

The 72nd Annual Scientific Assembly Highlights

The ARKANSAS FAMILY PHYSICIAN

Volume 23 • Number 2



Dr. Matthew Nix
*Installed the 73rd
Arkansas AFP President*



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Dear Academy Member,

A picture is worth a thousand words but the memories are priceless! This issue has dozens of pictures to show those of you unable to attend what you missed! The Annual Assembly was perfect – with great high rated speakers, a organized meeting from start to finish, a wonderful installation of officers event; a perfect program to honor me for my years of service complete with all of the Past Presidents that could attend and all of this you will see in this publication and know exactly what a grand meeting it was!



Registration numbers were about where they were last year at 157! Of the 157, 19 were residents, six were medical students and the remaining 132 were Family Physicians from across the state. The opening session with Dr. Gary LeRoy, our AAFP President Elect had 172 in attendance which included some guests and exhibit representatives.

Although at the writing of this Journal, it is unsure of the financial status of the meeting but we did make a profit although felt to be less than in previous years. Our pre assembly program on "Office Emergencies" was very well attended with 68 in the seats. New this year was the Resident Student Fair which drew quite a crowd including every Family Medicine Residency program in the state; students from UAMS, NYIT and ARCOM. It was difficult to know how many were in the room but the hotel counted 146 as eating so we feel it could be around 150 in attendance!

Our highest rated speakers were again our own Academy members with Dr. Jeff Mayfield ranking the highest at 98% overall: Dr. Lonnie Robinson, Dr. Larry Simmons, Dr. Lisa Larkin, Dr. Anthony Mancini and Jennifer Smith at 97% and others ranking in the 90's were Doctor LeRoy, Dr. Lee Radosh, Dr. Russell Mayo, Dr. Masil George, Dr. Shawn Purifoy. All other speakers ranked near the 90% score! And in spite of the massive construction at the hotel, our members liked the location and the dates of the meeting; several great topics were suggested for next year which will be given to the Program Committee for their review.

President Matthew Nix was installed President and I was honored at the Installation Lunch for my years of service to the AR AFP with most of the Past Presidents of the AR AFP standing on stage – many of them speaking and sharing favorite stories. It was emotional to say the least. The day was complete with a great reception at Trio's with more than 150 Academy members and their families dropping by to wish me well. A special appreciation to Michelle Hegwood and to the AR AFP Officers and Board for such a memorable event! I will never forget it.

I am anxious about the next four months - trying to wrap up the office for my successor so they can find what they need; leave with no regrets although probably with many tears. I will say it again before I leave December 31 but I thank you each for your membership, for your support and I wish you well! Tentative plans are to begin interviews in October and possibly have someone hired by the end of November to begin in January.

(Carla)

On the cover:

73rd Arkansas AFP President,
Dr. Matthew Nix and his family.

Photographs in this Journal are by Darrick
Wilson Photography of Little Rock



Doctor Matthew Nix Installed the 73rd Arkansas AFP President

before becoming President. He has also served on the Arkansas Early Childhood Commission and the Arkansas Child Health Advisory Committee.

During his year as President Elect, he orchestrated rewriting the ByLaws of the Arkansas AFP to be more current with the time; he was instrumental in rewriting several policies and manuals of the ARAFP for the Board and instrumental in developing a new travel

policy and reimbursement policy to be more in line with other chapters. He has also served many days the last several months working on a successful and smooth transition for the Academy's new Executive Director who will be hired in November and begin employment shortly before the first of the year.

We welcome President Nix and look forward to his leadership in the coming year!

With his family, friends, colleagues and attendees of the Arkansas Academy's Annual Assembly, Doctor Matthew Nix took the oath of office as President from AAFP President Elect Gary LeRoy of Dayton, Ohio on Friday, August 2 before over 140 Academy members, friends, colleagues and his family: wife Amy and children: Morgan who is a student at Henderson; Nathan who just started college at Southern Arkansas University in Magnolia and Norah who is a 7th grade student at North Heights Junior High in Texarkana.

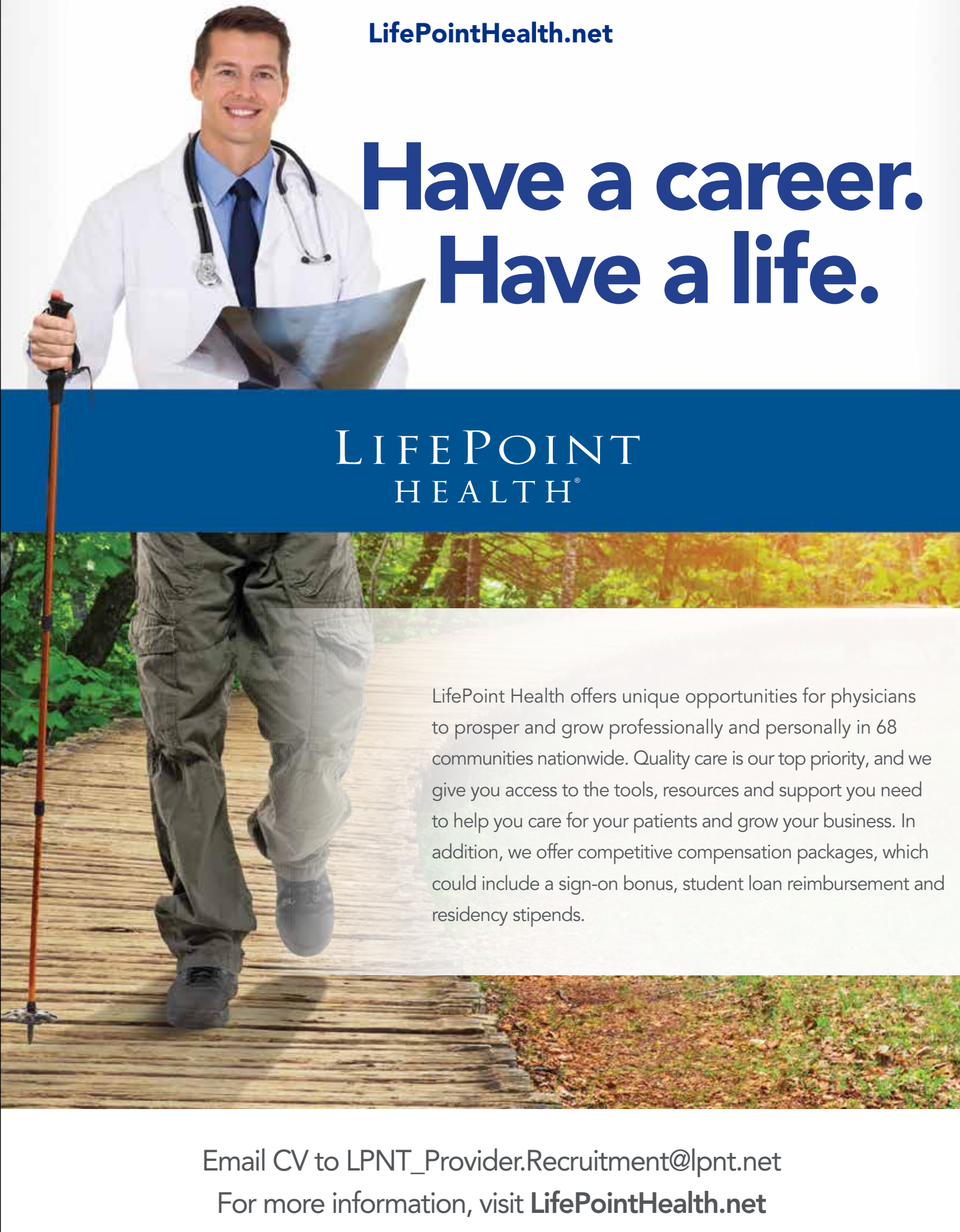
Dr. Nix graduated from UCA and received his medical degree from the University of Arkansas for Medical Sciences then completed a Family Medicine Residency at UAMS Southwest where he served as Chief Resident. He joined the UAMS SW faculty in 2010 and has served as the Clinic's Medical Director since 2014. He was promoted in 2017 to Associate Professor and was recently named the Associate Program Director at AHEC SW in Texarkana.

