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FAMILY DOCTOR
An Official Publication of the Louisiana Academy of Family Physicians
Winter 2018
Louisiana's Delegation
Representing You
at Congress of Delegates in New Orleans
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A Message from the President

Christopher Foret, MD
LAFP President

LAFP Members:

Welcome to the winter! Hopefully, we will now get a break from summer temperatures and humidity.

October was a busy month for the LAFP. With FMX being in NOLA for the first time in this decade, your staff was in host mode. A social at the Chicory provided a wonderful opportunity to network with members from both the LAFP and the MAFP. Additionally, Dr. Michael Madden was honored for his years of distinguished service as a teacher of Family Medicine. Well done Dr. Madden! Additionally, Dr. Wayne Gravois presented a resolution for consideration and Drs. Jim Campbell, Brian and Cissy Picou represented us well as delegates and alternates.

The fall brought football season and the LAFP tailgate for the LSU vs. Rice game. A good time was had by all and many thanks to our sponsor Carpenter Health Network.

The membership committee met in October via teleconference. Dr. Alan LeBato informed us of regional statistics of state membership. Approximately 25% of all family physicians in Louisiana are not members of the LAFP. In this area, we need your help. If you know someone who is not a member, please ask them to join. If there is a negative response, please notify the LAFP staff as to the reasons. We would like that input to better reach that group of physicians. Our impact and influence grows with increasing our numbers!

A new year brings a new legislative session. Please make contact with your legislators now. A connection now could benefit our Academy later when legislative action is being undertaken at the capitol. In addition to a personal connection, a donation to LAFAMPAC enables us to help further influence change through participation in the process.

With no physicians currently in the legislature, these are the only way we can affect progress towards our motto: Stronger Medicine for Louisiana!

Finally, any time is a good time for philanthropy! Your LAFP Foundation is working hard to keep young family physicians in Louisiana! Please consider this organization for a charitable donation.

Lastly, as always, save the date for the LAFP Annual Assembly & Exhibition! August 1-4, 2019 at the Roosevelt Hotel in New Orleans, LA.

Have a great winter,

Christopher Foret, MD
LAFP President

A Message from the Secretary

Mary Thoesen Coleman, MD, PhD
LAFP Secretary

Dear Colleagues,

It is not that often that Louisiana is the location for our national Family Medicine meeting but this year, FMX took place in New Orleans October 9th through the 13th and offered us many opportunities. One of the benefits was attendance by many of our FM residents from nearly all of our residency programs, presenting case studies and other scholarly works through a vast array of posters. Events also included our own LAFP Welcome Social at The Chicory Tuesday night. Here are some of the educational highlights that I enjoyed:

Diabetes:

Continuous blood glucose monitoring using simple skin application is here; insurance reasonably covers its cost. I was fortunate to hear Dr. William Gibson, Jr. from Shreveport who demonstrated how he is using continuous blood glucose monitoring with his patients. He finds the graphics allow him to understand how to adjust medications and work with patient's diet to improve his patient's A1c levels dramatically. Physicians are able to bill for the sensors and interpretation.

Dementia:

The AAFP website has a **Cognitive Care kit** used to identify, treat and support patients with cognitive impairment. Tools such as the Mini-Cog and the Geriatric Depression Screen are easily downloadable. Also available is a clinical dementia rating based on memory, orientation, judgment and problem solving, community affairs, home and hobbies, and personal care. A table summarizing and comparing current medications as well as driving contract can be found online.

Obesity:

Dr. Leonard Finn elaborated on how mindfulness is one strategy to help obese patients choose and sustain healthy diet, activity, exercise, and sleep. He discussed studies that showed how mindfulness interventions for obesity-related eating disorders respond to mindfulness training with decreased binge eating, emotional eating and eating in response to external cues.

Osteoporosis:

A physical therapist, citing the LIFTMOR RCT study, reported evidence that suggests exercise alone may be able to manage osteoporosis. Large multi-joint compound exercises such as the squat and deadlift that are conducted in weight-bearing positions and involve extensive muscle recruitment have the potential to apply large loads at clinically relevant bone sites such as the spine and hip. The study demonstrated that eight months of twice-weekly 30 minute supervised high intensity resistance and impact training enhanced bone strength and functional performance in postmenopausal women with low bone mass.

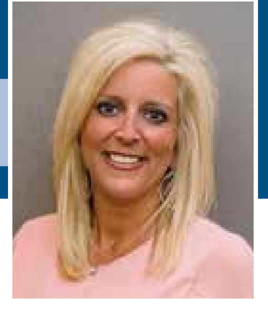
HIV Prophylaxis:

We only need to treat 13 individuals with daily Tenovir disoproxil fumarate/ emtricitabine (Truvada) to prevent 1 HIV infection in males having sex with men.

As you are all aware, keeping up with medicine is always a challenge. Attendance at our local LAFP and national AAFP events makes the task both easier and enjoyable.

Sincerely,

Mary Coleman, MD, PhD
LAFP Secretary



Ragan LeBlanc
LAFP Executive Vice President

Final Rule On The 2019 Medicare Physician Fee Schedule Delays Major Changes To E/M Documentation

AAFP, LAFP and the rest of organized medicine scored a win last month as the Centers for Medicare and Medicaid Services decided not to go forward with a proposed restructuring of its E/M documentation guidelines. That change would have collapsed payment rates for eight office visit services for new and established patients down to two each, a change physician organizations opposed vigorously during the comment period.

The Centers for Medicare and Medicaid Services (CMS) released its much-anticipated final rule on the 2019 Physician Fee Schedule, which includes some simplifications to evaluation and management (E/M) documentation but delays other major changes. The calendar year (CY) 2019 PFS final rule is one of several final rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation. The provisions in the rule build on the foundation established in the first two years of the program and are reflective of the feedback we received from LAFP members and the Board of Directors.

