The Arkansas Family Physician

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The 2019 Arkansas Delegation to the AAFP Congress of Delegates

Philadelphia, PA

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The Arkansas Family Physician

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

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Dear Academy Member,

It is hard to believe how fast time goes by and it's now time to say "Till we meet again" – not goodbye! The year 1983 seems like a short time ago when I started to work with you and I cannot believe the last six months are history but as I write my last AFP Journal, and by next week I will have finished all of my "last meeting, last annual meeting, last Congress of Delegates, last Journal) and soon it will be my last day! I'm sure I will cry as I have done the last 8 months but I think there would be something wrong if I didn't.

This has been such an enjoyable career! For someone who never really knew what they wanted to do, I have been blessed to do something for more than half my life that has been more than perfect for me. It's been enjoyable, fulfilling and such a variety that how could I ever get bored here! The best part has been working with all of you, the ARAFP members ; meeting many of you in medical school and watching you finish your residency and practicing, teaching, and doing all the things you do. I've worked with the brightest, most giving members who volunteer their time as a member, a Director, an Officer and as a President of this organization and I have great respect for your dedication . Todate I have planned and attended 170 board meetings, 36 Annual Scientific Assembly Programs, 36 AAFP Congress of Delegates Meetings, served as editor and written the Arkansas Family Physician Journal for 22 years or 88 issues and participated in many other in and out of state meetings. I am the only original member of the "Multi State Meeting" that started in 1985 and continues today. I wrote the articles of incorporation of our Foundation in 1991 and successfully after two years was approved by the IRS! I was proud to be a part of the history of the Arkansas Chapter – with the successful candidacy and election of Dr. James Weber of Jacksonville as the 1994 AAFP President : of the election of Dr. George Warren of Smackover as a director and officer of the AAFP: the great honor of being a part of the national awards bestowed upon our own Dr. Amail Chudy of North Little Rock and Dr. Les Anderson of Lonoke as National Family Doctor of the year – (Chudy in 1986 and Anderson in 1996); seeing our very first female President of the Academy installed – Dr. Linda McGhee followed by Dr. Julea Garner and so many other firsts for us! This is the fourth year we have been named by *Arkansas Business* as one of the top ten professional organizations in the state! I have traveled the state to all of our residency programs , gone with some of you on patient home visits; met with medical students about the opportunities of a career in Family Medicine and I am awed by the tremendous amount of knowledge and training a Family Doc must have.

Of all of the duties entailed with managing the ARAFP, I most enjoy planning and executing the Annual Scientific Assembly - working on it most every month of each year (yes next year's is started)! It is so enjoyable and fulfilling to see it all come together and yes, the hotel crews cringe when they see me walk in on set up day! They don't understand "chevron seating" in the grand ballroom so I learned years ago, just do it myself. The second favorite duty is this Journal which I started 22 years ago after having done a monthly Newsletter for the first 13 plus years. During the recent legislative session as its been every other year for 36 years or 18 sessions, I'm on the phone a lot before office, after office and *Dr. Scott Dickson* and I did our best work at our 7 a.m. and 7 p.m. phone calls this past February and many emails in between. Over 22 Family Docs came to testify and all it took was a call!

Each Arkansas AFP President will carry a special memory for me and I will forever treasure my last meeting where each of you stood with me as I listed one more memory in my many years with you. No, I don't remember one thing that day (shock?) and only fully understood the significance of the event after watching the video last week. Each President I have worked with , I have learned something new! *Dr Matthew Nix* just installed in August has hit the ground running – rewriting many of our policies and procedures that were outdated and obsolete and now being an important leader of this succession plan and the hiring of a new Executive Director! He will no doubt be listed among some of the most outstanding leaders of this organization. And to Michelle, I will miss you but we will always be friends!

The Arkansas AFP and it's members will always have my utmost respect . I look forward to seeing our primary care shortage filled from the newly opened residency programs and the new osteopathic schools in our state and know that I will always be a part of the ArAFP's "Strong Medicine for Arkansas"!
God Bless each of you. Thank you again for this amazing opportunity which has been a large part of my life.
With all my love and respect,

Carla Coleman
Executive Vice President

On the cover:

2019 Arkansas AFP Delegation to the AAFP Congress
Matthew Nix, M.D., Julea Garner, M.D., Lonnie Robinson, M.D., Jeff Mayfield, M.D., Dennis Yelvington, M.D. and Carla Coleman, Executive Vice President

Matthew Nix, M.D.

President's Message

Matthew Nix, M.D., President

This was the first year I attended the AAFP Congress of Delegates. It was also my first trip to Philadelphia (or anywhere that far northeast). As a history enthusiast, I was excited to visit Philadelphia. During my first night in the city of brotherly love, I was struck with a kidney stone and spent the first half of the week on my hotel room floor. Thankfully, my symptoms subsided long enough for me to do some sightseeing including a visit to Independence Hall where both the Declaration of Independence and the Constitution were debated and signed.

My father controlled the television remote most of the time while I lived at home. His interest in history became my interest as I was exposed to countless documentaries over the years. Unlike the impression I gained from school, those conventions in Independence Hall were quite contentious. While there were many issues that threatened to tear our Founding Fathers apart, they stayed focused on what they shared rather than where they differed. They frequently had to "agree to disagree" and postpone controversy for another day. Eventually, by Providence, those men were able to come together through great compromise and lay the foundation of our Republic. It wasn't perfect, but these gentleman farmers changed the course of human history.

What better backdrop for the COD than Philadelphia! Delegates from every state chapter came together to chart the future of our specialty and they brought their varied opinions with them. Even though we were all family physicians, we had very different ideas regarding the role family physicians should play and the best way to achieve that vision.

I want to thank Dr. Julea Garner, Dr. Dennis Yelvington, Dr. Lonnie Robinson, and Dr. Jeff Mayfield for honorably representing the family physicians of our state. I always learn a great deal from these individuals and our chapter is fortunate they volunteer their time and talents in this capacity.

With her retirement approaching, this was Carla's last year to attend the COD. Carla is like a "rock star" at the COD and I was proud to be one of her groupies during her final Congress. The AAFP presented her with a beautiful award in tribute of her distinguished service. Carla will not only be missed here in Arkansas, but she will be missed across our nation.

My family and I wish you all a Happy Holiday Season!!

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The AAFP Congress of Delegates, Philadelphia, PA

The Arkansas delegation joined every state chapter in the nation with a great group representing the Arkansas Chapter!

On the cover pictured are Dr. Matthew Nix of Texarkana, President: Dr. Julea Garner of North Little Rock, Senior Delegate serving for her last year: Dr. Lonnie Robinson of Mountain Home, Alternate Delegate , Dr. Jeff Mayfield of Bryant, Alternate Delegate and Dr. Dennis Yelvington, Delegate , Stuttgart with Carla Coleman, Executive Vice President in front representing the chapter for the last time before her retirement 12/31 of this year.

The AAFP Congress elected Dr. Ada Stewart of Columbia, South Carolina to be the Academy's President Elect. Dr. Stewart is a Family Physician in Columbia, SC where she has practiced since 2012. She serves as lead provider and HI specialist. From 2003 to 2012 she served as chief medical officer and HIV specialist at the Richmond Community Health Care Association in Eastover and Columbia, SC. She continues to work with underserved communities in both rural and urban settings. In the aftermath of 9/11/01, she enlisted in the US Army Reserves and achieved the rank of Colonel.