A Fellow of the American Academy of Family Physicians and a Diplomate of the American Board of Family Medicine, he received the Excellence in Teaching Award and has published and presented research at the state and national level. He has also served in several leadership and advocacy positions in the state: moving up from Director on the Arkansas AFP Board to each elective office



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Matthew Nix, M.D.

President's Message

Matthew Nix, President

While I was in college I worked in an Immunology lab. I enjoyed it so much that I briefly considered obtaining a Ph.D. and not applying to medical school. Late one night while I was working in the lab I had a change of heart. I decided I didn't want to spend my career staring at a computer screen – I wanted to be a physician instead. The irony in that statement is comical.

A recent study found that family physicians spend six hours of their

workday interacting with their EHR. For every one hour we spend with patients, we on average spend two hours in front of a computer. The new term for this is “administrative burden,” and it's a major contributor to physician burnout. Our national Academy is actively working with CMS to reduce this burden. I encourage you to read the AAFP website on this topic – it's enlightening and provided me a glimmer of hope.

This year we adopted a by-law change that gave the Board the ability to form “task forces” aimed to address specific issues more effectively and efficiently. Many state chapters have reported greater success in engaging

their members using this model compared to the standard committee. A task force is designed to be targeted in scope and can be composed of any member (not just a Board member). For example, instead of forming a committee to decrease “Administrative Burden,” a task force could specifically address “Prior Authorizations for Asthma Medications.” This targeted approach will decrease the time commitment of individual members and increase the chance the task force will achieve its goal. My desire is that we can start moving some of these seemingly insurmountable mountains one rock at a time. I invite you to share your thoughts with me on this topic at matthewnixmd@yahoo.com.

The keynote address this year at the Scientific Assembly was given by Dr. Gary LeRoy, the president-elect of our national Academy. His speech “We Are Here!” was a spoof of Dr. Seuss's *Horton Hears a Who!* Dr. LeRoy's main point was that family physicians need to be at the table when health care policy decisions are made. Maybe no one is listening to us because they don't know we are here. Like the residents of Whoville, we need to keep screaming “We are Here!” – our professional lives and the lives of our patients are depending on it. If you haven't read this classic story, or if it's been a while, I encourage you to read it again with a fresh perspective. In the story, the Mayor of Whoville finds a single child, JoJo, who isn't making any noise. The addition of JoJo's single yell of “Yopp!” pushes the collective noise past the sound barrier. Whoville is saved. Our members have remarkable insight and talent – and we need each of you to share it.

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AR AFP'S ANNUAL SCIENTIFIC ASSEMBLY A SUCCESS!

With 162 in the seats at the opening session of the Academy's 72nd Annual Assembly, it was so exciting to see so many in attendance for the presentation of the colors and the singing of the National Anthem by Dr. Tasha Starks followed by our keynote address by Dr. Gary LeRoy, President Elect of the American Academy of Family Physicians from Dayton, Ohio.

Twelve of the 17 speakers on the Annual Assembly program were Family Physicians and received excellent evaluations and scores from those in attendance. Dr. Jeff Mayfield of Bryant, was the top rated speaker at 98% followed by Dr. Lonnie Robinson and Lisa Larkin and Anthony Mancini with 96 and 97% overall scores.

The Pre Assembly had over 68 in attendance where "Office Emergencies" was presented. We extend our appreciation to those of you that attended and participated and hope you will plan on being with us again next year August 5-8 again at the Embassy Suites in Little Rock.





Officers and Directors Installed for the Coming Year at Annual Assembly!



The following 2019-2020 Officers and Directors were installed by Dr. Gary LeRoy, President-Elect of the American Academy at the Annual Assembly on Friday, August 2, 2019.

Officers:

President-Matthew Nix, M.D. of Texarkana

President Elect-Appathurai Balamurugan, M.D. of Little Rock

Vice President- Eddy Hord, M.D. of Stuttgart

Secretary/Treasurer-Leslye McGrath, M.D. of Paragould

Delegate-Dennis Yelvington, M.D. of Stuttgart

Alternate Delegate-Jeffrey Mayfield, M.D. of Bryant

Directors:

Brian Bowlin, M.D. of Vilonia

Nicole Lawson, M.D. of Newport

John P. Wornock, M.D. of Searcy

W. Matthew Peckat, M.D. of Texarkana

Kimberly Reynolds, M.D. of Little Rock

Chesley Murphy of Little Rock

Thank you to these members for your willingness to serve on the Arkansas Academy Board of Directors!

Our appreciation is extended outgoing directors, Dr. Ross Halsted and Dr. William Brent Bennett for their service on the board.

Arkansas AFP confers the Honorary Degree of Fellow to Four Members!

Dr. Gary LeRoy, President-Elect of the American Academy of Family Physicians presented four members of the Arkansas Chapter their Degree of Fellow at the Annual Scientific Assembly on Thursday, August 1, 2019.

Those receiving their certificates and pins were:



Dr. Roddy Lochala of Searcy, Dr. Chad Sherwood of Searcy, Dr. Leslye McGrath of Paragould and Dr. Kristin Martin of Little Rock.

The American Academy of Family Physicians Degree of Fellow was established in 1971 as a special honor bestowed upon AAFP members who have distinguished themselves among their colleagues by their service to Family Medicine and their commitment to their professional development through medical education and research. The criteria for this honor is a minimum of six years of membership, and points for the application based on experiences and activities in Life Long Learning, Practice Quality and Improvement, Volunteer Teaching, Public Service, Publishing, Research, and Service to the Specialty. If you wish to participate and obtain your degree, please complete the Fellowship application that can be found on the American AAFP website at <http://www.aafp.org/membership/involve/fellow.html>.



First Resident-Student Fair a Success!

Wednesday evening, July 31 following the Pre-Assembly of the Annual Meeting, we held the first Resident-Student Fair for medical students to meet Residency Programs and other vendors from around the state! We had a great turnout of students from each school: UAMS, NYIT and ARCOM. Exhibitors included UAMS Residency programs from Jonesboro, Fayetteville, Fort Smith, Batesville, Pine Bluff, Texarkana, Little Rock, and Magnolia. The UAMS/ Baptist Health Program, Unity Health-White County Medical Center, State Volunteer Mutual Insurance Company, Arkansas Foundation for Medical Care, and the UAMS Physician Relations were also exhibiting. We are excited that the program was a hit with the students in attendance as well as those exhibiting and look forward to an even larger attendance next year!



Our appreciation is extended to Jessica Burske of the UAMS Regional Programs for the photographs

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Dr. R.B. Robins, Camden, Ar

Dr. Rufus Benjamin Robins, (Dr. Bob, as he was known,) was born in 1899 in the small community of Ozan, Arkansas in Hempstead County. A bright child, he was schooled in a small school in Ozan. For high school, he took the train each morning to Old Washington. At age sixteen, he began to teach school himself. His father was the station manager at the Ozan train station, Dr. Bob learned telegraphy from his father and in the summer earned and saved money to further his education. He graduated from Hendrix College in 1921, earning a bachelor's degree in Science. He was awarded a Noyes Scholarship that assisted him to continue his postgraduate studies at Chicago University. In 1925, he received his M.D. degree and, in 1926, completed an internship at Norwegian-American Hospital in Chicago. That summer he returned to Arkansas and established a practice in Camden, Arkansas, a small but well-established community of 3200 people. In the following years, his postgraduate studies included courses at the University of Michigan, the University of Indiana, the University of Tennessee, Cook University Graduate School of Medicine and Harvard University.

In addition to being very bright, he was a perfectionist in the operating room, with long-fingered fast hands.

By the mid-nineteen thirties, he was well established in the community. In 1937, he built a clinic in downtown

Dr. R.B. Robins, Camden

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

Camden. Robins Clinic would become a landmark in the Camden community for three decades.

He was devoted to his patients and his community. By the 1940s, his scope had begun to reach well beyond the borders of Ouachita County and the State of Arkansas.