The AAFP prepared a summary of the 2019 final Medicare physician fee schedule to help family physicians digest the portions of the rule that will most affect their practices in the coming year and beyond. The summary also points out important wins where AAFP guidance on key issues averted questionable CMS proposals that would not have benefitted physicians or their patients. The final rule was filed for public inspection on Nov. 1 and should have been published in *Federal Register* on Nov. 23.

For family physicians who need to get on with treating patients today, here is a rundown of topics covered in the summary.

Perhaps the most contentious item in the proposed 2019 fee schedule was the introduction of CMS' controversial blended payment rate for evaluation and management (E/M) visit levels two, three and four. Importantly, CMS delayed for two years, until Jan. 1, 2021, the implementation date for the collapse of those middle E/M code levels. Physicians likely remember that levels one and five were left untouched.

Two-year implementation delays were finalized in other areas, as well, with CMS vowing to consider further suggestions provided by stakeholders -- including the

Continued on page 8

E&M Payment Amounts

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	*Visit Code Alone**	*Visit Code Alone Payment*	*Visit Code With Either Primary or specialized care add-on code***	*Visit Code with New Extended Services Code (Minutes Required to Bill)*	*Visit with Both Add-on and Extended Services Code Added***	*Current Prolonged Code Added (Minutes Required to Bill)**
New Patient	Level 2	$76					
	Level 3	$110	$130	$143	$197 (at 38 minutes)	$210	
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45					
	Level 3	$74	$90	$103	$157 (at 34 minutes)	$170	
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.
Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.
**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.
***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

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AAFP, the AMA and the CPT Editorial Panel -- in that expanded time period.

Importantly, the final rule omits two parts of the proposed rule that the AAFP objected to: add-on codes for primary care and a multiple-procedure payment reduction that would have reduced by half payment for office visits that occur on the same date as a procedure or other services.

2019 Medicare Conversion Factor

Payment is made under the PFS for services furnished by physicians and other practitioners in all sites of service. These services include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.

In addition to physicians, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician assistants, and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a dollar multiplier known as the “conversion factor.” The final 2019 MPFS conversion factor is $36.0391, a slight increase above the 2018 MPFS conversion factor of $35.9996.

Changes Coming in 2019

Beginning Jan. 1, 2019, Medicare will allow ancillary staff to perform and record the chief complaint and history of present illness. As the E/M documentation guidelines are currently understood and interpreted, these two elements of documentation must be personally documented by the performing provider – even if they are already recorded by another member of the care team.

Glossary

New Primary Care Complexity Code:
Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Non-procedural Specialty Care Complexity Code:
Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Extended Visit Code:
Extended time for evaluation and management service(s) in the office or other outpatient setting, when the visit requires direct patient contact of 34-69 total face-to-face minutes overall for an existing patient or 38-89 minutes for a new patient (List separately in addition to code for level 2 through 4 office or other outpatient Evaluation and Management service)

Existing Prolonged Services Code:
Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)

Medicare recognizes this requirement no longer reflects most providers’ workflow and represents an unnecessary redundancy in documentation.

Additionally, for established patient office/outpatient visits, when the medical record already contains relevant information, Medicare will allow physicians to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and not re-record the defined list of required elements. Physicians will still need to review prior data, update it as necessary, and indicate in the medical record that they have done so.

Major Changes Delayed to 2021

The proposed rule contained provisions concerning to many primary care physicians, including a single blended payment rate for office visit levels two through five for both new and established patient visits. The proposed blended payment rate was between the current rate for a level three and level four visit. Despite the ability to add on a $5 primary care payment for the majority of services to Medicare patients, family physicians and others were concerned their payments would be substantially affected and expressed frustration with the differential between the primary care add-on code and the $17 payment bump offered for specialist visits.

The final rule addresses some of these concerns. Although Medicare still intends to pursue a blended payment rate, it will apply only to levels two through four, leaving level-five office visits as an option for the most complex patients. And, recognizing the drastic change this represents, Medicare is delaying the effective date of the blended payment rate until Jan. 1, 2021. Notably, Medicare recognized the frustration with the proposed differential payment for primary care and specialty care add-on codes that may be reported in conjunction with this blended payment and, in the final rule, stated both services would be valued the same. Once the blended payment concept is applied to level-two through level-four office visits, the add-on code for inherent complexity for a primary care service can be reported in conjunction with the level of E/M service. Medicare notes it expects that certain specialties, like family medicine and internal medicine, would include this add-on code on nearly every visit.

Documentation requirements will be relaxed in several ways once the new blended payment takes effect in 2021. First, providers will still be able to report any level of service for office visits. When reporting a level-two through level-four code, providers will only have to document the medical necessity of the service to justify the visit and to satisfy the requirements of a level-two

service. This should help providers focus on clinical information that is relevant to the care of the patient, instead of worrying about whether they satisfied the complex documentation requirements of a code, particularly for level-four visits. Providers will be able to meet these criteria by using the existing rules under 1995 or 1997 E/M guidelines. Alternatively, providers will be able to code visits based solely on the medical decision making component of the E/M service, regardless of whether criteria for history or examination are met. Finally, providers will be able to select a level of service based on time. However, unlike current requirements that mandate greater than 50 percent of the visit be spent in counseling or coordination of care to use time as the controlling factor, providers will simply need to document that they personally spent the time described by each level of service face-to-face with the patient.

Evaluation and Management (E/M) Documentation Guidelines Relief

In the 2019 final rule, per AAFP advocacy and effective on January 1, 2019, CMS has finalized several favorable changes to E/M documentation guideline.