Doctor Alan Schwartzstein of Oregon, Wisconsin and Dr. Russell Kohl of Stilwell, Kansas were both re-elected unopposed to the positions of Speaker and Vice Speaker: Directors elected were: Dr. Andrew Carroll of chandler, Arizona; Steven Furr of Jackson, Alabama; Margot Savoy of Newark, Deleware, New Physician – Brent Sugimoto of Richmond, California and Kelly Thibert D.O. of Columbus, Ohio and Margaret Miller of Johnson City Tennessee as Student Board Member.

The week was short especially for me who said goodbye to many state Chapter colleagues and AAFP staff that I had worked with for many years. I was one of four retiring chapter execs awarded the Executive Legacy Award (a large crystal bowl with our name and date etched). This presentation was made by Doctor Doug Henley, AAFP Executive Vice President at the Chapter Executive Awards Luncheon on September 24.

I was surprised and thrilled to be honored by President Gary LeRoy who thanked me in his opening speech to the Congress of Delegates for his warm welcome to the Arkansas meeting in August and the events scheduled for him to attend. And finally, I was honored to be mentioned at the conclusion of the Congress by Speaker Alan Schwartzien of Wisconsin and by Dr. Julea Garner who went to the microphone to thank me for my years with the Arkansas Chapter.

Carla receives award from AAFP EVP Dr. Doug Henley

Dr. Julea Garner, Carla, Dr. Scott Dickson and Dr. Dennis Yelvington

In Memory

Dr. Jerry Kendall of Camden passed away on August 31, 2019.

He attended Louisiana Tech in Ruston, LA and UAMS in Little Rock for medical school, graduating in 1969. He practiced in Camden for almost 30 years and was a Life member of the Academy of Family Physicians, with 47 years of membership.

Dr. Kendall was survived by his wife, Nancy, of almost 58 years until her death two weeks after Dr. Kendall. Together they are survived by three children, John Kendall (Michelle) of Greenbrier, AR, Stan Kendall (Chenoa) of Greenwood, LA and Kelly Kendall of Conway, AR; his five grandchildren and two great-grandchildren.

Memorials may be made to First United Methodist Church, 121 Harrison, Camden, AR, 71701.

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

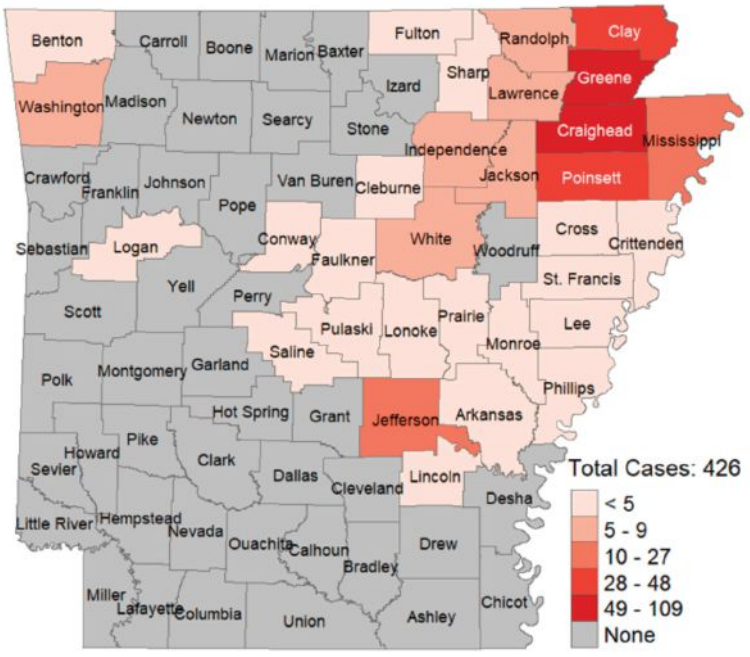
The Ongoing Hepatitis A Outbreak in Arkansas

By:
Michael Cima, PhD, MPH
ADH Chief Epidemiologist and Associate Director for Science

Joel Tumlison, MD, Diplomate ABFM
ADH Medical Director for Child & Adolescent Health

Jennifer Dillaha, MD
ADH Medical Director for Immunizations

Figure 1: Number of Hepatitis A Cases by County Since February 2018.



Source: Arkansas NEDSS Base System (NBS)

Background

Since late 2016, the United States (US) has been experiencing a multi-state outbreak of Hepatitis A among high-risk individuals, including those using and injecting drugs, who are homeless, and men who have sex with men (MSM).

Hepatitis A is caused by the hepatitis A virus, which infects the liver and generally leads to a self-limited disease. Hepatitis A virus causes symptoms that include fever, loss of appetite, nausea, vomiting, diarrhea, body aches, jaundice, dark urine, and/or light stools. Symptoms considered more specific to hepatitis, such as jaundice, are not always present, and the overlap of Hepatitis A's more general symptoms with those of other common illnesses, such as viral gastroenteritis, make diagnosis difficult. The virus is transmitted person-to-person through the fecal-oral route from close personal contact (e.g. household, sexual contact), contaminated food or water, or by blood exposure. [1, 2] Prior to the advent of the hepatitis A vaccine in 1995, which confers greater than 90% immunity with one dose, the US typically reported between 20,000 and 30,000 cases per year. [3, 4] After the hepatitis A vaccine was added to the recommended childhood immunization schedule, the yearly incidence of hepatitis A dropped by 95% from 1995 to 2011. However, a subsequent increase of 140% was observed between 2011 and 2017. [4]

California first identified an outbreak of hepatitis A mainly among the homeless and drug-using population in November 2016. Since then, cases have spread to 29 other states and have resulted in nearly 27,000 cases as of October 2019. Of these, 60% have required hospitalization, and 274 individuals have died from their infection.

Arkansas' Outbreak

In Arkansas, the first cases of hepatitis A in this outbreak were identified in Clay County during February 2018 and were largely attributable to drug use. Since then, 426 individuals have become infected with hepatitis A, leading to 222 (52%) hospitalizations and three deaths. Thirty-one counties have reported at least one case, with the northeastern counties having the highest burden of disease (Figure 1). However, in recent months new cases have been diagnosed in counties which previously had none, with Jefferson County a notable example. Table 1 shows the demographic breakdown of hepatitis A cases in Arkansas. More men than women (65% vs. 35%) and more white individuals (93%) than any other race have been infected. Table 2 shows the risk factors and co-morbidities that have been identified among cases. A majority of cases (60%) have reported drug use as their primary risk factor. Among these individuals, 58% reported injecting drugs. A quarter of hepatitis A cases have tested positive for hepatitis C, substantially more than the general population prevalence estimated at around 2%. Other identified risk factors include 8 (2%) MSM, 13 (3%) homeless individuals, and 17 (4%) recently incarcerated individuals. Finally, 21 (5%) were food handlers. Hepatitis A among food handlers can potentially expose patrons of restaurants to the virus

if proper sanitation and handwashing guidelines are not followed. Therefore, a public health response, including public notification and mass vaccination, has at times been warranted. Fortunately, no secondary cases of hepatitis A have been identified after a food exposure.

Since February 2018, the Arkansas Department of Health (ADH) has continuously monitored and responded to the outbreak of hepatitis A. More than 35,000 vaccinations have been given to individuals at risk for acquiring the virus (at no cost) at over 30 mass clinics, and 15,000 vaccinations have been given as a result of a food exposure. In an effort to bring about an end to this outbreak, ADH continues to investigate cases in a timely manner, communicate relevant information to the public, stakeholders and policy-makers, and target high-risk populations for vaccination.