From the start of his professional life, he was active in state and local medical politics. He was the President and Vice-President of the Arkansas Medical Society in the mid-1940s. In 1946, Harry S. Truman proposed a new national health care program. In his message, Truman argued that the federal government should play a role in health care, saying *"The health of American children, like their education, should be recognized as a definite public responsibility."* The American Medical Society launched an organized effort against the bill capitalizing on the fear of Communism in the public's mind. Every member of the AMA, nationwide, was docked \$25.00 to fund the campaign. The AMA created a National Education Campaign aimed at educating the general public about what they perceived to be the dangers of this form of socialism. Dr. Robins was placed on this committee of ten men and for several years spent a great deal of his time, traveling around the country planning and giving speaking engagements. One of his recurring themes is exemplified by this quote: *"When the life or health of a loved one is at stake; hope lies in the devoted service of your family doctor. Would you change this picture? Compulsory health insurance is political medicine. It would bring a third party—a politician between you and your doctor. It would bind up your family's health in red tape. Political medicine would result in heavy payroll taxes—and inferior medical care for you and your family. Don't let it happen here! You have a right to prepaid medical care—of your own choice under voluntary health insurance, your health is your business. Keep it that way!"*

With his efforts and the efforts of others like him the legislation was stalled in the legislature. During the same time frame, Blue Cross/Blue Shield grew from twenty-eight million to sixty-one million.



In June of 1947 the American Academy of General Practice (forerunner of the American Academy of Family Practice) was created at the meeting of the American Medical Society. In April of 1948, the Arkansas Medical Society met at the Marion Hotel in Little Rock and created the Arkansas Academy of General Practice. Drs. R.B. Robins of Camden and Dr. Fount Richardson of Fayetteville proposed a constitution and set of bylaws that were accepted by the twenty-eight members present. Dr. Robins was elected the first president of the new organization. The motto of the new organization was: *For Every Family, a Family Doctor.*

**“For every family,
A family doctor”**

Dr. Robins would go on to serve as the President of the American Academy of General Practice again in 1953.

In 1994, Jim Lair, a former patient and friend said of Dr. Robins: *“Camden and Ouachita County have known and respected many physicians during the long and unique history of this place, but one of that number stands alone as a person who knew the unquestioned esteem of his many patients, the unwavering respect and admiration of his peers and who rose to the pinnacle of national prominence in his chosen profession to become the quintessential physician.”*

Dr. Robins died at age 71 in Chicago.

(Lair, Jim, Dr. R.B. Robins’ rise to greatness, A physician’s odyssey in Ouachita County, Ouachita County Historical Quarterly, Vol. 26 #2 Winter 1994, p 14-19))

(Genealogytrails.com/ark/ouachita/bios.htm, R.B. Robins Jr. last accessed 4-5-2018)

(Dr. R.B. Robins, the Alarm Clock of the Medical Profession, p309-318)



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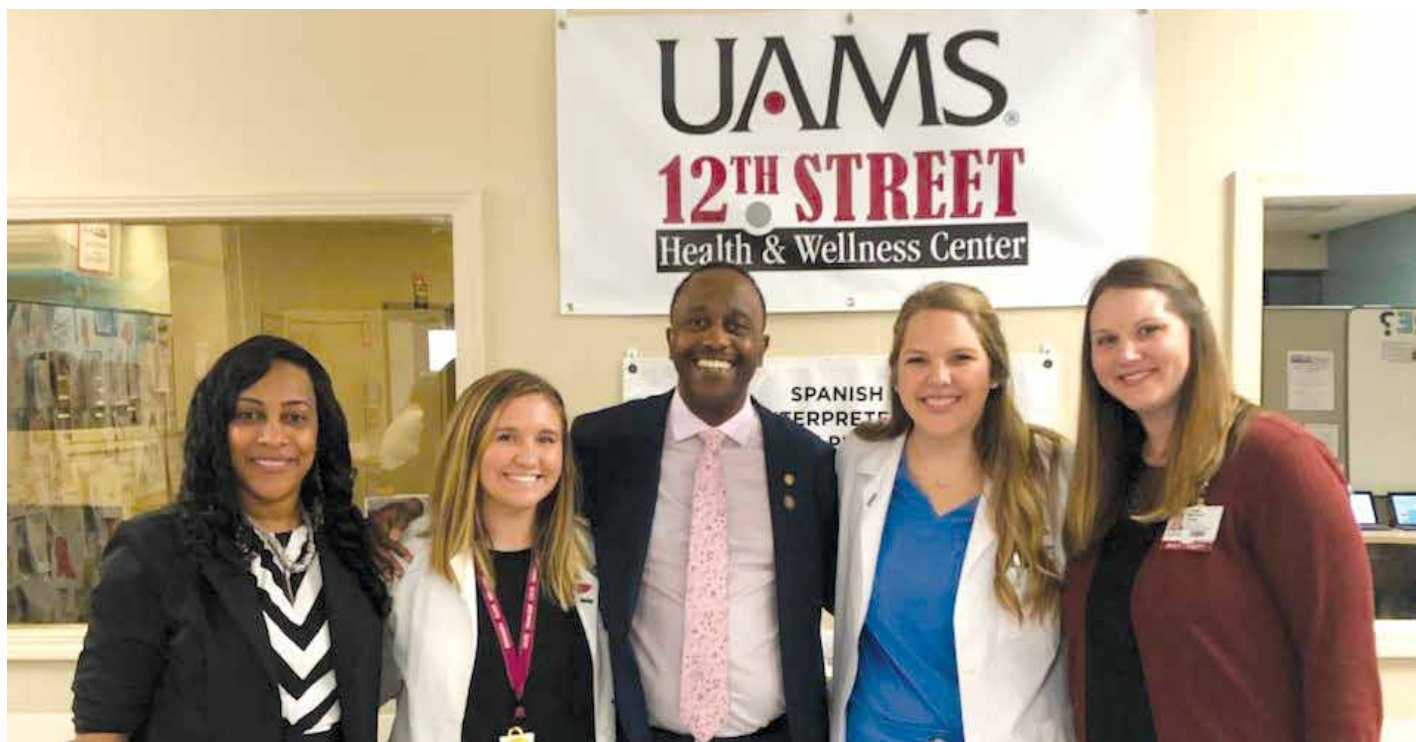
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Arkansas Academy of Family Physicians Chapter Visit Report



2019 Arkansas AFP Annual Scientific Assembly and Meeting July 31-August 3rd Little Rock, Arkansas

By Gary L. LeRoy, M.D.

I was honored to represent the AAFP Board of Directors at the 2019 Arkansas Academy of Family Physicians (AR-AFP) Annual Scientific Assembly and Meeting. The event began on July 31st at the Embassy Suites Hotel located in Little Rock, AR.

This was the first time in thirty plus years that I have set foot in Arkansas. I drove through it once after college on my way to Houston, Texas. As our plane descended into the Little Rock airport, I looked out the window and thought to myself, "Trees, this big city has lots of trees." It made me ponder the question of why Arkansas is pronounced differently than Kansas. Unlike Kansas, the name Arkansas was derived by virtue of French explorer's using the phonetic spelling of the indigenous Quapaw tribe's word "acansaw" – meaning downstream place – to describe the lush forest river basin region of the Arkansas Territory acquired as part of the Louisiana Purchase.

The conference began on Wednesday with a pre-assembly session on Office Emergencies. That evening the AR-AFP held their first ever Resident & Student Fair. I arrived at a room filled beyond capacity with medical students, residents,

and faculty from all 10 of Arkansas' family medicine residency programs. It was a wonderful experience!

One hundred and seventy two members and guests attended their opening session on Thursday morning. This was the Arkansas AFP's 73rd annual meeting. It was a historic event, because Ms. Carla Coleman celebrated her 36th year serving as the chapter's EVP. However, this was her last annual meeting. Earlier this year Carla announced her retirement effective December 31, 2019. I was exceptionally honored to have been asked by Carla to serve as the AAFP Board representative to provide the keynote address for this special event.

The theme of my speech was "We Are Here" – Imagine Family Medicine in the 21st Century and Beyond. I shared some key outcomes of both our AAFP Member Satisfaction Survey and a few preliminary elements of our recent strategic planning session in Colorado Springs. Dr. Warren P. Newton, ABFM President and CEO, followed with an update on family medicine certification. An interesting element of his "What's True, What's Ahead?" presentation was a discussion about reclaiming diplomates. A pilot reclamation program is in the works that would cost former ABFM diplomates ~\$10-15,000 to complete the reinstatement process. More details will undoubtedly follow.

