C.E. Southern Stories: Anniversary of My Seventy-Sixth Birthday (Read before the Little Rock Medical Society, pp 26-32, Biographical Sketches of Pat Cleburne and Gen. T. C. Hindman, pp 52-57)
Pre Assembly Opportunity – Wednesday, July 31

1:00 - 4:45 p.m. Ballroom IV

“Office Emergencies”
1:00 p.m. Pediatric Emergencies
1:45 p.m. Cardiovascular Emergencies
2:30 p.m. Stroke and Stroke Mimics
3:15 p.m. Break
3:30 p.m. Anaphylaxis

ANNUAL ASSEMBLY PROGRAM – Thursday, August 1

8:15 a.m. Opening Ceremony With Presentation Of Flags/National Anthem Announcements And Welcome Remarks

8:40 a.m. “The AAFP Update”
Gary Leroy, M.D., President, AAFP

9:15 a.m. “Whats New, What’s True”
Warren Newton, M.D., MPH, American Board of Family Medicine

10:00 a.m. Break – Visit Exhibits

10:30 a.m. “Asthma Update”
Larry Simmons, M.D.

11:15 a.m. “Oral Health”
Doug Bernard, M.D.

12:00 p.m. Fellowship Convocation

12:20 p.m. Lunch Meeting “Patient Satisfaction”
Steve Dickens, JD

1:30 p.m. “Pain Management”
Lee Radosh, M.D.

2:30 p.m. Break – Visit Exhibits

3:00 p.m. “When To Think Beyond Azithromycin For Pneumonia”
Mary J. Burgess, M.D.

3:40 p.m. “Having Those Difficult Conversations With Patients”
Russell Mayo, M.D.
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:15 a.m.</td>
<td>Visit Exhibits</td>
<td></td>
</tr>
<tr>
<td>8:30 a.m.</td>
<td>&quot;Adverse Childhood Experiences&quot;</td>
<td>Chad Rodgers, M.D.</td>
</tr>
<tr>
<td>9:15 a.m.</td>
<td>&quot;Atopic Dermatitis&quot;</td>
<td>Anthony J. Mancini, M.D.</td>
</tr>
<tr>
<td>10:15 a.m.</td>
<td>Break Visit Exhibits</td>
<td></td>
</tr>
<tr>
<td>10:30 - 11:00 a.m.</td>
<td>&quot;Physician Burnout&quot;</td>
<td>Jordan Weaver, M.D.</td>
</tr>
<tr>
<td>11:00 a.m.</td>
<td>&quot;Pediatric Emergencies&quot;</td>
<td>Speaker TBA</td>
</tr>
<tr>
<td>11:40 a.m.</td>
<td>Installation Of Officers With Lunch Following</td>
<td></td>
</tr>
<tr>
<td>1:00 p.m.</td>
<td>Final Break With Exhibitors</td>
<td></td>
</tr>
<tr>
<td>1:30 p.m.</td>
<td>&quot;Addressing Women's Sexual Wellbeing&quot;</td>
<td>Lisa Larkin, M.D.</td>
</tr>
<tr>
<td>2:30 - 2:40 p.m.</td>
<td>Stretch Break</td>
<td></td>
</tr>
<tr>
<td>2:40 p.m.</td>
<td>&quot;Hypoactive Sexual Desire Disorder&quot;</td>
<td>Lisa Larkin, M.D.</td>
</tr>
<tr>
<td>3:45 p.m.</td>
<td>&quot;Legal And Medical Issues&quot;</td>
<td>Jennifer Smith, J.D., R.N.</td>
</tr>
<tr>
<td>8:30 a.m.</td>
<td>&quot;Medicare Wellness Exam&quot;</td>
<td>Shawn Purifoy, M.D.</td>
</tr>
<tr>
<td>9:15 a.m.</td>
<td>&quot;Sexually Transmitted Infections&quot;</td>
<td>Sara Holcomb, M.D.</td>
</tr>
<tr>
<td>9:45 a.m.</td>
<td>&quot;GLP-1 Receptor Agonist&quot;</td>
<td>Jeff Mayfield, M.D.</td>
</tr>
<tr>
<td>10:00 a.m.</td>
<td>&quot;Telemedicine&quot;</td>
<td>Lonnie Robinson, M.D.</td>
</tr>
<tr>
<td>10:45 a.m.</td>
<td>Adjourn</td>
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**Saturday, August 3:**

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<thead>
<tr>
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</thead>
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<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>

**Other Highlights!**

A Resident/Medical Student Fair will be held on Wednesday, July 31 from 5-7

32 Companies will be Exhibiting with us on Thursday and Friday, August 1 and 2

A special group rate has been extended to us by the Embassy Suites

The official Program will be mailed soon with registration and hotel room accommodation information!
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• Wellness counseling to help manage diabetes
• Wellness counseling to help manage high blood pressure