Conclusions

The current multi-state outbreak of hepatitis A among high-risk individuals has proven difficult to address and contain. Many states, including Arkansas, have been responding to the outbreak for over a year. The difficult nature of this outbreak is largely due to the difficulty of effectively engaging and providing preventative care to high-risk groups, like drug users, MSM, and homeless individuals, who experience marginalization and stigmatization. Additionally, the worsening opioid and stimulant epidemic, compounded with a scarcity of drug abuse treatment resources, has likely contributed to the perpetuation of the hepatitis A outbreak nationally and in Arkansas. More cases of hepatitis A are likely in the coming months, but ADH and its partners will continue to find innovative strategies to combat the outbreak and stymie the spread of the virus through targeted vaccination and education. ADH needs the help of Family Physicians to control this outbreak, and we ask you to intervene in two ways: 1) **Consider a diagnosis of Hepatitis A in any case with typical symptoms, and order Hepatitis A IgM testing in those patients;** (2) **Please identify and vaccinate those with risk factors (illicit drug use, homelessness, MSM, etc.) for Hepatitis A.** Remember to report all cases of Hepatitis A to ADH.

Complete Hepatitis A vaccination recommendations are available at https://www.cdc.gov/hepatitis/outbreaks/InterimOutbreakGuidance-HAV-VaccineAdmin.htm

The Health Alert Network (HAN) gives notification regarding outbreaks or other public health events. To learn more about HAN and sign up for alerts go to https://hanregistration.adh.arkansas.gov.

To report Hepatitis A, or other reportable diseases, to ADH call 1-501-537-8969.

Table 1: Demographic Breakdown of Hepatitis A Cases in Arkansas, February 2018 – October 2019.

Characteristic	Number (%)
Gender	
Men	278 (65%)
Women	148 (35%)
Race	
Black or African American	13 (3%)
White	394 (93%)
Other/Unknown	19 (4%)
Total	426
	Median (minimum, maximum)
Age	39 (2, 80)

Table 2: Risk Factors and Co-morbidities Identified Among Cases of Hepatitis A, February 2018 – October 2019.

Characteristic	Number (%)
Drug use	254 (60%)
Injection drug use*	144 (57%)
Food handlers	21 (5%)
Co-infected with hepatitis C	106 (25%)
Co-infected with hepatitis B	19 (5%)
Hospitalizations	222 (52%)
Men who have sex with men (MSM)	8 (2%)
Incarcerated in the past two months	17 (4%)
Homeless individuals	13 (3%)

**Number and percent among those reporting drug use.*

References

1. Purcell, R.H., D.C. Wong, and M. Shapiro, *Relative infectivity of hepatitis A virus by the oral and intravenous routes in 2 species of nonhuman primates.* J Infect Dis, 2002. 185(11): p. 1668-71.

2. Fiore, A.E., *Hepatitis A transmitted by food.* Clin Infect Dis, 2004. 38(5): p. 705-15.

3. Ott, J.J. and S.T. Wiersma, *Single-dose administration of inactivated hepatitis A vaccination in the context of hepatitis A vaccine recommendations.* Int J Infect Dis, 2013. 17(11): p. e939-44.

4. CDC, *Viral Hepatitis Surveillance, United States*. 2017.

Congratulations Arkansas AFP Members with 45 Plus Years of Membership!

The Arkansas Chapter, American Academy of Family Physicians was established in 1947 and was the 7th state chapter chartered by the American Academy of Family Physicians on April 20, 1948.

We are pleased to acknowledge our members listed below who have held continuous membership with the AAFP for at least 45 years – many of them still practicing!

Dr. Amail Chudy, North Little Rock - 64 years

Dr. John E. Alexander, Sr., Magnolia – 61 years

Dr. Douglas Lowery, Russellville - 60 years

Dr. Lee B. Parker, Springdale – 60 years

Dr. Jim Lytle, Batesville – 60 years

Dr. James Laurence Jones , Fayetteville – 59 years

Dr. Bruce E. Schratz, Little Rock - 58 years

Dr. Wallace Mathews, Hot Springs – 57 years

Dr Peter James Carroll, El Dorado – 56 years

Dr. Grover D. Poole, Jonesboro - 56 years

Dr. William H. Riley, Little Rock - 56 years

Dr. William Wells, Heber Springs - 56 years

Dr. Tina Wells, Gonzales, La - 55 years

Dr. Larry Hanley, Fayetteville - 55 years

Dr. Harold H. Hedges, Little Rock - 54 years

Dr. Kenneth Koehn, Tahlequah, Ok. – 53 years

Dr. Hiram Ward, Murfreesboro - 53 years

Dr. Robert Weaver, Garfield – 53 years

Dr. Lester Darden, Little Rock, 52 years

Dr. Forrest Miller, Little Rock - 51 years

Dr. Joseph Farmer, Little Rock – 48 years

Dr. Mahlon Maris, Little Rock – 48 years

Dr. Kenneth New, Russellville – 47 years

Dr. Jim Citty, Searcy - 46 years

Dr. Joseph Hughes, Jonesboro – 46 years

Dr George McCrary, Fayetteville - 46 years

Dr. R. Jerry Mann, Bismarck – 46 years

Dr. Ronald Smith, Blytheville - 46 years

Dr. Stanley Teeter, Russellville – 46 years

Dr. Katie Youngblood, Rogers - 46 years

Dr. Leslie F. Anderson, Lonoke - 45 years

Dr. Ron Fewell, Cabot – 45 years

Dr. John Lee Garrett, Decatur – 45 years

Dr. Charles H. Rodgers, Little Rock - 45 years

Dr. Hoy Speer, Stuttgart – 45 years

Dr. Stephen Tilley, Little Rock – 45 years

Members due for Re-Election in 2019- Have you met your CME Requirements??

You have until December 31, 2019 to earn your CME!

CME Requirements for Membership

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

Reporting Your CME

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

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

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

Questions About CME

If you have questions about your reelection or need a current copy of your CME record, please call Michelle at 1-501-223-2272 or email arafp@sbcglobal.net

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Membership Dues for 2020 are now due!

If you have not already done so, please renew your AAFP membership now. You can pay in one of three ways:

- Return your invoice and payment in the envelope provided
- Call the AAFP to pay or to set up monthly installment payments, 1-800-274-2237
- Online at http://www.aafp.org/checkmydues

It's Easy to Pay Your 2020 Dues ONLINE

Thank you for maintaining your membership in the AAFP!

Degree of Fellow Convocations

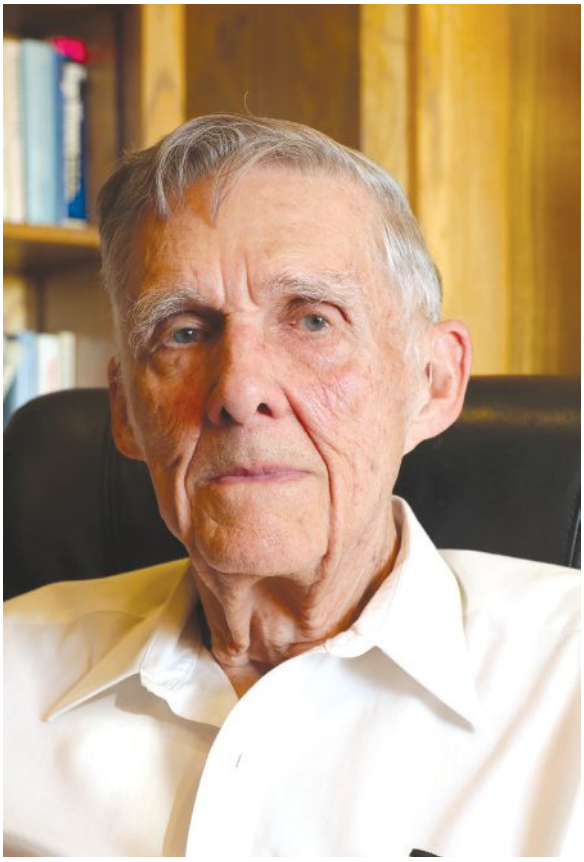
The American Academy of Family Physicians Degree of Fellow was established in 1971 is a special honor bestowed upon AAFP members who have distinguished themselves among their colleagues by their service to Family Medicine and their commitment to their professional development through medical education 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 in August 2020 at Embassy Suites. You must have completed the application and earned your Degree of Fellow by May 15, 2020 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 501-223-2272 or email us at arafp@sbcglobal.net.