The annual assembly featured a wide variety of top quality CME offerings. Noteworthy topics included a 2019 Asthma Update; Having Difficult End of Life Conversations; Atopic Dermatitis; Genitourinary Syndrome; Telemedicine for Family Physicians; and a 2019 Physicians Legal Update.

During the meeting I conferred the degree of AAFP Fellow to four eligible attendees; Installed the chapter's newly elected officers; and gave the Arkansas AFP presidential oath of office to Dr. Matthew Nix.

The top three priorities of the AR-AFP chapter are 1) Retention of members; 2) Involvement of young doctors; and 3) Scope of practice issues. The chapter is doing a meritorious job in addressing each of these issues head on. During the Q & A portion of my presentation 86 year-young Dr. Hedges asked me about national malpractice resources for retired members who wished to volunteer their professional services to the community. He also expressed concern that the AAFP seems to have lost its focus on providing preventative care training to its membership. With his prompt I clarified to the audience that we are the specialty of medicine who has not lost our focus on health promotion and disease prevention. It is hardwired into many of our policies statements, position papers, and member resource educational materials. Our Commission on Health of the Public and Commission on Education are the genesis of many of these initiatives.

Prior to leaving Little Rock, Dr. Tasha Starks treated me to a personal mini tour of the city. We visited the enormous healthcare complex within the city of Little Rock. It includes the University of Arkansas Medical School (UAMS), the VA hospital, the Arkansas Department of Public Health, the UAMS University Hospital, their Children's Hospital, and a vast network of other medical specialty support facilities. In contrast, we then drove less than a mile from the medical mecca to tour the UAMS 12th Street Health and Wellness Center. This urban interprofessional clinic is staffed and run by a small army of students. It was invigorating to watch these young enthusiastic medical, dental, nursing, pharmacy, social services, and behavioral health students from various levels of the educational ladder collaborate to care for marginalized segments of the Arkansas population, who are unable to access the medical resources within walking distance of the little free clinic. Many of these clients are "undocumented" workers living in the area.

The stop on my tour that left the most indelible impression on me was our visit to the Little Rock Central High School. There in front of me stood the massive red and white brick building where in the fall of 1957 the Little Rock Nine incident placed Little Rock, AR in the spotlight of international attention. The 1954 Brown vs Topeka Board of Education Supreme Court ruling led to a sequence of events in Little Rock where mobs of citizens denied nine Colored [African-American] teenagers' access to the - then - Whites only high school. This ultimately resulted in the "Lost Year" of 1958 when all four of Little Rock's public schools were closed. In stark contrast I witnessed a cultural rainbow of professional students at the 12th Street Clinic welcoming a diverse group of patients in the same community that once stood in opposition of civil rights for all. It was obvious Little Rock has come a long way in the ensuing 56 years.

A very special thanks must go to Ms. Carla Coleman and her staff. They ran an extremely well organized meeting. Carla has been a constant figure guiding the course of the AR-AFP for 36 years. Prior to my departure I witnessed twenty plus AR-AFP past-presidents standing on the stage to offer testimony regarding Carla's nearly four decades of invaluable service to the chapter. I was blessed to have been there to witness this unprecedented display of love and respect.

My thanks to the Arkansas chapter for their invitation, your undivided attention to detail, your southern hospitality, your friendship, and for allowing me to be part of history in the making.

Epilogue
The Ohio AFP Report
August 2-4, 2019
Columbus, Ohio

I departed Little Rock on Friday afternoon, August 2nd, to attend the Ohio Academy of Family Physicians Annual Celebration in Columbus, Ohio. On Saturday morning the news broke of the El Paso, Texas Walmart shootings - 847 miles from Little Rock, AR. Reports of 22 killed and 32 injured crashed through my consciousness. I had been relatively near yet another gun related tragedy in the United States (the 149th this year). Given the nature of the killer's reported reason for his violent rampage, I was no longer reassured our country had come as far in 56 years as I had proudly imagined the previous day when I left the Little Rock Central High School National Park visitor center.

On Saturday I performed my designated AAFP duties of conferring Fellowship degrees, installing OAFP officers, participating in a panel discussion, joining in on a variety of OAFP Celebration activities, and experiencing a relaxing dinner with my Ohio friends. As usual, the OAFP put on an excellent meeting.

I awoke on Sunday morning to the news of yet another mass shooting occurring just 72 miles from Columbus. The added shock was that it occurred within 10 minutes from where I live and work, in the Oregon District of Dayton, Ohio. The report of 9 killed and 27 injured flashed across my hotel room's TV screen to become seared into my soul. I thought to myself, "Was one of the dead or injured a family member, one of my students, a patient, a friend, or someone else I know?" The senseless public health tragedy of assault weapon violence plaguing our nation had followed me home. Thoughts, prayers, lowering flags, and moments of silence are hollow gestures of hope when tragedy strikes at home. Upon my return to Dayton on Sunday I attended an evening prayer vigil in the Oregon District. As Ohio's Governor, Mike DeWine, took the stage to begin his remarks the chant, "Do something" began to crescendo from the thousands in attendance. On Monday morning Gov. DeWine held a news conference to announce 16 proposals to fight gun violence in Ohio. On Wednesday I received a phone call from the president and CEO of the Dayton Foundation asking me to co-chair the Dayton Oregon District Tragedy Fund established for the shooting victims and the families of those killed.

If we wish to break the cycle of complacent silence, "Do something" by saying something in your respective communities about this public health tragedy. We are family physicians. We can make a difference.

AAFP EVP Dr. Doug Henley's Succession Plan

Colleagues,

As you know, the AAFP Board during its July meeting discussed the process and timeline for the search to identify my successor. The Board approved the general composition for the search committee, approved the engagement of Korn Ferry as the national search firm, and approved necessary fiscal note to conduct a vigorous national search.

The attached document indicates the members of the EVP/CEO Search committee as appointed by Dr. Cullen (Board Chair for 19-20). Under the chairmanship of Dr. Gary LeRoy, the search committee in concert with Korn Ferry will soon begin to meet and further develop the timeline and process for this national search. A general timeline indicates the following:

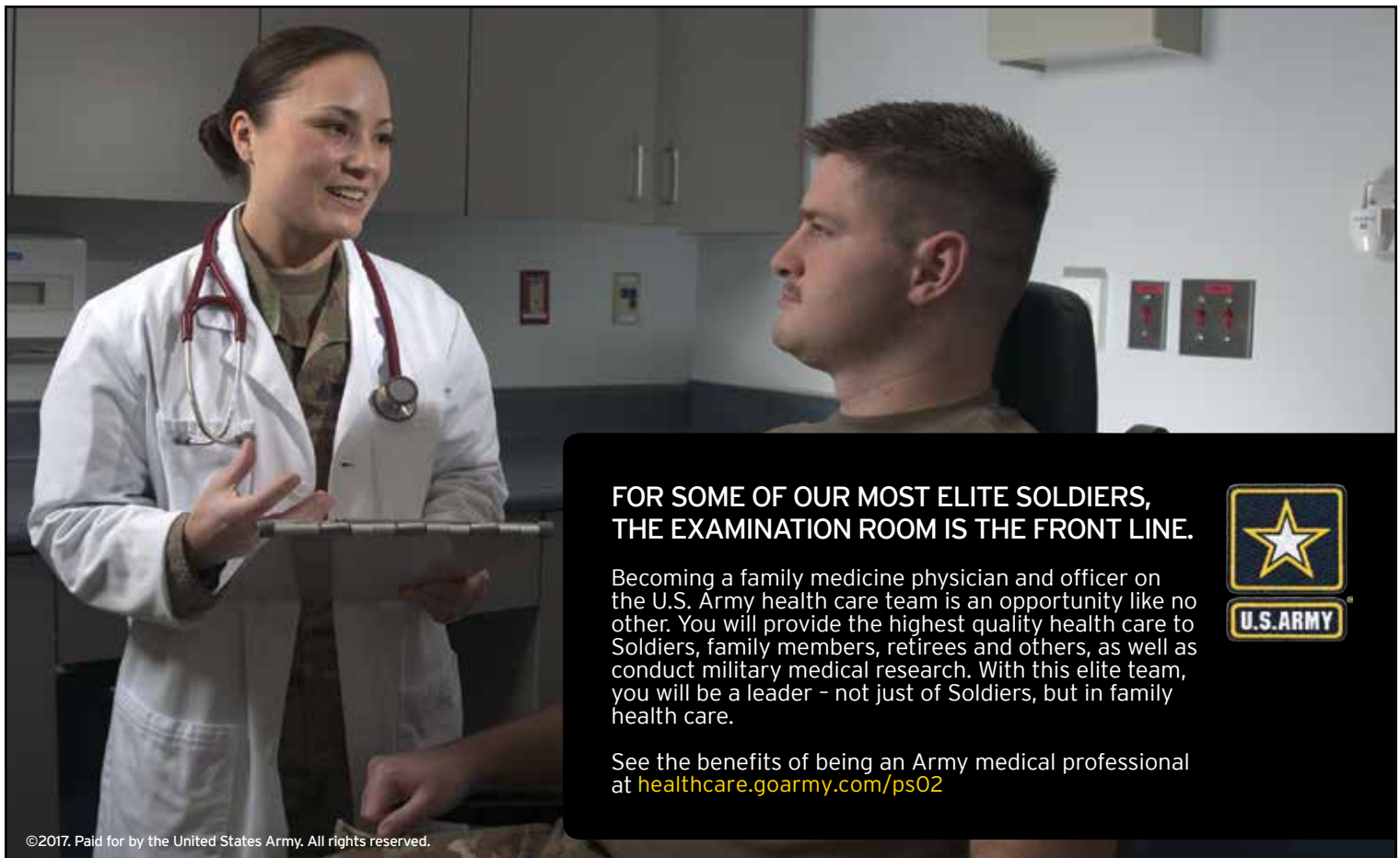
1. Solicitation of candidates/nominees between mid-September to mid-November
2. Search committee decision of candidates to interview by mid-December
3. Search committee in-person interviews by mid to late January, 2020 and recommendations of finalists to the AAFP Board
4. Finalist interviews with the AAFP Board during its meeting in late February, selection of a preferred candidate, and initiation of negotiations with this person
5. Anticipate a public announcement of the new EVP/CEO by the time of the ACLF 2020
6. Transition work between me and the new EVP/CEO in June and July

Please keep in mind the tentative nature of this timeline. The search process is just beginning, so the timing is subject to change as the committee does its work.

I hope you find this information helpful. I remain very confident of this process and its eventual success!

Best,
Doug


Douglas E. Henley, MD, FAAFP
Executive Vice President/CEO
American Academy of Family Physicians
11400 Tomahawk Creek Parkway
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Tom Frazier, M.D.
Sean Morell, M.D.
Mark Tait, M.D.
Theresa Wyrick-Glover, M.D.

Musculoskeletal Non-Op

Michael Cassat, M.D.
Kristin Garner, M.D.

Hip & Knee

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Paul K. Edwards, M.D.
Simon C. Mears, M.D., Ph.D.
Jeffrey Stambough, M.D.

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Corey Montgomery, M.D.
Richard W. Nicholas, M.D.

Pediatric

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Michael Israel, M.D.
Brien Rabenhorst, M.D.
Brant Sachleben, M.D.

Shoulder

Shahryar Ahmadi, M.D.
Lawrence O'Malley, M.D.
Chuck Pearce, M.D.

Sports Medicine

Lawrence O'Malley, M.D.
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John L. Vander Schilden, M.D.

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Steve Cherney, M.D.
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MACRA Basics

CMS Primary Cares Initiative

New Alternative Payment Models for Primary Care Physicians

CMS Primary Cares Initiative, the program recently announced by the Centers for Medicare & Medicaid Services (CMS), provides new alternative payment models for primary care physicians. The program includes five new payment model options under two paths:

- Primary Care First
- Direct Contracting

Learn more about what each option entails.

Primary Care First

The Primary Care First (PCF) models are designed to be transparent, simple, and create opportunities for practices ready to take on more risk through payments based on utilization outcomes.

There are two models in PCF:

PCF - General

What it includes:

- Risk-adjusted population-based payment (ranging from \$24 to \$175 per member per month [PMPM] based on average panel risk).
- Flat visit fee (\$50) for each face-to-face primary care visit with a primary care physician (procedures and vaccines will still be billable through fee-for-service).
- Upside performance-based payment that is potentially up to 50% of total revenue.
- Downside risk is capped at 10% of revenue. This incentive is intended to reduce costs and improve outcomes.

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PCF - High-need Populations

How it works:

The High Need Populations PCF model allows PCF practices to opt in to the Seriously Ill Population (SIP) portion of the model. SIPs are determined through claims data and are defined as having multiple co-morbid conditions, patterns of emergency department and/or hospital utilization, the presence of proxies for frailty, and no primary care physician. In exchange for taking on these patients with uncoordinated care and complex chronic conditions, a higher PMPM payment (\$325 for the initial visit then \$275 PMPM) will be made for the initial 12 months the patient is assigned to the practice.

Palliative care and hospice practices can apply to participate only in the SIP portion of the PCF model. If practices only participate in the SIP portion of the PCF model, they are ineligible for the additional population- and performance-based payments but will receive the flat visit fee (\$50) in addition to the PMPM.

Eligibility Criteria

Practices will be eligible to apply if they meet the following criteria:

- Primary care physicians (MD and DO) and non-physicians (CNS, NP, PA), practicing in a primary care specialty (internal medicine, general medicine, geriatric medicine, family medicine and hospice and palliative medicine)
- A minimum of 125 attributed Medicare beneficiaries (excluding Medicare Advantage)
- 70% of practice revenue coming from primary care services

- Experience with value-based payment arrangements/payments based on cost, quality, and/or utilization performance
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE) (in regions where one is available)
- Attest on practice application to advanced primary care functions (24/7 access, empanelment, etc.
- Participation is limited to eligible physicians and practices, as outlined above, in the following states/regions:
- Comprehensive Primary Care Plus (CPC+) states/regions: Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Louisiana, Michigan, Montana, Nebraska, North Dakota, Greater Buffalo Region of New York, North Hudson-Capital Region of New York, New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee
- CPC+ participants are ineligible for participation during the first year of the PCF model
- New states/regions added for PCF: Alaska, California, Delaware, Florida, Maine, Massachusetts, New Hampshire, and Virginia
- Regions were selected based on CPC+ regions and regions with limited CPC+ comparison group practices

Timeline

- April 22, 2019 – CMS Primary Cares Initiative announced
- April 30, 2019 – Overview Webinar
- May 16, 2019 – Overview Webinar
- Spring 2019 – Practice applications open
- Summer 2019 – Practice applications due and payer solicitation begins
- Fall-Winter 2019 – Practices and payers selected
- January 2020 – Model launches

- April 2020 – Payment changes begin
- Mid-2020 – Second round applications
- January 2021 – Second round begins

For more information, see the CMS PCF web page([innovation.cms.gov](https://www.cms.gov/innovation.cms.gov)) and fact sheet([links.govdelivery.com](https://www.links.govdelivery.com)).

Direct Contracting

The Direct Contracting (DC) models are built on the NextGen ACO model and offer new forms of population-based payment (PBP), enhanced cash flow options, and an increased flexibility that allows practices the ability to meet beneficiaries' medical and social needs. The DC model aims to reduce cost and improve the quality of care for beneficiaries in Medicare fee-for-service. The three DC models are:

Professional Population-based Payment What it includes:

- Monthly risk-adjusted primary care capitation payment for enhanced primary care services.
- 50% shared savings/losses.

Global Population-based Payment What it includes:

- Monthly risk-adjusted primary care capitation payment for enhanced primary care services OR a monthly risk-adjusted total care capitation payment for all services provided by the DC entity and preferred providers with whom the DC entity has an agreement.
- 100% savings/losses.

Geographic Population-based Payment

CMS has issued a Request for Information (RFI)([links.govdelivery.com](https://www.links.govdelivery.com)) on the Geographic PBP model. More details on this model will be available in the coming months.