What Does Be Well Provide?
• Telephone counseling for interested callers
• In-person counseling at select locations for Arkansans without private insurance
• Referrals to and assistance navigating resources available through private insurance, employee assistance programs and more
• Nicotine Replacement Therapy (NRT) for Arkansans with Medicare or no insurance, a prescription for NRT for those with Medicaid, or assistance with accessing NRT through private insurance
• Online resources available to help all Arkansans, including a new website, texting programs and mobile apps

How Can I Refer Patients to Be Well?
• Use the Be Well fax form, which can be downloaded at bewellarkansas.org (the fax number hasn’t changed: 1-800-827-7057)
• Call 833-283-WELL to connect patients to the Be Well Call Center. If counselors are not available, leave the patient’s contact information and they will receive a callback within one business day. The number 1-800-QUIT-NOW still works and will route callers to the Be Well Call Center.
Adverse Childhood Experiences
Impact Health

By Chad Rodgers, MD, FAAP and Michelle Murtha, RN

“The single greatest unaddressed public health threat facing our nation today,” according to Dr. Robert Block, past president of the American Academy of Pediatrics, “is adverse childhood experiences (ACEs).”1 ACEs, or traumatic events that occur before age 18, include abuse, neglect, divorce, witnessing domestic violence, an incarcerated parent or a parent suffering from mental illness or substance abuse.

Experiencing one or more ACEs significantly increases an individual’s risk for chronic disease, mental illness, substance abuse and premature death. Arkansas has the highest percentage of children with at least one ACE.2 In Arkansas, 60 percent of adults and 56 percent of children have experienced one or more ACEs; nationally, 46 percent of children have at least one ACE.2,3

Physicians see first-hand the negative outcomes associated with ACEs, and can play a crucial role in identifying, treating and preventing them. Knowledge about and incorporating ACEs and resilience science into clinical settings is not widespread in Arkansas. The statewide ACEs and Resilience Workgroup, co-founded by AFMC and the Arkansas Department of Health, is working to help health care providers incorporate ACEs awareness and trauma-informed care into their practices. The statewide collaboration includes more than 100 individuals, and 60 organizations and agencies. It is focusing on a comprehensive statewide plan to assist communities, local health units and health care providers in developing comprehensive, place-based changes to help communities address ACEs and flourish.

Original ACEs study
Vincent Felitti, MD, and Robert Anda, MD, first introduced the term ACEs in their groundbreaking study published in 1998. Funded by Kaiser Permanente and the Centers for Disease Control and Prevention, researchers surveyed 17,000 Kaiser Health plan enrollees about 10 types of childhood trauma. Each positive response was one point, and points were totaled to reach an ACE score from zero to 10. The majority of those surveyed were white, college-educated and middle-aged.

The results were surprising: 64 percent had at least one ACE, 37 percent had more than one, and people with one ACE were 87 percent more likely to have two or more ACEs.2 When researchers compared respondents’ ACE scores with health insurance claims, they found those with ACEs were more likely to have poor health outcomes. Those with high ACE scores were more likely to experience negative effects, indicating a dose-response relationship. For example, an ACE score of six is associated with a shortened lifespan of 20 years; an ACE score of four means a person is 40 percent more likely to develop chronic obstructive pulmonary disease.4 ACEs are also associated with significantly higher risks for obesity, low impulse control, chronic disease, mental illness, substance abuse and suicide attempts.4

Subsequent ACE surveys, from other states with more diverse populations, mirrored the results of the original study. Other studies have examined the role of economic and community factors such as poverty and violence have as ACEs. Current evidence shows that it is not necessarily the type of ACE, but the number of ACEs and the absence of protective factors that have the greatest impact on health outcomes.1 Toxic stress
Numerous studies have helped identify how ACEs affect a child’s developing mind and body. The current understanding is that ACEs activate a child’s stress response system. Without protective factors such as a secure attachment to a parent or other adult, the stress response becomes chronic or toxic, which in turn affects development of the brain and other organs. Fewer neural connections develop in the brain; the amygdala increases in size and the hippocampus decreases. These changes impair impulse control, cognitive and executive function and increase the chance of developmental delays.5 Children experiencing toxic stress may adopt coping behaviors that mimic the fight, flight or freeze response, leading to lower school engagement, behavior problems and potential involvement with the criminal justice system.

As children get older, they may adopt other high-risk coping behaviors such as overeating, tobacco use and substance abuse, increasing the likelihood of chronic disease and early death. Attempts at behavior modification may not be successful in the long term if underlying ACEs are not treated.

ACEs and toxic stress can also affect the body on a genetic level. Relationships and social interactions — both positive and negative — have an influence on neuroendocrine response, which in turn can make epigenetic changes to gene expression. These epigenetic changes, which can make an individual genetically more susceptible to the negative effects of toxic stress, are transmitted to the next generation.

continued on page 26
Your job is keeping your patients healthy. So who’s watching their health information?

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What physicians can do

The good news is, ACEs are preventable. Toxic stress is treatable through the development of protective factors and resilience in individuals, families and the community. Physicians can play a critical role in the prevention and treatment of ACEs and toxic stress by incorporating knowledge of ACEs and toxic stress science into clinical practice. Treatment begins with screening both adult and pediatric patients for childhood trauma. Make referrals to community mental health professionals who specialize in trauma, maternal home visiting programs and parent support programs.