Dr. Hiram Ward and Murfreesboro

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

Murfreesboro is located in Pike County, Arkansas in the southwest section of the state. The county is named after Zebulon Pike of Pike's Peak fame. The town was originally named Zebulon and changed in the 19th century to Murfreesboro after Murfreesboro, Tennessee. Part mountains and part river bottomland the county has features of both. An ancient volcano left in its wake an eruption of diamonds that represents one of the few places in the world where diamonds can be found in loose soil after a good rain. In addition to the diamonds, a broad swath of kaolin (pottery clay), gypsum (plaster stone) and cinnabar (mercury ore) stretches across the county. These compounds were mined extensively during the first half of the 20th century. The county was prone to flooding and, in the early 1950s, the Narrows Dam was completed on the Little Missouri River creating Lake Greeson. The lumber industry was a major source of jobs and revenue at the beginning of the 20th century but eventually that played out. Row crop cultivation in the county was prevalent during the first part of the century sustaining cotton gins and gristmills in all of the small communities in the county. In 1904, a 4,600-acre peach orchard in Highland, a few miles south of Murfreesboro produced 240,000 bushels of Elberta Peaches; the orchard business eventually died out.

As with many parts of Arkansas, Pike County began to lose farm-family population as early as the 1910s and continued to shrink until the 1970s. The town of Murfreesboro had a population of 200 at the turn of the 20th century, since 1950 it has varied between 1000 and 1700.

As for the medical profession, there are several names that stands out in the history of Murfreesboro. In 1841, the Reverend Madison Alford moved with his family from Alabama. Reverend Madison is said to have trained for medicine before the move but after moving to Arkansas he devoted his full attention to being the presiding elder of the Ouachita Conference of the Methodist Episcopal Church. His eldest son, William was born in 1835 and at age 21 entered the Confederate Army and was appointed the assistant surgeon for his unit. After the war he attended medical school at American College in St. Louis. Dr. William served as a physician in Pike County for the rest of his life.

His son, Thomas Alford was born in 1874 and, like his father, attended medical school in St. Louis and returned to practice in Murfreesboro. (His daughter Emily Ruth Darnall wrote a loving piece about her father entitled Steadying Hands of a County Doctor published in The Early History of Pike County)

Dr. Thomas Alford's son, Dale Alford, was born in 1916 and would go on to become an ophthalmologist in Little Rock. He would also serve as the Congressional Representative for two terms.

Dr. Hiram Ward was born, raised and has practiced medicine in Murfreesboro, Arkansas all of his life. He was born November 26th, 1925. His family were farmers and merchants. Both his mother and father were school teachers in Polk County. Hiram's father went off to Kansas City and took a course in automotive and tractor repair and soon after opened a repair shop on Main Street in Murfreesboro. Dr. Ward had one brother, five years his senior, who worked with their father in the repair shop most of his life.

Hiram's mother was chronically ill. He indicates that as early as five years old he realized that the doctors in the community didn't know what was wrong with her and weren't doing her right. At age five, he vowed to himself he would get an education, become a doctor and properly treat his mother. Many years later when he first set his practice, he set his mother up in a flower shop and she never was sick anymore. She simply didn't like housework she; lived to a ripe old 91.

With two school teachers as parents, education was an important. By 1942, Hiram had completed all of the courses offered in Murfreesboro except for Home Economics , he quit during his senior year and applied to Ouachita College in Arkadelphia. With the credit he had in hand he was admitted to classes immediately. This was during the middle of World War II and after a year and a half he was drafted. When he went for his induction physical in Little Rock, the officer noted that he was Pre-Med. Because of that he was assigned to a medical laboratory on Camp Robinson. He indicated he had never set foot in a medical laboratory prior to that day. Six months later the unit he was assigned to was moved to Fort Chaffy in Fort Smith. Despite the fact that there were several people assigned to the lab, he was the only one with any experience. At that point he was put in charge of the lab. Just as the war was ending, he was shipped off to Pusan, Korea and again was placed in charge of a hospital laboratory. He was discharged from the service in 1946, returned to Ouachita for an additional year and was notified by the medical school in little Rock that they would accept his credits and he could be admitted into medical school in the Fall of 1948.

He had always done well in academics but was concerned that medical school might be a different game all together. For the first six weeks he studied extremely hard and ended up with the highest grade in the class on his first biochemistry test. It was then that he was able to relax a bit. Throughout medical school he worked as a laboratory tech in the old Baptist Hospital on 12th street in Little Rock. Medical school turned out to be relatively easy for Dr. Ward and he especially enjoyed the clinical years with the exception of general surgery. He never had any intention of being a surgeon or a city doctor. There was never any question but that he would return to Murfreesboro and do general practice. He interned at Baptist Hospital in Little Rock and thoroughly enjoyed the experience.

He returned to Murfreesboro in the summer of 1953 and set up a solo practice. At the time Dr. Duncan, his physician when he was a child, and Dr. Thomas Alford, an elderly doctor, who only saw a few patients, were the only

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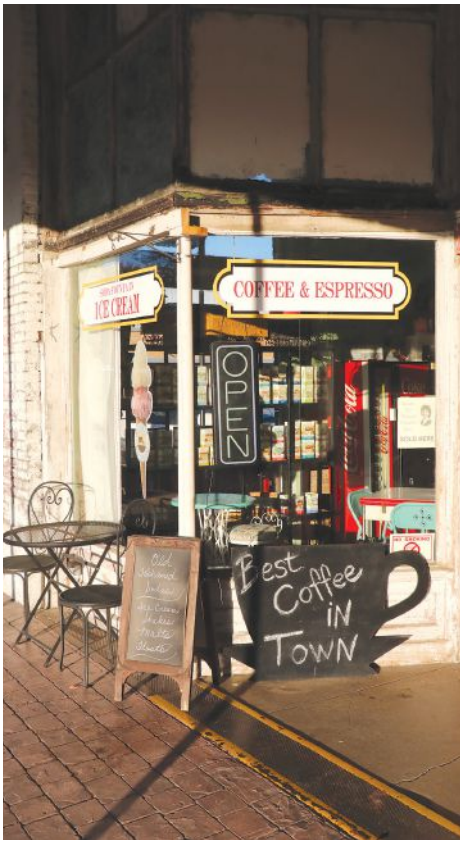
physicians in the county. Dr. Duncan died four months after Dr. Ward opened his door. This made Dr. Ward the only full-time physician for miles around.

Setting his office up, he purchased equipment from a doctor who had recently retired and the rest from Stover's Medical Supply in Little Rock. All-in-all he paid $1,390 dollars to get things up and going. He no debts from medical school but he was broke. He borrowed the money from a local bank. After six months he was able to purchase more equipment but from the very first was able to make ends meet. After a year or two he was joined by Dr. Granville Jasper Floyd, one of his classmates, in the practice of medicine. For the first twenty years of practice he did OB but never did any major surgery. For the first five years of practice he did his hospitalizations in Nashville, fifteen miles away. Often, he would make the drive to Nashville four to five times a day. In 1958 he and Dr. Floyd were instrumental in the building of a small Hill-Burton hospital in Murfreesboro which dramatically reduced the amount of time he spent driving back and forth to Nashville.