Eligibility

Organizations will be eligible to apply if they meet the following criteria:

- There are no geographic limitations on the DC model.
- Professional PBP and Global PBP: minimum of 5,000 attributed

Medicare lives.

- Geographic PBP: proposed minimum of 75,000 beneficiaries in target region.
- All participants must submit a non-binding letter of intent (LOI) before applying.
- Organizations operating in the Medicare Advantage program and Medicaid Managed Care Organizations that provide Medicaid benefits for full-benefit dually eligible beneficiaries will be eligible to apply.
- Subject to RFI responses, the Geographic PBP model would encourage participation from innovative organizations (e.g., health plans, health care technology companies, and others) that want to contract with physicians and suppliers and take risk for a Medicare FFS beneficiary population in a defined geographic region.
- Medicare ACOs will be eligible to participate in all three DC payment model options.

Timeline

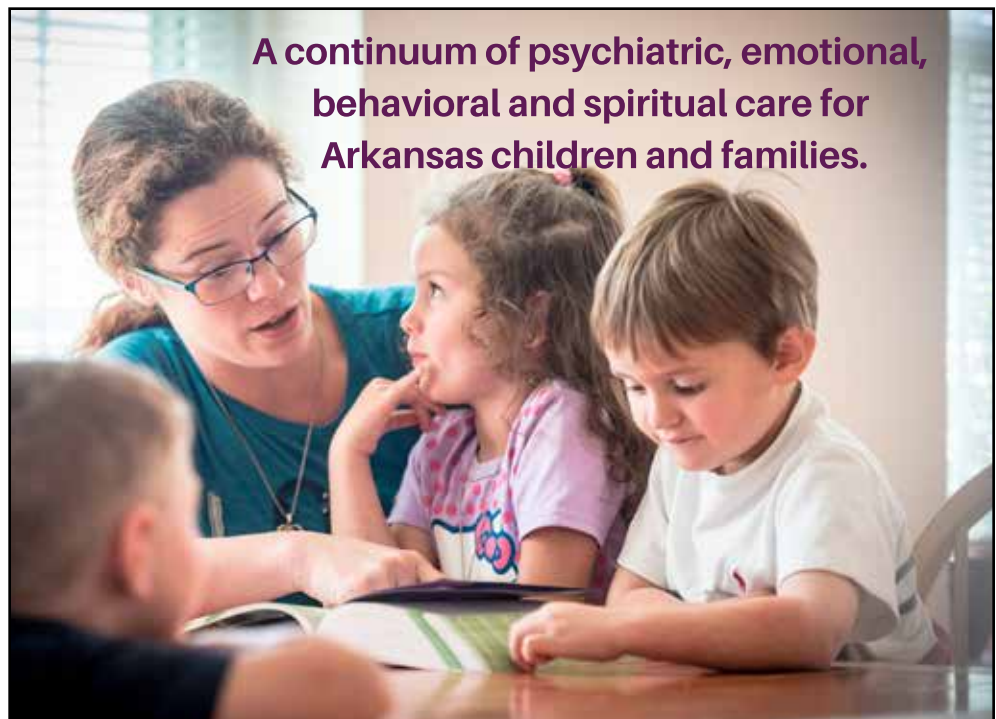
Professional and Global Population-based Payment:

- Summer-Fall 2019 – Organizations submit LOI
- Fall 2019 – Organizations with completed LOI submit applications
- Fall-Winter 2019 – Organizations selected
- January 2020 – Model launch (Year ○ – onboarding year, performance will not be measured and payment structure does not change until 2021)
- January 2021 – Performance period begins

Geographic Population-based Payment:

- Pending RFI – Organizations submit LOIs, applications, and are selected to participate
- January 2020 – Model launch (Year ○)
- January 2021 – Performance period begins

For more information, see the CMS DC web page([innovation.cms.gov](https://www.innovation.cms.gov)) and fact sheet(www.cms.gov).



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Arkansas Medical History

Early Days of Osteopathic Medicine in Arkansas

In the early 1900s, an osteopathic hospital was established in Stuttgart, a rural town in the state's eastern Delta region. Stuttgart is most well-known for its duck hunting and rice farming and has been deemed the Rice and Duck Capital of the world. During the 1920s, a small-town doctor named Frank Glenn decided to build a hospital in the growing town.

Frank Glenn grew up in Missouri and attended the American School of Osteopathy. He became friends with fellow classmate Carl Fagan, a Stuttgart native whose father was founder of the Stuttgart Rice Milling Company. After receiving their degrees, Fagan and Glenn moved to Stuttgart and opened a practice together. Dr. Glenn and his wife had two sons, Howard and Harold, who would both follow in their father's footsteps to become osteopathic doctors.

The Glenn Hospital opened in 1922 in the top floor of Glenn's practice. The hospital had seven beds, an



Frank Glenn



Howard Glenn



Harold Glenn

X-ray room, an operating room, three treating rooms, kitchen/dining area, a lavatory and was equipped with all the most modern technology available in those days.

Dr. Glenn's eldest son Howard returned to Stuttgart after attending college in Missouri and worked alongside his father at the newly established family hospital. Howard soon married and moved to Iowa, his wife's home state. In 1924, Dr. Howard Glenn was tragically killed in an auto accident in Waukon, Iowa. Dr. Glenn's younger son, Harold, operated a practice in Paragould for five years before relocating to Stuttgart where he would join his father at the Glenn Hospital. Just two short years later, tragedy struck again when Dr. Frank Glenn was killed in an auto accident, like his oldest son. Dr. Harold Glenn continued operating the hospital until 1945 when he purchased a private practice from another local doctor. Harold died in 1965.

The Glenn family was instrumental in introducing osteopathic medicine to Arkansas. Today we have two osteopathic schools: Arkansas College of Osteopathic Medicine in Fort Smith and the NYIT College of Osteopathic Medicine in Jonesboro.

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Its Accomplishments
Its Progress
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In Memory

Dr. Edwin N. Barron passed away on Monday, August 12, 2019. Dr. Barron had a successful family practice for 53 years. He practiced in Little Rock, founded and served as a director of the free Catholic Clinic from 1970-1984, was appointed by Governor Rockefeller as Special Director for updating and organizing medical care in the state prison system, served as chairman to the Governors Committee on Highway Safety and was the face of the weekly medical "HealthWatch" program on KTHV Channel 11 in Little Rock.

Dr. Barron is survived by his wife of 38 years Bunny and 5 children and preceded in death by his parents and 1 daughter.

Dr. Barron's Mass was held August 16 at Christ the King Catholic Church in Little Rock.

Our condolences are extended to Dr. Barron's family and friends.

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Stopping Burnout at the Source: *Delegating the Administrative Burden*

By: Peter Anderson, MD with James Anderson, MD
Reprinted with permission by the Ohio Academy of Family Physicians

I was drowning in a sea of administrative requirements. With the advent of the electronic health record (EHR) at my health system, I moved much more slowly through patient visits and spent much of my time staring at the screen rather than making eye contact with my patients. I poured more and more of my days (and my evenings) into tasks that did not require years of medical school and residency training. Like all too many other family physicians, I was burning out.

My long-time nurse felt similarly worn out and when she turned in her resignation, it was the last straw—I knew I needed to figure out a better way of practicing medicine.

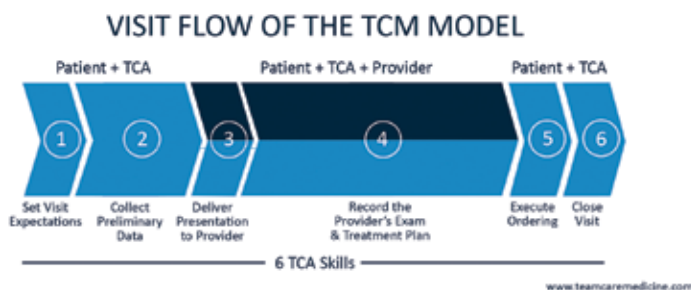
What I wanted was an experience more like a surgeon, who walks into the operating room with the patient prepared, the equipment ready, and the nurses available. That vision inspired me to tinker, experiment, and innovate to create a comprehensive primary care workflow that would allow me to focus just on the tasks that required my MD designation.