- The requirement to document medical necessity of furnishing visits in the home rather than office will be eliminated.
- Physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
- Physicians must only document that they reviewed and verified information regarding chief complaint and history that is already recorded by ancillary staff or the patient.
- CMS removed potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

Add-on codes

In conjunction with its proposal to implement a single payment rate for level 2 through level 5 office office/outpatient visits, CMS had proposed an add-on code to each office visit performed for primary care purposes and an add-on code for specialties with inherently complex E/M visits. The AAFP called on CMS to eliminate the proposed primary care add-on code and replace it with a 15 percent increase in payment for E/M services, provided by physicians who list their primary practice designation as family medicine, internal medicine, pediatrics, or geriatrics. In the final rule, CMS discussed opposition to the original proposal and did not finalize either add-on code proposal for 2019.

Multiple Procedure Payment Reduction

CMS proposed a Multiple Procedure Payment Reduction (MPPR) policy that would potentially reduce payment by 50 percent for office visits that occur on the same date as procedures or other services. The AAFP opposed application of this policy to primary care practices whose designation is family medicine, internal medicine, pediatrics, or geriatrics. The AAFP expressed opposition to such a policy or any other policy that seeks the reduction of payment for services provided to patients in connection to E/M services. We believe that the valuation of such services, as established through the Relative Value Scale Update Committee process, already accurately accounts for any efficiencies that may exist, and further reductions are not justified. Per AAFP advocacy, CMS did not finalize the proposed MPPR policy.

Site-neutral payment policies

The AAFP supported the CMS proposal to further align payment policies for physicians in independent practice with those whose practices are owned by hospitals. CMS finalized their proposal to maintain the MPFS Relativity Adjuster at 40 percent for 2019, meaning non-excepted items and services are paid at 40 percent of the amount that would have been paid for those services under the outpatient prospective payment system.

Communication Technology-Based Services

The AAFP supported, and CMS its proposal to pay separately for two newly defined physician services furnished using communication technology:

- Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012, approximately $14.78) and
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010, approximately $12.61).

CMS also finalized policies to pay separately for new coding describing chronic care remote physiologic monitoring (CPT codes 99453 ($19.46), 99454 ($64.15), and 99457 ($51.54)) and interprofessional internet consultation (CPT codes 99451 ($37.48), 99452 ($37.48), 99446 ($18.38), 99447 ($36.40), 99448 ($54.78), and 99449 ($72.80)).

CMS is also removing the originating site geographic requirements and adding the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

For 2019, CMS will add HCPCS codes G0513 and G0514 (Prolonged preventive service(s) (both approximately $65.95)) to its list of telehealth services.

Finally, for 2019, CMS finalized payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit.

Continued on page 10

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Quality Payment Program (Year 3)

Updates for the 2019 QPP performance year and provisions for small practices include:

- Expanding the definition of low-volume threshold to include those who have allowed charges for covered professional services ≤ $90,000; those who provide covered professional services to 200 or fewer Part B-enrolled individuals; or those who provide 200 or fewer covered professional services to Part B-enrolled individuals.
- As supported by the AAFP, giving eligible clinicians who meet or exceed one or two elements of the low-volume threshold the choice to participate in MIPS (referred to as the opt-in policy.)
- Decreasing the quality performance category to 45 percent and increasing the cost performance category to 15 percent.
- Increasing the performance threshold to earn a neutral or positive payment adjustment to 30 points and the exceptional performance threshold to 75 points.
- Requiring the use of 2015 Edition CEHRT. The AAFP opposed the mandate to adopt 2015 Edition CEHRT and suggested CMS create scoring incentives to encourage practices to upgrade.
- Maintaining the 8 percent revenue-based nominal risk standard until performance year 2024, which the AAFP supported.
- Increasing the small practice bonus to 6 points, but including it in the Quality performance category score of clinicians in small practices instead of as a standalone bonus.
- Continuing to award small practices 3 points for submitted quality measures that don't meet the data completeness requirements.
- Allowing small practices to submit quality data for covered professional services through the Medicare Part B claims submission type for the Quality performance category.
- Providing an application-based reweighting option for the Promoting Interoperability performance category for clinicians in small practices.
- Continuing to provide small practices the option to participate in MIPS as a virtual group.
- Offering no-cost, customized support to small and rural practices through the Small, Underserved, and Rural Support (SURS) technical assistance initiative.

Limitations of the Final Rule

While the goal of the final rule is to reduce physicians' documentation burden, in the short-term, providers should realize its limitations. First, most of the finalized rules will not take effect until 2021. Second, they will only apply to Medicare. Unless commercial payers adopt similar guidelines, providers may have different rules for different payers for a period of time. However, when Medicare eliminated payment for consultation codes nearly a decade ago, many commercial payers quickly followed suit. Finally, the rules only apply to office visit codes at this time. Providers using codes from various categories of E/M services like hospital care codes should recognize the current documentation requirements will still apply for the time being.

CMS notes that, *"the 2-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders. We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes."*

The AAFP will continue its in-depth review of the massive document and will provide, on behalf of members, further comment on certain sections as requested by CMS ahead of the Dec. 31 deadline. Please continue to monitor the LAFP website and look for updates in the Weekly Family Medicine Update. If you have any questions in the meantime, please contact the LAFP office at info@lafp.org or 225.923.3313.

Sincerely,

Ragan LeBlanc
Executive Vice President

AAFP Physician Health First is the first-ever comprehensive initiative devoted to improving the well-being and professional satisfaction of family physicians, and reversing the trend toward physician burnout.

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Supported in part by a grant from the American Academy of Family Physicians Foundation.