When asked about his charges in the first few years of practice he said: "At first my office call was $2.00 a visit. I tired keeping books and sending bills but found that it didn't even pay for the postage. I've never sent bills since that time. People pay if they can and if they can't they won't. I never did worry about it much."

Dr. Floyd died of heart disease in his early fifties and a few other physicians came and went over the years. In 2007, there were two physicians with St. Joseph Hospital out of Hot Springs who were affiliated with the hospital and they ceased hospitalizing or doing ER work at the local hospital. For a short period, it looked like the hospital would close. Dr. Ward told the hospital: "Don't shut anything down. I'll take call 24-7 until you can find somebody to help" And he did for three to four months.

In 2007, at age 81, Dr. Ward had a stroke with a partial left sided hemiplegia. When he asked about it, he is quick to state that he, "missed two whole day of work." He immediately instituted a rehab program that involved walking five miles a day most days of the week. In the last few years with the ultimate closing of the hospital he has cut back to the point that he only sees a few select patients and does not keep an office. The patients he sees are seen in his home.

When asked about his view of the future of medicine, Dr. Ward shakes his head. "It is going to be entirely different than anything I would recognize as the practice of medicine. From my view point, medicine is no longer a profession, it is a business and I don't approve at all. I think human life is more important than that."

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You won't want to miss another great CME opportunity with networking time to visit and share with your colleagues from across the state!

The Keynote AAFP speaker has been announced as Doctor John Cullen of Valdez, Alaska who served as the President of the AAFP from September 2018 until September, 2019 will be our special guest to provide the keynote address on Thursday, August 6 and to preside over the Fellowship Convocation and Installation of Officers on August 6 and August 7.

He has been actively involved in residency and medical student teaching for many years and is an Associate Clinical Professor at the Geisel School of Medicine at Dartmouth College. He previously served on the Alaska State Medical Board and on the National Advisory Committee on Rural Health and Human Services for the Centers for Medicare and Medicaid.

He has served on several AAFP commissions and committees before being elected to the AAFP Board and then as President. He earned his Bachelor of Science degree from the University of California, San Diego; earned his medical degree from the University of Arizona College of Medicine in Tucson and completed his residency at the Stanislaus Family Medicine Residency Program in Modesto, California, He is board certified by the American Board of Family Medicine.

Dr. Cullen is a Fellow of the AAFP, and has practiced the full scope of family medicine in a rural community of 4000 in Alaska for the past 25 years. He works in a small group practice and is director of emergency medical services at Providence Valdez Medical Center.

Other topics confirmed at this time are: Lupus; Influenza in High Risk Patients; Manipulation Techniques and Wound Care but we are just getting started! If you have a topic or speaker you would like to recommend, please contact this office at arafp@sbcglobal.net or Dr. Scott Dickson, chair of the Scientific Assembly Program!

From AAFP NEWS NOW:

Memo on White House Executive Order

On October 3, the White House issued an Executive Order (EO) on "Protecting and Improving Medicare for Our Nation's Seniors."

The EO, which was signed by the President at an event in Florida, is being positioned as the Republican alternative to "Medicare for All" and other plans proposed by Democrats and Presidential candidates. The EO opens with a clear explanation of why the Administration is pursuing the proposed changes in policy, stating:

> *"The proposed Medicare for All Act of 2019, as introduced in the Senate ("Medicare for All") would destroy our current Medicare program, which enables our Nation's seniors and other vulnerable Americans to receive affordable, high-quality care from providers of their choice. Rather than upend Medicare as we knowit, my Administration will protect and improve it."*

In 10 categories, the collection of proposed policies in the EO includes both recommendations that are supported and opposed by the AAFP. Those categories are:

1. Protect and improve the Medicare program by enhancing its fiscal sustainability through alternative payment methodologies that link payment to value, increase choice, and lower regulatory burdens imposed upon providers.
2. Providing More Plan Choices to Seniors
3. Improving Access Through Network Adequacy
4. Enabling Providers to Spend More Time with Patients
5. Encouraging Innovation for Patients
6. Rewarding Care Through Site Neutrality
7. Empowering Patients, Caregivers, and Health Providers
8. Eliminating Waste, Fraud, and Abuse to Protect Beneficiaries and Taxpayers
9. Maximizing Freedom for Medicare Patients and Providers
10. General Provisions

The EO directs the Department of Health and Human Services (HHS) to study, develop and propose policies that achieve the directives of the EO under two primary time frames – 180 days (March 2020) or one year (October 2020) from the date of the EO. **It is important to note that the proposed changes in policies included in the EO direct the Secretary of HHS to pursue certain actions via proposed changes in regulation. The provisions of the EO do not have the effect of law, they are proposals that will require full compliance with the rulemaking process.**

As noted, the EO contains policies that are both consistent with and in opposition to AAFP policies. We have expanded on those items in the next section of this memo. We have already initiated conversations with the Administration via the White House and HHS, and we will continue this engagement in the weeks and months ahead as we work to shape the policies in a manner that is beneficial to family medicine.

PROTECT AND IMPROVE THE MEDICARE PROGRAM BY ENHANCING ITS FISCAL SUSTAINABILITY THROUGH ALTERNATIVE PAYMENT METHODOLOGIES THAT LINK PAYMENT TO VALUE, INCREASE CHOICE, AND LOWER REGULATORY BURDENS IM POSED UPON PROVIDERS.

AAFP Policy: in general, the AAFP agrees. We continue to promote policies that would expand access to family medicine, reduce the administrative complexity of participating in the Medicare program and increase the programs investment in family medicine and primary care. We continue to advocate for more Advanced APM options must be available to primary care physicians to move the Medicare program towards value—especially for small and rural practices.

IMPROVING ACCESS THROUGH NETWORK ADEQUACY.

Within 1 year of the date of this order, the Secretary shall propose a regulation to provide beneficiaries with improved access to providers and plans by adjusting network adequacy requirements for MA plans to account for:

(a) the competitiveness of the health market in the States in which such plans operate, including whether those States maintain certificate-of-need laws or other anti-competitive restrictions on health access;and

(b) the enhanced access to health outcomes made possible through telehealth services or other innovative technologies.

AAFP Policy: The AAFP encourages HHS and policymakers to examine network adequacy as a factor in identifying core health services. Strong network adequacy standards promote the primary care medical home model as a way to deliver higher quality, lower costs, and a stronger patient-physician relationship. Primary care capacity should be the focal point of network adequacy. Additionally, when determining network adequacy, the ratios for primary care physicians to covered persons and for physicians to covered persons by specialty, should reflect physician FTEs, because physicians may practice part-time or in multiple locations. In addition, non-physician providers (i.e., nurse practitioners and physician assistants) should not be counted because listing these providers creates the illusion that there is more access to physicians.

The AAFP supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within

the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, longitudinal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care (for clarification, forwarding documentation by electronic means, including fax, is not acceptable for coordination of care with the primary care physician or medical home). As such, the treating physician within a telemedicine care encounter should bear the responsibility for follow-up with both the patient and the primary care physician or medical home regarding the telemedicine encounter.

ENABLING PROVIDERS TO SPEND MORE TIME WITH PATIENTS.

Within 1 year of the date of this order, the Secretary shall propose reforms to the Medicare program to enable providers to spend more time with patients by:

(a) proposing a regulation that would eliminate burdensome regulatory billing requirements, conditions of participation, supervision requirements, benefit definitions, and all other licensure requirements of the Medicare program that are more stringent than applicable Federal or State laws require and that limit professionals from practicing at the top of their profession;

(b) proposing a regulation that would ensure appropriate reimbursement by Medicare for time spent with patients by both primary and specialist health providers practicing in all types of health professions; and

(c) conducting a comprehensive review of regulatory policies that create disparities in reimbursement between physicians and non-physician practitioners and proposing a regulation that would, to the extent allowed by law, ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician's occupation.