Equipping, empowering, and expanding my clinical support staff not only freed me up from administrative tasks that I should have delegated years earlier, it also allowed me to improve care and increase patient access. I was enjoying medicine again and was going home at night with my charts 100% current. My patients were delighted to find that they could now make same-day appointments for acute conditions rather than seeing a stranger at an urgent care center. System leadership at Riverside Health System in Newport News, VA, was delighted to see my financial profile flip from losing six figures per year to the most productive practice in the network.

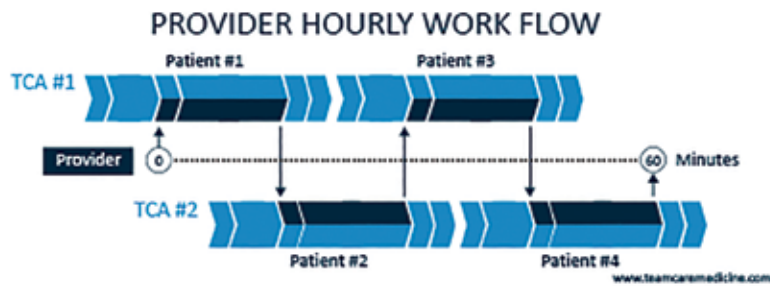
In the ensuing years, the Team Care Medicine (TCM) Model has been endorsed by the American Medical Association, the American Board of Internal Medicine, the American Academy of Family Physicians, and other healthcare leaders across the United States. The TCM Model reflects a handful of basic insights but, like individual steps in a dance, putting them all together in a cohesive, organic sequence takes good coaching and intentional practice. To be clear, it is not a set of tips and techniques to be selected a la carte based on personal preference.

The transformation starts with a major shift in mentality for the physician. Though medical schools rarely include the management training coursework included in an MBA program, providers must embrace the reality that they manage a team. Their role can and should be less like the star player that needs the ball in their hands all the time and more like the team captain that raises the performance of the entire team through coaching and leadership on and off the court.

In the TCM Model, the clinical staff (registered nurses, medical assistants, etc.) take on a role called the Team Care Assistant (TCA). They execute six discrete steps in the patient visit. Crucially, the physician is only present for two of them. Much of the administrative work is performed at the beginning and the end of the visit, and is performed by the TCA rather than the physician. When the physician is present, the TCA summarizes the preliminary medical information that has already been collected, in much of the same way that a medical student presents the patient's case to the attending physician. Then the TCA scribes the very concise examination by the physician, freeing up the physician to hone in on the diagnosis and prescription without even touching the keyboard.



Because they operate extensively without the physician in the room, each TCA offers dramatically more leverage to the physician's time than a scribe. Indeed, a high functioning TCM physician can be supported by up to four TCAs at the same time, while an individual physician never needs more than one scribe. A simple workflow with two TCAs is illustrated below.



In recent years, the TCM Model has been adopted by a range of practices from coast to coast, including small federally qualified health centers and large integrated delivery networks. Physicians have learned to coach, to lead, and to delegate in the exam room. They're reporting restored joy in medicine as they engage the patient rather than the computer and go home on time with all their charts current. With improved clinic access, patients

What I wanted was an experience more like a surgeon, who walks into the operating room with the patient prepared, the equipment ready, and the nurses available. That vision inspired me to tinker, experiment, and innovate to create a comprehensive primary care workflow that would allow me to focus just on the tasks that required my MD designation.

are delighted to get same day acute appointments with their own physician rather than an urgent care center. Executives are pleased by a strong ROI as the increase in visit volumes easily covers the conversion costs, not to mention the improved morale and retention of the physicians. This is just the beginning and I'm delighted that relief from administrative burden is beginning to restore primary care nationwide.



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A Day of Goodbye's, Tears and a Lifetime of Memories at My Last Annual Meeting

It was much more than I could have ever imagined to share the stage at our Annual Scientific Assembly with most of the Past Presidents of the AR AFP I have served . President Matthew Nix after being installed graciously shared his special day with me for many of the Past Presidents to line up behind me on the stage and speak and share memories of some of the light hearted and special times we shared.

Needless to say I was honored but also sad to know it would be the last time I would ever see so many of our members and our past presidents that I have worked with for so very long. Dr. Scott Dickson, our outgoing President presented me with a beautiful strand of pearls on behalf of the ARAFP and Dr. Nix had the largest bouquet of flowers I had ever seen! I was overjoyed to have some of my state chapter colleagues present (from Tennessee, Texas, Oklahoma and Iowa) as well as my husband Carter and my three nieces.

Then that evening, a grand reception was held at Trios in West Little Rock where more than 150 Academy members and their families along with business friends dropped by with well wishes. My "bucket list" was filled with ideas from those of you that attended on what to do with my spare time! And the amazing variety of flowers and gifts from so many of you are so much appreciated and will always be remembered .

I have found that preparing to leave a career I have loved for more than half my life; opening the state's very first office and watching it grow for more than three and one half decades – I have found that retiring is much harder than I could have ever imagined. I thank each of you from the bottom of my heart and wish you only the best personally and for the Family Medicine Movement in Arkansas! I will be with you until December 31 at which time a successor will have been named and they will take over in January.





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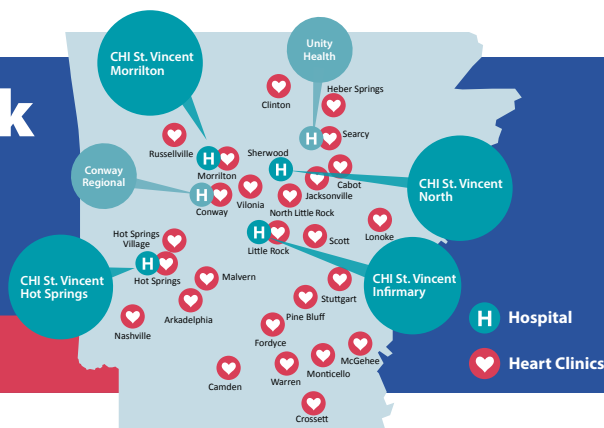


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Chronic Kidney Disease Needs a Second Look

This article provided by Arkansas Foundation for Medical Care

By Gerren Hobby, MD; Andrea Easom, MNsc, APRN; and Manisha Singh, MD

More than 45 million Americans have kidney failure, or chronic kidney disease (CKD). The number of Arkansans with some degree of CKD exceeds 400,000. On average, CKD patients have at least six symptoms across different organ systems and take more than eight medications. CKD patients have complex, intertwining medical conditions, high morbidity and mortality, high health care expenditures and a low quality of life.

CKD presents unique challenges for all physicians. We all treat these

patients, regardless of our medical specialty. Yet, medical professionals' awareness of CKD symptoms, the disease's course and outcomes is low. This often causes a low level of support for CKD patients.

In a large managed-care cohort of CKD patients stages 3-5, physician documentation was 14.4 percent.¹ In a survey of high-risk, urban, African American adults, less than 3 percent named kidney disease as an important health problem, compared to 61 and 55 percent naming hypertension and

diabetes, respectively.^{2,3} Even among patients with stages 4-5 CKD, less than half were aware of their disease.

CKD is defined by the presence of kidney damage or decreased kidney function for at least three months.⁴ Kidney damage is defined by albuminuria >30mg/24 hours, urine sediment abnormalities, electrolyte abnormalities due to tubular disorders, abnormalities shown on renal histology and structural abnormalities shown on imaging. Kidney transplant also qualifies as CKD.

Treatment costs for CKD and end-stage renal disease (ESRD) comprise some of Medicare's highest costs. ESRD is permanent renal failure requiring chronic dialysis to maintain life. Medicare spending for beneficiaries younger than age 65 with CKD exceeded \$8 billion in 2014, representing 44 percent of all health care spending for this age group. Medicare spending for CKD patients above age 65 was \$50 billion, or almost 21 percent of this cohort's total health care spending.