Metformin Associated Lactic Acidosis (MaLA): A Case Presentation

Marco Chavez, MD; Jessica Miller, MD; Joseph Oschwald, MD; Jaime Lovitt, MD; Janice Hudson, MD; Muhammed Usman, MD; Samera Majeed MD; Peter Lin, MD; Andrew Morris MD; Erwin Aguilar, PharmD, MSc, MPH1, 2

Department of Family Medicine1, Department of Medicine, Section of Nephrology and Hypertension2 LSU Health Sciences Center in New Orleans, New Orleans, LA, United States

Background: Diabetes is a common condition affecting millions of Americans each year. Many treatment modalities exist for treatment of diabetes. Metformin is a commonly prescribed first line medication for treatment of diabetes. Although a relatively safe medication, it is associated with a number of adverse reactions which may be life threatening. Lactic acidosis is one such reaction which has been associated with this drug.

Methods: A 68-year-old African American female with history of hypertension and Type 2 DM who presents with complaint of low blood sugar. EMS was called and blood sugar was found to be 16 mg/dL. Pt has a history of T2DM treated with Glargine insulin and Metformin as prescribed by her primary care physician. Patient endorses compliance with Metformin but family endorses she occasionally will miss taking her insulin. Pt endorses 1 week history of decreased appetite and fatigue secondary to the loss of a loved one. She does specifically endorse taking her Metformin though she has not been eating well.

Results: The patient presented with presumed acute kidney injury with Cr of 7.4 mg/dL and BUN of 64 and no previous history of kidney disease as reported by the patient and confirmed by prior normal kidney function labs. Patient also had a bicarbonate level of 9 mg/L on presentation and was thus started on D5 ½ NS with bicarbonate maintenance fluids in the ED after 1 L bolus performed by the ED physician. It was also noted that the patient had a LA of >12 on presentation which was concerning for MALA. With IVF the patients' UOP was at 900cc on first full hospital day but by the second day urinary output (UOP) was at 2 liters and averaged around this amount for the remainder of the hospitalization. The patient's Cr took a few days to trend down, but on 5th day had started improving to 6.8 mg/dL and on discharge was down to 4.0 mg/dL. The patient never required dialysis and improved with fluids alone. 2 week clinic follow-up had improved Cr to 2.5 mg/dL and patient returned to Texas for follow-up with her PCP and further management of her diabetes and renal disease.

Conclusion: This case helps to illustrate the relationship between Metformin and lactic acidosis and the importance of counseling patients on reducing or stopping medication when they are ill or have decreased intake. Although Metformin is shown to increase risk of lactic acidosis, patients with MALA typically have preexisting conditions, which may further increase their risk of lactic acidosis. These conditions may include renal failure, cardiovascular event, pulmonary failure, hepatic failure, sepsis or alcohol use.

References

Tahrani, A. A., Varughese, G. I., Scarpello, J. H., & Hanna, F. W. F. (2007). Metformin, heart failure, and lactic acidosis: is metformin absolutely contraindicated? BMJ : British Medical Journal, 335(7618), 508–512. http://doi.org/10.1136/bmj.39255.669444.AE

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The Buzz on Malaria

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Alexandria Family Medicine Residency Program

Case Report

History of Present Illness:
Patient is a 29 y.o. caucasian male presented with dizziness, abdominal pain, & LUQ cramping. Also had fevers, headaches, body aches, nausea without vomiting, & watery diarrhea (non bloody) for the past three days. He had traveled to Equatorial Guinea (Africa) for work less than one month ago. Took Doxycycline prophylaxis for two weeks before travel, two weeks during travel, but failed to take it for two weeks following return to the United States. Patient denies chest pain, SOB, palpitations, vision changes, seizure activity, focal weakness, coughing, or sore throat. Did eat & drink food locally in Africa. Denies any sick contacts.

Past Medical History:
GERD, Seasonal Allergies, for which he takes Zantac, Nexium, and Zyrtec respectively. Reports allergies to macrolides, & anaphylaxis to penicillin. Reports up to date on immunizations. Surgical hx: Tonsillectomy, Adenoidectomy. No significant family hx. Denies ETOH, Illicit drug use. Current smoker, ½ pack per day, x 11 years.

Physical Examination:
A&O x 4. Diaphoretic. EOMI, PERRL, Sclera normal. No lymphadenopathy. No meningismus. S1 S2 present, Decreased capillary refill, tachycardia. Lung exam WNL. Abdomen soft, LUQ tenderness. Moves all extremities. No focal weakness.

Laboratory:
WBC 2.6 with 42% bands, H/H 14.7/42.7, Platelets 42, BUN/Cr 17/1.15
Peripheral Smear: Ring Forms and Blast Forms of Malarial parasite
Total Bilirubin 1.8, Direct 1.5. AST 133, ALT 177. Alkaline Phosphatase 151, LDH 451

Assessment

Patient presented with fevers, chills, dizziness, and myalgias. Patient recently traveled to a malaria endemic country and did not take his malaria prophylaxis upon returning to the United States. Onset of symptoms was 2-3 weeks after returning to the country, which is consistent with reactivation of latent malaria. Given the symptoms of diarrhea, as well as travel to a country where typhoid is prevalent, will need to cover for typhoid fever as well.

Treatment

Initial testing for hepatitis viruses as well as HIV was performed. Patient was treated with a three day course of Malarone (Atovaquone/Proguanil) 1000 mg/400 mg. Also treated with Ciprofloxacin x 7 days empirically, to cover for possible concomitant typhoid. Remainder of treatment was supportive, including IV fluids (D5), antipyretics, electrolyte replenishment, close monitoring in ICU, etc.

Characteristic Features of Patient

Typical physical findings in this patient were limited to diaphoresis, and splenomegaly. Despite thrombocytopenia, patient did not have any rash or petechiae. Taken together with the travel history to an endemic area, failure to continue prophylaxis after returning, and onset of symptoms (within 7-30 days after return), features were highly suggestive of malarial infection. The identification of the parasite in peripheral smears confirmed the diagnosis. Smears were monitored and as patient completed the course of Malarone, parasitemia in the patient's blood smears also resolved.