AAFP Policy: Item (a) is vague and confusing. Its true intent is not clear and will require additional analysis to determine our position on this proposed policy. Item (b) is consistent with AAFP policy on Medicare payment. Item (c) is inconsistent with AAFP policy on coding and payment and we will be expressing our opposition to the Secretary in advance of the rulemaking process. The AAFP guidelines on the supervision of certified nurse midwives,

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nurse practitioners and physician assistants opposes the independent practice of non-physician providers and equity in payment for those who may have independent practice authority under state law.

ENCOURAGING INNOVATION FOR PATIENTS

Within 1 year of the date of this order, the Secretary shall propose regulatoryand sub-regulatory changes to the Medicare program to encourage innovation for patients by:

(a) streamlining the approval, coverage, and coding process so that innovative products are brought to market faster, and so that such products, including breakthrough medical devices and advances in telehealth services and similar technologies, are appropriately reimbursed and widely available, consistent with the principles of patient safety, market-based policies, and value for patients. This process shall include:

(b) adopting regulations and guidance that minimize and eliminate, as appropriate, the time and steps between approval by the Food and Drug Administration (FDA) and coverage decisions by the Centers for Medicare and Medicaid Services (CMS);

(c) clarifying the application of coverage standards, including the evidence standards CMS uses in applying its reasonable-and-necessary standard, the standards for deciding appeals of coverage decisions, and the prioritization and timeline for each National Coverage Determination process in light of changes made to local coverage determination processes; and identifying challengesto the use of parallel FDA and CMS reviewand proposing changes to address those challenges; and modifying the Value-Based Insurance Design payment model to remove any disincentives for MA plans to cover items and services that make use of new technologies that are not covered by FFS Medicare when those items and services can save money and improve the quality of care.

AAFP Policy: The AAFP does not have policy on bringing innovative products and services to market faster. The AAFP believes that physicians should receive payment for services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be a consideration, only whether the service is medically reasonable and necessary. The AAFP would oppose mandatory use and purchase of new technologies without appropriate reimbursement and payment for them.

REWARDING CARE THROUGH SITE NEUTRALITY

The Secretary shall ensure that Medicare payments and policies encourage competition and a diversity of sites for patients to access care.

AAFP Policy: The AAFP strongly supports this objective and will be working with the Secretary and Congress to achieve the enactment and enforcement of this recommendation.

EM POWERING PATIENTS, CAREGIVERS, AND HEALTH PROVIDERS

(a) Within 1 year of the date of this order, the Secretary shall propose a regulation that would provide seniors with better quality care and cost data, improving their ability to make decisions about their healthcare that work best for them and to hold providers and plans accountable.

(b) Within 1 year of the date of this order, the Secretary shall use Medicare claims data to give health providers additional information regarding practice patterns for services that may pose undue risks to patients, and to inform health providers about practice patterns that are outliers or that are outside recommended standards of care.

AAFP Policy: In general, the AAFP agrees with both objectives. The AAFP believes that transparency in health care refers to reporting information which can be easily verified for accuracy. Both data and process should have transparency and

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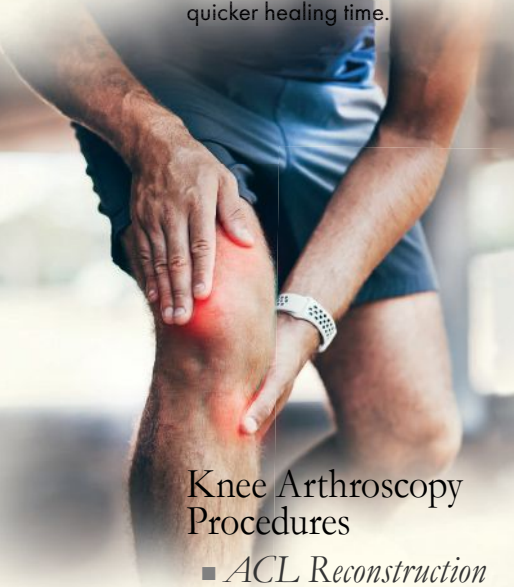
Arthroscopic Procedures for Knee Pain Relief

What is Arthroscopy?

Arthroscopy is a surgical procedure that involves tiny instruments inserted into small incisions. This minimally invasive surgery allows an orthopedic surgeon to view inside the joint with a tiny camera called an arthroscope. A second small incision allows the surgeon to perform procedures such as cutting and removing tissue. Because the incisions are much smaller than in traditional open surgery, there is far less damage to the soft tissues around the joint, resulting in less pain and a quicker healing time.



Knee Arthroscopy Procedures

■ *ACL Reconstruction & Repair*

In an arthroscopic ACL repair, the orthopedic surgeon reattaches the ligament to the bone. If the ligament has a slight tear, the surgeon can also sew it back together arthroscopically. When the ligament has torn in two, the ligament is removed completely and replaced with graft tissue.

The graft tissue—which typically comes from the patient's knee, their thigh, or from a donor—is secured to the ends of the femur and tibia. As the patient's body heals, the graft tissue will attach fully to the bone, effectively becoming their new ACL.

■ *Meniscus Repair & Removal*

The menisci, shock-absorbing cushions of cartilage that distribute weight across the knee, can become torn due to injury or degeneration. Minor tears in the meniscus can be repaired using tacks or sutures. For major tears, the surgeon will trim and remove the damaged tissue that cannot be healed in a procedure called a menisectomy.

■ *Lateral Release*

Some kneecap dislocations are caused by a tightening of the ligament in the knee that helps it move, resulting in the kneecap being pulled to the side of or even out of the groove it sits in on the end of the femur. A lateral release involves cutting through the overly tight ligament, allowing the kneecap to return to its groove.

■ *Microfracture*

Microfracture is a procedure that involves penetrating the outer layer of bone with tiny holes to expose marrow cells, which can stimulate cartilage growth. Because microfracture stimulates the growth of scar tissue cartilage (fibrocartilage) instead of the standard cushioning cartilage *(hyaline cartilage)* found in the knee, it is not recommended for patients with widespread arthritis.

Is Your Patient Living with Knee Pain?

Arthroscopy is just one of the many ways an orthopedic surgeon at Arkansas Surgical Hospital can help relieve your patient's knee pain. To learn more, call Arkansas Surgical Hospital at **(877) 918-7020.**

Dr. Jason Stewart
Orthopedic Surgeon
Arkansas Surgical Hospital

Dr. Jason Stewart specializes in minimally invasive surgery of the shoulder, knee, and hip, including arthroscopy and joint replacement procedures. He has been published in Clinical Orthopedics and Related Research for his work on minimizing blood loss during joint replacement surgery.

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an explicit disclosure of data limitations. Transparency in health care includes, but is not limited to, easy availability of:

- payers' payment policies
- payers' claims adjudication software logic edits
- payers' fee schedules
- payers' clinical policies
- payers' data analysis methodology and performance measures used in rating
- physician performance
- reporting of physician health care cost and quality information

Determining how this data will be presented, transmitted and used are important questions we will need to answer. Item (b) is a policy the AAFP has promoted for several years. It is our belief that access to quality and cost data at the primary care practice level will assist family physicians in managing their patient population and is central to being successful in value-based payment models.