Physicians have a leadership role to play in helping build resilience in the greater community. By working collaboratively with policy makers, social service organizations, and local and state agencies, physicians can influence systems and services beyond the health care setting.6

Ms. Ginocchio is lead policy and program analyst at AFMC. Dr. Mease is the medical director for Child and Adolescent Health at the Arkansas Department of Health.

References

Baby’s best medicine doesn’t come from a bottle.

Breastfeeding babies for 6 months or more helps prevent illnesses such as respiratory infections, gastroenteritis, SIDS and atopic dermatitis. Talk to your expectant and new moms about the benefits of breastfeeding over formula.

Breastfeeding is best.

Earn FREE CME and learn the latest on breastfeeding and other trending family medicine issues at the UAMS Family Medicine Spring Review, May 1-3. To see if you qualify, email dfpmcme@uams.edu.

Learn more about SPAN:
State Physical Activity and Nutrition for Arkansas.
Visit uams.health/breastfeeding
Diagnosing arthritis is often a challenge because of the sheer number of conditions—including over 100 different types of arthritis—that can cause joint discomfort. Because few tests can definitively diagnose arthritis, physicians must rely on their patients’ ability to communicate their symptoms and other important information about their joint pain.

A complete and accurate patient medical history is critical in the diagnosis and treatment of arthritis, as is understanding when the pain began and any activities that increase the pain. Knowledge of any medical events that occurred near the time of the symptoms—such as injuries, infections, or new medications—can also provide valuable perspective.

Keep these tips in mind to help your patient communicate useful information about their joint discomfort:

- How does your patient describe what they’re feeling? For example, do they describe burning or aching, or do they only report stiffness?
- Do their joint symptoms occur at a particular time of day?
- Was the onset of the symptoms gradual or sudden?
- Does the intensity of pain change or stay the same?
- Does activity reduce pain or make it worse?
- What other symptoms is your patient experiencing? For example, do they report fever, skin issues, swelling, or redness?

If you have patients that are living with joint pain and stiffness, contact Arkansas Surgical Hospital at 877-918-7020 to learn about diagnosis and treatment options.
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THANK YOU!

…to those who we worked alongside in communities throughout the state to pack more than 1.1 million meals in the Fearless Food Fight to support local food shelters helping our neighbors in need. You helped us exceed a goal of 700,000 meals in celebration of our 70th anniversary.

And to the thousands of doctors, nurses, therapists, pharmacists, counselors, hospitals, medical suppliers and many other healthcare providers who have cared for our members and their families for seven decades, thank you! You play a critical role in ensuring our members receive quality, compassionate care during some of their most vulnerable moments in life.

As a not-for-profit, mutual insurance company, our commitment to investing in Arkansas, its people and its healthcare delivery system began in December 1948 and will continue.

Our work is not done, but by facing the future together, we can keep our great state strong.

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FCC Forrest City, AR currently has (2) vacancies for Medical Officer. Please note the following requirements:

Training - for the GS-15, 5 years of residency training or equivalent experience and training. (You may still be qualified with less residency/experience at a lower GS.)

Degree - Doctor of Medicine from a school in the United States or Canada approved by a recognized accrediting body; if degree from foreign medical school, must have the certification by ECFMG (Educational Commission for Foreign Medical Graduates)

Licensure - a permanent, full and unrestricted license to practice medicine in a State, District of Columbia, The Commonwealth of Puerto Rico, or a territory of the United States.

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Apply today for the 2018 – 2019 Physician Practice Quality Improvement Award

The Physician Practice Quality Improvement Award Program online application is live! Physician practices continue to make great strides in providing reliable preventive services and implementing effective care management methods. We think these practices should be recognized for their hard work. The Arkansas Medical Society, Arkansas Academy of Family Physicians, Arkansas Osteopathic Medical Association, and TMF® Health Quality Institute have partnered to offer the Physician Practice Quality Improvement Award program to physician practices in Arkansas.

Apply today. It’s easy.

Download the program overview (PDF) and criteria (PDF) to learn what your practice needs to do to prepare to complete an online application by May 31, 2019. Award-winning practices will receive commemorative items to display and will be recognized through a media campaign. Announcements will also be made at meetings and in journals by the Arkansas Medical Society, Arkansas Academy of Family Physicians and the Arkansas Osteopathic Medical Association. Learn more and view the list of previous award recipients.

FAMILY PHYSICIAN OPENING

We are the Department of Family and Preventive Medicine at the University of Arkansas for Medical Sciences. For more than 40 years, we have served the health care needs of Arkansans and have trained generations of residents and medical students. Our department also includes the Research and Evaluation Division, and the Division of Community Health and Education.

We are actively seeking candidates who are excited about teaching, passionate about clinical care, and eager to join a team of dynamic faculty members who make a difference in the community on a daily basis.

The successful candidate will demonstrate knowledge, integrity, enthusiasm, and commitment to work in an intellectually stimulating environment of diverse teachers and learners.

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Providing protection and support for Arkansas is our natural state.