Typical Physical Findings

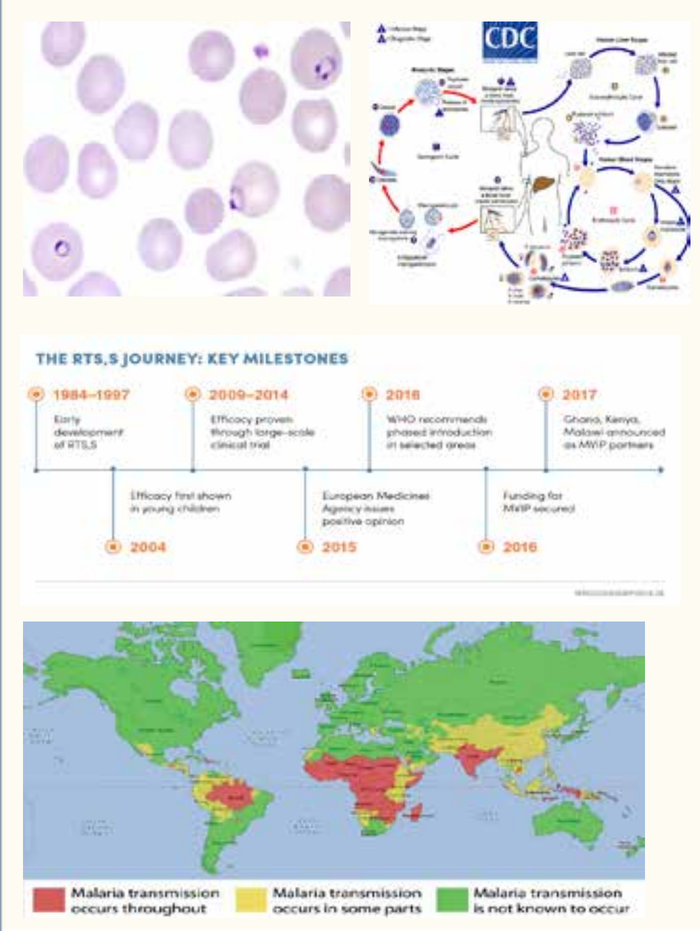
Physical exam findings tend to be non-specific such as fever, chills and myalgias. Severe cases may show hepatomegaly and/or splenomegaly, petechiae due to thrombocytopenia, jaundice due to rapid hemolysis. Altered mental status may indicate cerebral malaria or severe infection. Virtually any organ system can be affected and go into failure.

Common Laboratory Abnormalities

- Presence of the Plasmodium Parasite in Blood Smears, PCR for Speciation
- Thrombocytopenia, Normocytic Anemia, possible DIC
- Metabolic Acidosis, Hypoglycemia, Renal Impairment

Characteristics

- Malarone has two components, atovaquone and proguanil hydrochloride, and it can be used for both the prophylaxis and treatment of malaria. It interferes with 2 different pathways involved in nucleic acid replication
- . Atovaquone is a selective inhibitor of Plasmodia species' mitochondrial electron transport, ,and therefore ATP & pyrimidine biosynthesis.
- Proguanil is a slow-acting blood schizonticidal agent. It suppresses intraerythrocytic schizogony and has no effect on exoerythrocytic (intrahepatic) forms. The activity of proguanil is due to its active metabolite cycloguanil. Cycloguanil selectively inhibits the dihydrofolate reductase/thymidalate synthase of plasmodia.
- Proguanil does not kill gametocytes, but it does impair their development, making them non infective to the mosquito.



Summary

A 29 year old male with a history of GERD, admitted to the hospital with fevers and sepsis. He had traveled to equatorial Guinea for his job working on turbines. He took malaria prophylaxis prior to and during the trip, but not after returning. He was admitted to the hospital with fevers, chills, and abdominal pains. Found to have thrombocytopenia and leukopenia. Was diagnosed with malaria, which was confirmed with peripheral blood smear showing the parasite (seen above).

Per recommendations from Infectious Disease, patient was given 3 days of Malarone therapy. Blood smears showed improvement and eventual clearing of the parasite from the blood. Platelets and WBC improved markedly, LDH normalized. PCR for speciation identified species as Plasmodium Falciparum, so patient did not require additional Primaquine therapy on discharge. Given a seven day course of ciprofloxacin to treat for possible concomitant typhoidal infection. Patient was advised of splenomegaly precautions and discharged home.

It is important to advise people traveling to at risk areas about proper precautions, both environmental (netting, repellent, etc) and pharmacologic. Make sure your patients understand that therapy must continue for two weeks after returning home, to prevent latent malaria from becoming active, de to release of the parasites from the liver.

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Bigeminy Crickets!!!
Management of Asymptomatic Bigeminy In a Pediatric Patient

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Family Medicine Residency – Shreveport

Case report

A 10 year-old WF with no significant PMH presented to the ED with complaint of several day history of severe sore throat and malaise. Patient denied sinus congestion, sneezing, rhinorrhea, chest congestion, or cough. ROS was otherwise unremarkable. On physical exam she was found to have enlarged tonsils and an erythematous posterior oropharynx. Her heart was noted to have a regularly irregular rhythm, with a noted double beat followed by a pause, then another double beat. There were no murmurs rubs or gallops. Her lungs were clear to auscultation bilaterally, no wheezes rales or rhonchi. The rest of the physical exam was within normal limits.

Assessment

Rapid Strep A test- positive
CBC, CMP unremarkable
EKG (Figure 1)
Placed in observation
Telemetry monitoring per inpatient protocol

Pediatric Cardiology Referral
- 24-hour Holter Monitor Report (Figure 2)
- Echocardiogram: Normal Anatomy. Frequent Ectopy noted throughout study.