ELIMINATING WASTE, FRAUD, AND ABUSE TO PROTECT BENEFICIARIES AND TAXPAYERS

(a) The Secretary shall propose regulatory or sub-regulatory changesto the Medicare program, to take effect by January 1, 2021, and shall propose such changes annually thereafter, to combat fraud, waste, and abuse in the Medicare program. The Secretary shall undertake all appropriate efforts to direct public and private resources toward detecting and preventing fraud, waste, and abuse, including through the use of the latest technologies such as artificial intelligence.

(b) The Secretary shall study and, within 180 days of the date of this order, recommend approaches to transition toward true market-based pricing in the FFS Medicare program. The Secretary shall submit the results of this study to the President through the Assistants to the President for Domestic and Economic Policy. Approaches studied shall include:

a. shared savings and competitive bidding in FFS Medicare;

b. use of MA-negotiated rates to set FFS Medicare rates; and

c. novel approaches to information development and sharing that may enable markets to lower cost and improve quality for FFS Medicare beneficiaries.

AAFP Policy: The AAFP supports strong and appropriate efforts to prevent fraud, waste and abuse. As HHS contemplates ways in which it may reduce fraud, waste, and abuse and improve program integrity, we would urge it to focus more on outcomes related to quality and cost and less on procedural safeguards. Such an approach would be more consistent with the guiding principle of choice and competition in the market based on quality, costs, and outcomes than the current approach of subjecting beneficiaries and physicians to increasingly stringent forms, coverage criteria, and documentation requirements.

REDUCING OBSTACLES TO IMPROVED PATIENT CARE

Within 1 year of the date of this order, the Secretary shall propose regulatorychanges to the Medicare program to reduce the burden on providers and eliminate regulations that create inefficiencies or otherwise undermine patient outcomes.

AAFP Policy: The AAFP strongly supports this objective and will be working closely with HHS and CMS to effectuate this proposal into actual policies that achieve a reduction in point-of-care administrative burden for family physicians. Reducing administrative complexity is a strategic priority for the AAFP. We will advocate policymakers closely consult and adhere to AAFP's principles for administrative simplification. Adherence to these principles will ensure that patients have timely access to treatment while reducing administrative burden on physicians.

MAXIMIZING FREEDOM FOR MEDICARE PATIENTS AND PROVIDERS

(a) Within 180 days of the date of this order, the Secretary, in coordination with the Commissioner of Social Security, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A, and propose other administrative improvements to Medicare enrollment processes for beneficiaries.

(b) Within 1 year of the date of this order, the Secretary shall identify and remove unnecessary barriers to private contracts that allow Medicare beneficiaries to obtain the care of their choice and facilitate the development of market-driven prices.

AAFP Policy: The AAFP does not have policy regarding Medicare beneficiary enrollment. The AAFP policy on access to comprehensive care supports the concept of access to essential health care to all peoples regardless of social and economic status. The AAFP supports efforts to identify appropriate funding of these essential medical services, and the AAFP continues to support its basic concepts and long-term goals of access to comprehensive and continuing medical care for all.

GENERAL PROVISIONS

(a) Nothing in this order shall be construed to impair or otherwise affect:

a. the authority granted by lawto an executive department or agency, or the head thereof; or

b. the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable lawand subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at lawor in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

AAFP Policy: The AAFP appreciates that the EO acknowledges the public rule-making process.

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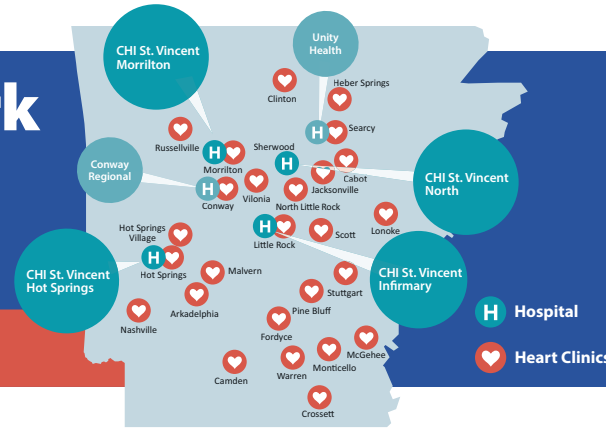

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- Varicose Veins

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Physicians Engaged in CPC+ Can Receive ABFM Performance Improvement Credit – Here's How!

According to the Centers for Medicare and Medicaid Services (CMS), Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States.

Are you a participant in this program? If so, you can claim American Board of Family Medicine (ABFM) Family Medicine Certification Performance Improvement credit for your involvement – providing you with 20 certification points for your current stage!

The ABFM recognizes the work you are currently doing and understands that your involvement in the CPC+ initiative is designed to improve the performance of your practice and strengthen primary care for our country. Therefore, there is an option within your physician portfolio to include your participation in CPC+ and receive credit.

To find this option, visit your ABFM Physician Portfolio, then:

- Access performance improvement activities
- View all PI activities
- Find "Comprehensive Primary Care Plus – Certification Performance Improvement Credit"
- View more information and select start

Once you hit start, the system will walk you through a simple attestation application process. You will then be guided through about 11 questions. Many of these questions have a drop down answer selection, while others ask for brief information regarding your participation in the program including a problem statement, how you chose to improve care, and simple baseline and outcomes data.

Overall, this is much simpler than other performance improvement activity steps in regards to data entry to the ABFM. As stated, it's because the ABFM recognizes the in-depth work you're doing as a participant in the CPC+ initiative – a win, win for all!

The ABFM can also help with any specific Family Medicine Certification questions. Please call the support center at 877.223.7437, email at help@theabfm.org, or utilize the live chat function on the website.

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You Can Prevent Suicide

Submitted by: Arkansas Foundation for Medical Care

By Ladeana Bell, MS, LPE-I and Molly M. Gathright, MD

One Arkansan dies by suicide every 14 hours, on average. Arkansas ranks 14th in the nation in suicide deaths with 621 lives lost to suicide in 2017, more than double the number of homicides.[1]

While more than half of all Americans will experience a mental health crisis during their lifetime, most go unrecognized and untreated.[2] Mental health crises increasingly include a suicide attempt or suicide death.

One study found that suicide victims are often likely to have visited their primary care physician (PCP) in the one month prior to their death.[3] Because patients often have a long-standing relationship with their PCP, PCPs are in an integral position to prevent suicides.

Some individuals may need more intensive mental health intervention. However, the reality is that primary care may be the only setting in which many patients receive health care. For a person at risk of suicide, a visit to the PCP may be the one chance to access care and save his life.

Physicians, especially in rural areas and underserved areas with limited access to mental health professionals, need to become more comfortable with being that one point of contact. This may seem daunting and is a definite shift from the traditional training of "refer for consult." The Suicide Prevention Resource Center provides a Toolkit for PCPs at www.sprc.org/settings/primary-care/toolkit.

Research has provided increasing knowledge about suicidal behavior, who is at risk for suicide and how to intervene. The key message for all practitioners is: suicide is preventable.

Integrating behavioral health care into an individual's overall wellness plan is a first step to suicide prevention. Be willing to ask the suicide question and work toward mental health "checkups" as part of wellness visits, like blood work and blood pressure. Providers should check for mental health changes in all patients, even those with no diagnosed mental illness.

Contrary to a once popular myth, asking about suicide does not plant the idea in a person's head. Interviews with suicide-attempt survivors indicate that being asked about suicide in a concerned manner often provides some relief.[4] In her suicide research, Ursula Whiteside, PhD, states, "Many described feeling that they weren't listened to or understood and this, in itself, was driving their suicidal thoughts."[4] Think of patients with chronic physical pain that is so poorly controlled or long-standing that it affects every area of their life. When the physician acknowledges this suffering, it does not make the pain subside, but it potentially creates an atmosphere of trust and opens an opportunity to begin a new treatment

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plan. Similarly, the person thinking of suicide needs to be acknowledged.