The most common causes of CKD are diabetes and hypertension. Other risk factors include African American descent, older age, low birth weight, family history of CKD, smoking, obesity, analgesic medications, exposure to heavy metals, excessive alcohol consumption, acute kidney injury, cardiovascular disease, hyperlipidemia, metabolic syndrome, hepatitis C virus, HIV infection and malignancies.⁵

Rates of re-hospitalization for CKD patients are higher (22.3%) than



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for patients without diagnosed CKD (15.8%). In 2013, adjusted mortality rates remained higher for Medicare patients with CKD (117.9/1000) than for those without CKD (47.5/1000).⁶ Coronary artery disease is common in CKD patients. The risk of coronary death or nonfatal MI in adults, with CKD stages 1-4 who are over age 50, is greater than 10 percent in a 10-year period.⁷ Dialysis patients have an adjusted one-year survival rate of 76 percent; dropping to 36 percent at five years. A study of patients with stage 4 or 5 CKD revealed a poor quality of life⁸, and 61 percent of patients regretted their decision to start dialysis.⁹

To control CKD progression, the first step is to identify high-risk patients and attempt to reduce the modifiable risk factors such as smoking or obesity. Treat the underlying etiology by controlling diabetes,

hypertension and using antiproteinuric medications. Nephrology referral is critical. Referring patients to dietitians and CKD education programs helps to slow progression. If controlling progression is not possible, patients must understand their remaining options: dialysis, kidney transplant and palliative care.

Dialysis is available by:

- In-center hemodialysis (IHD), the most common and expensive, involves three- to four-hour treatments, three times weekly.
- Home dialysis (HoD+) provides patient autonomy, the convenience of home, diet liberalization and ability to continue employment. HoD provides better clinical outcomes, higher patient satisfaction and saves about \$19,000 per patient, per year. It

most closely mimics the body's natural physiological renal clearance, with more frequent and longer dialysis.

- HoD can be administered via peritoneal dialysis (PD), using the peritoneal membrane as a filter; no blood or needles are involved.
- Home hemodialysis (HHD) usually provides shorter but more frequent dialysis using patient-friendly machines.

Kidney transplantation can be performed with a living or deceased donor. Except for patients with cirrhosis, many individuals with stage 4 or 5 CKD are eligible for possible transplantation. Most transplants occur after patients are on dialysis, but preemptive transplants can occur before patients need dialysis. Early referral for transplant evaluation is important.

Palliative care discussions can be part of the patient and family treatment goals discussion. For some patients, the burden of chronic disease or frequent hospitalizations prevents an acceptable quality of life. Renal failure compounds this situation and for some patients, dialysis does not increase quality of life or longevity.

Improving CKD-patient care:

1. At the primary care level, recognize high-risk patients, assess glomerular filtration rate (GFR) using urine dipstick for proteinuria/albuminuria and have the lab calculate estimated GFR to establish stage of CKD.
2. Involve nephrology care as soon as appropriate.
3. Optimize care using CKD management guidelines, produced and freely accessible from Kidney Disease/Improving Global Outcomes (KDIGO) at kdigo.org.
4. Know the options for CKD control and ESRD management.



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The UAMS Division of Nephrology and Arkansas Department of Health's Chronic Disease Branch are working to increase CKD awareness and education. The Arkansas State Chronic Kidney Disease Advisory Committee is a collaboration that is working to improve awareness, detection and education through community engagement. AFMC has ongoing initiatives for similar goals, including grassroots health education for CKD patients.

The authors practice in the Division of Nephrology, Department of Internal Medicine, UAMS.

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Visit uams.health/breastfeeding to learn more about breastfeeding, tips on making your office BreastFeeding Friendly (BFF) and find information on lactation consultants.



Is there a “Right Time” for Total Hip Replacement Surgery?

The “right time” for a hip replacement varies from person to person based on age, severity of symptoms, and other medical conditions. By being aware of the most common signs that your patient may need a total hip replacement surgery, you can more confidently recommend the right course of action for each patient’s situation.

A variety of conditions can cause a patient to present complaining of “hip pain.” Posterior hip pain, especially if it radiates distally beyond the knee, is typically lumbar in origin. Lateral, peri-trochanteric, non-radiating pain is classically secondary to trochanteric bursitis with or without abductor tendon tearing. Anterior or antero-lateral groin pain often arises from the hip joint. Patients with advanced osteoarthritis in need of hip replacement commonly present with this pain and on examination demonstrate an obligatory external rotation when the hip is passively flexed to 90 degrees. It is not possible to internally rotate the hip. Plain films are usually sufficient to confirm bone-against-bone, advanced arthritis.

The indication for hip replacement is debilitating pain coupled with loss of mobility. Some patients will tolerate advanced osteoarthritis well for a period of time and report mild pain or interference with activities despite advanced radiographic changes. I tell patients the time to have it replaced is when they reach the “grouchy and miserable” phase. Often the spouse will volunteer that that stage has been reached.

Patients with mild symptoms sometimes respond to fluoroscopic-guided, intra-articular steroid injections, NSAIDs and physical therapy. When the hip pain becomes intolerable and results in inability to sleep, missing work or social/family activities it is time to consider hip replacement surgery. Patients are often on a cane or walker at this point. They may complain of grating and locking of the hip and difficulty with simple activities like climbing stairs or getting in and out cars, bathtubs, and chairs. Implant selection is determined for each patient based upon bone quality and degree of bone loss on the femoral or acetabular side. Preoperative planning with digital templating on all hip replacement patients allows customization of the reconstruction so as to restore leg length and offset that matches the patient’s native anatomy which will optimize mobility, strength and functionality.

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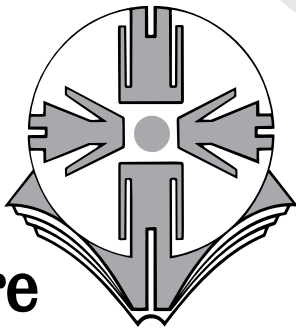
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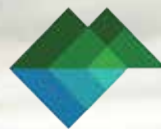
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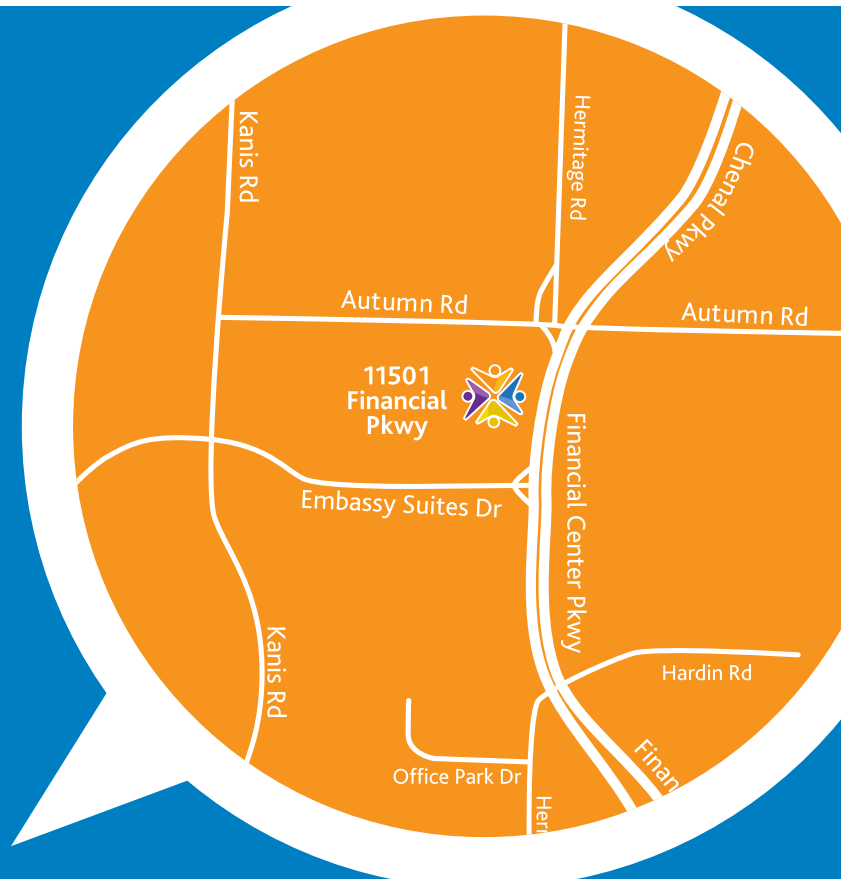
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