Figures

Figure 1: EKG of patient

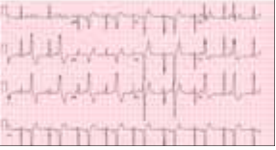
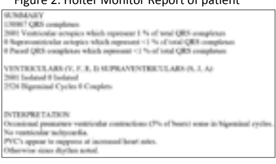


Figure 2: Holter Monitor Report of patient



SUMMARY

INTERPRETATION
No ventricular tachycardia.
PVC's appear to suppress at increased heart rates.
Otherwise sinus rhythm noted.

Figure 3: Example of Sinus Arrhythmia [5]

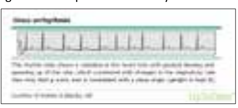


Figure 4: Example of PVC [5]

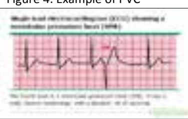
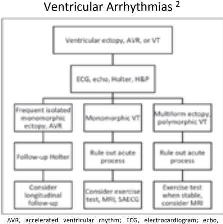


Figure 5: Example of Bigeminy [5]

Figure 6: Algorithm for Evaluation of Pediatric Ventricular Arrhythmias [2]



AVR, accelerated ventricular rhythm; ECG, electrocardiogram; echo, echocardiogram; H&P, history and physical examination; MRI, magnetic resonance imaging; SAECG, signal averaged electrocardiogram; VT, ventricular tachycardia

Discussion

Irregular heartbeats in children are a common finding on physical exam and can range from benign variants to dangerous heart rhythms. It is important to determine the underlying cause of the arrhythmia as it can be indicative of a life-threatening condition.[1,2,4,5] For this discussion, the most common arrhythmia presentations will be discussed as related to the patient presentation.

The most common arrhythmias in children include sinus arrhythmia, atrial premature beats, and ventricular premature beats. These are usually benign in nature and are incidentally found in asymptomatic patients.[5]

Sinus arrhythmia is a normal variant in which the heart rate fluctuates with inspiration and expiration. The heart rate is increased during inspiration and decreases during expiration. Diagnosis is usually made by EKG.[5]

Atrial premature beats (APBs), also known as premature atrial contractions (PACs), are usually caused by an area of increased automaticity located in the right atrium, which causes a premature depolarization to be conducted down through the AV node to the ventricles. This causes a premature contraction followed by a non-compensatory pause. On EKG the premature atrial beat, called P' (P prime), is different in size and shape from the P wave in the normal sinus beat and usually is followed by a longer PR interval due to delayed conduction in the AV node.[3,5]

The ventricular premature beats (VPBs) (Figure 4) are also known as premature ventricular contractions (PVCs). The PVCs are caused by premature depolarizations of the ventricles leading to an early systolic contraction. Sometimes they occur randomly producing an irregular heart rhythm and other times they occur in an regular pattern, such as every other beat with bigeminy (Figure 5), or every third beat with trigeminy.[5] Bigeminy is a rhythm that is characterized by a narrow QRS complex followed by a wide-based premature ventricular beat then a compensatory pause. On physical exam, this is often heard as 2 beats-pause-2 beats.

This patient presented with complaints of sore throat, and was found to have streptococcal pharyngitis. The bigeminy rhythm was heard as an incidental finding on physical exam. The patient had no complaints of chest pain, palpitations, shortness of breath, pre-syncope or any other signs of circulatory collapse.

As the patient was observed throughout the hospital course, she was noted initially to be in a sustained bigeminy rhythm. After she was treated with antibiotics and IV hydration, she was noted to fluctuate between bigeminy and normal sinus rhythm for >24hrs before she was finally able to sustain normal sinus rhythm prior to discharge.

The patient was referred to pediatric cardiology after discharge and underwent further work-up, including 24-hour Holter monitoring and an echocardiogram. On the cardiologist's examination at the first visit, she was found to be in regular rate and rhythm, but the EKG showed bigeminy leading to the conclusion that she was fluctuating back and forth between the two rhythms. This refuted our initial hypothesis that the bigeminy would be a short-lived finding related to the acute streptococcal infection because it continued to occur for several months after resolution of the acute infection.[4]

Interpreting Holter Monitors and the Importance of PVC burden

When an asymptomatic patient is in bigeminy, the Holter monitor is very important for determining the extent of involvement and the risk of ventricular dysfunction. The Holter monitor counts the number of total QRS complexes and abnormal beats such as PVCs. This information is then used to calculate the percentage of abnormal beats called the PVC burden. A PVC burden >10% in a 24-hour period increases the risk of developing ventricular dysfunction, even in an otherwise normal heart.[2,4,5]

The exact PVC burden at which ventricular dysfunction occurs is unclear, but general consensus from previous studies is that 20-30% ectopy is usually needed to increase the risk of ventricular dysfunction. [2,4] In general, treatment is not considered unless the patient is symptomatic and/or has a more than 15-20% PVC burden.[4] There are generally two situations in which treatment of PVCs may be warranted: 1) a noted decline in ventricular function or 2) symptomatic complaints of palpitations that are clearly attributable to the PVCs.[2]

The results of our patient's 24-hour Holter monitoring showed that out of a total of 138,867 beats, she had 2,601 isolated PVCs and 2,526 bigeminy cycles for a total of 5,127 PVCs. This is equivalent to a 3.7% PVC burden. This is interpreted as occasional PVCs (<5%). No ventricular tachycardia or other malignant rhythm was noted during the study. [4]

Signs that this condition is benign includes suppression of the abnormal rhythm with increasing heart rate and exertion, normal cardiac function, and normal anatomy on echocardiogram. In majority of children, rhythms with PVCs, such as bigeminy, can be a transient finding that may resolve spontaneously as they age.[2,4,5]