By utilizing the chronic disease model, suicide prevention can be treated in health care systems like we treat other chronic diseases. Risk is managed by providing interventions to decrease risk. For example, there are well-known risk factors for heart attack and having a subsequent heart attack. Applying this same model can create a suicide prevention framework. A framework can help reduce feelings of being overwhelmed at the prospect of taking a more pro-active role in patients' mental health care.

Patients with a history of mental illness or substance use disorder (SUD) should be on your radar to assess increased risk factors. On the other hand, there are patients in acute distress with no history of mental illness or SUD. A PCP visit may reveal a recent significant life stressor that subsequently triggers a mental health screening or conversation with the patient.

Risk status can include being middle age; a history of bipolar disorder, major depression, SUD, previous suicide attempts or traumatic brain injury; and serious physical health conditions including pain. These risk factors cannot be changed but provide a general guideline to use regarding who may be at risk.

How much a person's risk level increases at any point is referred to as "risk state." If a patient's life drastically changes due to recent changes in marital status, job loss, grief or situational stressors, the risk state increases. If a patient already has an undiagnosed, underlying, low-level depression or anxiety disorder, a life stressor can complicate his emotional health and the risk state can rapidly change. Assessing mental health as part of every visit can potentially lead to detection of mental health issues and better patient outcomes.

Every person with suicidal thoughts does not require psychiatric hospitalization, but action is indicated. Action can include, but is not limited to, securing a safety plan and means reduction for each care setting (i.e., arrange and confirm removal or reduction of lethal means). The safety plan should include the National Suicide Prevention Lifeline number (1-800-273-8255) and the crisis text line (741741 text TALK). Additional protective factors include follow-up phone calls to check on at-risk patients, verifying and encouraging follow-up appointments with a mental health provider, and collaborating with patient's family and friends (as patient allows and including a release of information) to discuss the safety plan.[5]

Suicide prevention is everyone's business. All physicians can be integral in this public health challenge by thinking of the three As: awareness, assessment and action.[6] As practitioners become more aware of the problem and are better equipped to assess it, they are poised to take lifesaving actions.

Ms. Bell is an outreach specialist with AFMC. Dr. Gathright is associate professor, psychiatry, and director, faculty wellness at UAMS.

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Suicide Symptoms

Talking about these things can signal suicidal thoughts:

- Killing themselves
- Feeling hopeless
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Behaviors can signal risk, especially if related to a painful event, loss or change:

- Increased use of alcohol or drugs
- Looking for suicide methods; searching online
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression
- Fatigue

Mood changes include:

- Depression
- Anxiety
- Loss of interest
- Irritability
- Humiliation or shame
- Agitation or anger
- Relief or sudden improvement in mood

Source: www.samhsa.gov/suicide-prevention

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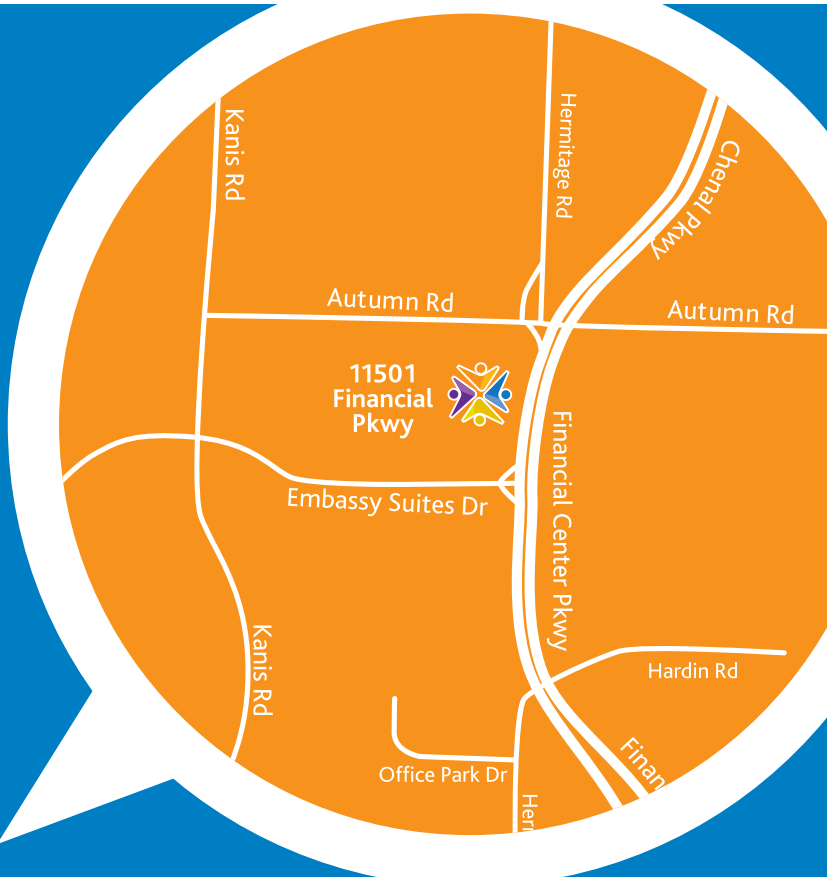

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Pinnacle Pointe Behavioral Healthcare System is located in Little Rock and is one of Arkansas' largest behavioral inpatient facilities that offer acute and residential services for children and adolescents ages 5-17 who are struggling with emotional or behavioral health issues. The caring professionals at Pinnacle Pointe Behavioral Healthcare System help patients return to their community as healthier individuals.

OUR MISSION:

To Hope...To Heal...
To Laugh...To Live!!!

www.PinnaclePointeHospital.com

Join Your Colleagues and Be Part of the ABFM Engagement Network!

ABFM engagement

ABFM is searching for board-certified family physicians to become members of a virtual network to provide general and issue-specific feedback that will help us continually improve the certification process. We seek interested Diplomates who are willing to provide feedback, perspective and fresh ideas about a variety of issues, including changes being considered to improve and evolve certification

activities; optimization of the new ABFM website; redesign of the Physician Portfolio; development of independent assessment items; opportunities for certification to support broad-scope, comprehensive practice; and consideration of new areas of focused practice designation.

Involvement in the ABFM Engagement Network will involve periodically answering brief questions and short surveys that will provide us with valuable crowd-sourcing information to guide our work on evolving Family Medicine Certification. Other benefits of participating include:

- Influence aspects of ABFM's five-year strategic plan and provide information that can be used to inform Board of Director discussions and decisions
- Periodic invitations to attend optional, in-person feedback events such as regional or national focus groups
- Recognition opportunities through physician spotlight articles in ABFM's Phoenix newsletter, on social media, or in state chapter publications, etc.

Volunteer Today:
www.theabfm.org/volunteer

QR Code

We are interested in building an Engagement Network that includes physicians with diverse practice experiences, reflective of today's trends in practice. We are excited to work with you and learn about new ways to improve the certification process for you and your colleagues!

THE ARKANSAS DEPARTMENT OF HEALTH IS OFFERING NEW, ENHANCED TOBACCO CESSATION SERVICES:

be well

How Does Be Well Help Arkansans?

- Counseling and resources for quitting tobacco and nicotine products
- 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.

ARKANSAS DEPARTMENT OF HEALTH

Your Tobacco Settlement Dollars at Work

833-283-WELL
bewellarkansas.org

be well

HEALTHY ACTIVE ARKANSAS

Arkansas Academy of Family Physicians
P. O. Box 242404
Little Rock, Arkansas 72223-9998