Treatment

Generally, in the asymptomatic patient longitudinal follow-up with reevaluation is considered appropriate. [2,4,5] In this case, our patient was seen by a pediatric cardiologist within weeks of discharge from acute hospitalization and again 2 months later. She continued to be asymptomatic throughout the observational period and was cleared for all activities without restriction with scheduled follow-up in the next 6 months. If she becomes symptomatic at any point, which would include palpitations, lightheadedness, pre-syncope or syncope, decreased exercise tolerance, chest pain or discomfort, instructions are to return for further evaluation. [4]

In a rare case that a pediatric patient becomes symptomatic or has declining ventricular function, the usual first line treatment is medical therapy, often a beta-blocker. Calcium channel blockers could also be considered first line agents in patients older than 1 year. If these medications fail or the patient experiences adverse effects, second line antiarrhythmic agents or catheter ablation could be considered. Catheter ablation is highly successful in eliminating an area of increased automaticity or a single PVC focus, but the risks of the procedure have to be weighed carefully against the indication and the patient's chance of spontaneous resolution over time. [2,5]

Summary

- Irregular heart rhythms can be a fairly normal finding, and may be seen on Holter monitoring in up to 40% of otherwise normal, healthy children. [2]
- The three most common rhythms are usually benign:
  - Sinus arrhythmia
  - Atrial premature beats, also known as premature atrial contractions (PACs), and
  - Ventricular premature beats, also known as premature ventricular contractions (PVCs).
- Concerning symptoms include chest pain, palpitations, shortness of breath, lightheadedness, dizziness, presyncope or syncope.
- The work-up includes a detailed H&P, referral to pediatric cardiology, Holter monitoring, and echocardiogram.
- The Holter monitor will quantify the number of heartbeats as well as the number of PVCs and any other abnormal rhythm.
- The PVC burden can be calculated as follows: # of PVCs/ number of heartbeats
- A PVC burden of 20-30% is most concerning for possible ventricular dysfunction. Treatment is considered around 15%, or even lower if patient is symptomatic or shows any signs of ventricular dysfunction.
- Treatment includes, but is not limited to, beta blockers and/or calcium channel blockers, other antiarrhythmic drugs, and/or catheter ablation.
- Risks of catheter ablation therapy must be weighed carefully against the indication and the chance for spontaneous resolution over time.

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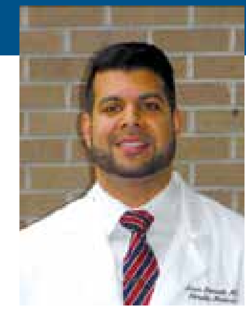
A Case Report on Mollaret's Meningitis

Arun Bansal, M.D. (PGY 3 FM residency LSU Kenner)



Introduction

Recurrent meningitis is a rare occurrence and has been associated with multiple disease states and factors. There have been some claims HER-2 breast cancers, intrathecal trastuzumab, or other medications may be associated with recurrent meningitis. In 1944 Dr. Mollaret was able to determine that the syndrome of recurrent benign lymphocytic meningitis (Mollaret's Syndrome) may have a direct association with viral meningitis specifically caused by Herpes Simplex Virus 2 (HSV2).

History and Examination

Patient is a 48-year old Caucasian female with a past medical history of cervical spinal stenosis, hypothyroidism, and as per patient had 17 episodes of meningitis since 1990 with her last episode being in 2013. Patient established care with LSU Kenner Family Medicine clinic in May of 2017 but did not provide any medical documentation to confirm this or refute this history. The patient did not recall any specifics in regards to her meningitis history. August 2017 patient presented to outside hospital for complaints of photophobia, fevers at home as high as 104C, intractable headaches for 2 days and concern these symptoms were similar to episodes of meningitis. At this time was transferred to University Hospital for IR Lumbar puncture and further evaluation. Patient was admitted CT brain did not show concern for bleed or masses. On physical exam Neurological functions were intact throughout but patient did have positive Kernig sign in lower left extremity. At the time of arrival Temperature was within normal limits and blood pressure was stable. Due to concern for bacterial versus Viral meningitis both Ceftriaxone and Acyclovir were started empirically until CSF results returned. As CSF results ***(Fig. 1)*** returned concern for viral causes increased while bacterial were ruled out and ceftriaxone was discontinued while acyclovir was continued.

SPINAL FLUID

Component Name	7/29/2017	7/29/2017
WBC, CSF		692 (H)
Lymphs, CSF		94
MONOCYTES,CSF		4
Eosinophils, CSF		1
Color, CSF		COLORLESS
Appearance, CSF	CLEAR	CLEAR
Tube Number, CSF		4
Glucose, CSF		56
CSF GLUCOSE NOTE:		THE ABOVE R...
Protein,Total CSF		181.9 (H)

Figure 1

Once this was noted patient had CSF screened for HSV1, HSV2. Results did in fact result with a positive PCR for HSV2. On day four of admission all symptoms had resolved and patient was discharged with close follow up with PCP and LSU Family medicine Kenner and with discontinuation of all antibiotics and antiviral medications.

Discussion

Various viruses can cause aseptic meningitis.3 In the adult population, a variant of recurrent aseptic meningitis has been identified, and this syndrome is known as the Mollaret syndrome. Mollaret described this unique form of recurrent aseptic meningitis in 1944. The clinical presentation of Mollaret meningitis is recurrent episodes of meningismus, headache, and fever, separated by symptom free episodes. Each episode can last from a few days to 3 weeks and generally resolves without any clinical intervention. Transient neurological symptoms may occur in some patients but the symptoms resolve with the resolution of the infection. The episodes of meningitis may not be associated with active herpetic lesions on the skin or mucous membranes. The course of the disease, although protracted, is benign, and does not pose a threat to the patient. In general, the symptoms tend to reoccur over a period of 3 to 5 years, although a case lasting more than 28 years has been reported

This patient fulfilled the criteria proposed by Bruyn et al ***(Table 1)*** for the clinical diagnosis: recurrent attacks separated by symptom-free weeks or months, spontaneous remission of symptoms and signs, recurrent episodes of severe headache, meningismus, and fever. Clinical and pathologic evidence of infectious meningitis were absent.

Recent data suggest that Herpes Simplex type 2 virus is identified as the most common agent causing Mollaret syndrome. After the primary infection, Herpes simplex type 2 virus becomes dormant, most commonly within the sensory neurons of the sacral dorsal root ganglia. It is believed that the retrograde seeding of the CSF by the Herpes simplex type 2 virus results in meningitis. With the advent of new

diagnostic procedures, such as the PCR, which is now widely available, it has become easy to identify the presence of Herpes simplex type 2 virus in patients with Mollaret syndrome, suggesting that it is a causative agent of benign recurrent meningitis. The detection of Herpes viral DNA in the CSF does not require any additional procedures; it is a simple test that can be done on the CSF that has already been collected. Detection of Herpes DNA in the CSF will allow the clinician to use abortive and preventive antiviral therapy.

The major problem in assessing the efficacy of any drug therapy is the nature of the disease, which has spontaneous resolution. The rarity of Mollaret syndrome precludes well-documented clinical trials studying the efficacy of various antiviral drugs. Although acyclovir is a safe, effective, and specific anti-Herpes drug, it has not been shown to definitively alter the natural history of the disease.

Table 1

Characteristics of Mollaret Meningitis

Characteristics of Mollaret Meningitis
Recurrent Episodes of Recurrent Meningitis
Episodes Separated by Symptom Free Periods
Spontaneous Remission of Symptoms
Transient Neurologic Symptoms in 50% of Cases
No Permanent Neurologic Sequelae
Probable Cause is Herpes Simplex Type 2 Virus

Conclusion

Mollaret syndrome, although rare, should be considered in all persons with recurrent aseptic meningitis (Table 1). It can be diagnosed by PCR analysis of spinal fluid for the presence of viruses, in particular Herpes simplex type 2. The diagnosis of this syndrome could prevent various hospital admissions for patients, and short-term attacks could be treated with acyclovir or valcyclovir. The efficacy of long-term antiviral prophylaxis is unknown and continuous to be avoided. With the assistance of LSU Infectious Disease Department this patient was given "pocket" valcyclovir and was told to start treatment on the first sign of meningitis, photophobia and headaches were her initial signs but fevers, and uncontrolled nausea and vomiting were also explained to be possible warning signs. Early treatment and immediate transportation to ED can reduce actual admissions as well.

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Medical Practice IT Is About Protecting Your Reputation At All Costs

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In my opinion, one of the biggest mistakes that people can make when thinking about IT within the context of their medical practice is to focus more on the "IT" part of the equation and less on its effect on the business itself.

Case in point: I was speaking with a friend of mine the other day, who also happens to run his own independent medical practice. We were discussing certain advancements down the lines, and things that I think might be a good fit for him, his people and what they're trying to do.

We were hitting all the most common notes -- increased productivity, superior collaboration and more - and then, when he continued to ask me questions, I came to a realization.

Everything that he was focused on was directed inward, towards his organization. This isn't a bad thing - but your frame of reference also can't stop there. You also need to think about IT's outward affect, too. Namely, you need to think about the effect that technology can have on your own reputation - something that could not be more important within the context of the healthcare industry than it is right now.

The Delicate Balance Between Trust and Outcomes

To get a better idea of what I'm talking about, consider the fact that people are researching their health care professionals now more than ever before making a decision about which practice in particular to go with. More than 40% of customers say that information they›ve found via social media affects what they do and who they choose to do it with, for example. Another 41% of people said that they›re very likely to use electronic methods like social media to pick a specific medical facility, hospital or even doctor.

So people are using technology to find out more information about you and your practice every single day. That information is going to directly contribute to whether or not they walk through your door. Based on that, it stands to reason that whatever they find can't just be good. It has to be *incredible.*

That, of course, is where your IT comes into play.

Healthcare in the IT space is about more than just giving your people the opportunity to do more with less. Even if you use IT to generate the desired outcome for a patient, but that patient had to wade through a cumbersome and unfortunate experience to get there, guess what - the latter half of that idea is what is going to directly contribute to how current and prospective patients see you from afar.

To get to this point, you really need to keep a few key things in mind. First, your IT and your organizational leadership must always be as closely aligned as possible. IT decisions must be strategic - which means that you're making choices based on more than just the aggregate cost. They must be made by people who understand the tech-related needs of individual departments and the entire organization at the same time and those people must also rise up to become the most passionate defenders of everything you do from that point.

Likewise, IT is also how you account for some of the other major factors that affect the way people view your reputation - namely, compliance and security. If you're still considering IT to be an afterthought, you're probably not paying enough attention to how choices affect your compliance with governing bodies like HIPAA.

But you also have to consider the fact that according to one recent study, the healthcare industry in particular was the target of 88% of ALL ransomware attacks in the United States in 2016. In the past two years alone, a massive 89% of healthcare organizations were breached in some way. If someone has their sensitive medical information exposed, they›re not going to care that you›re in an industry that is the top target for hackers around the world. They›re not going to get the nuance of the fact that there›s nothing you can actually do to stop that.

They're going to know that you let them down. Because you did. Because you were still focused too much on IT's inward effect on your practice instead of its outward effect on that practice's reputation.

Again, you must never forget that your reputation is ultimately one of the most important assets you have. Information directly related to that reputation can have a direct and powerful influence on whether or not someone becomes a patient of yours, how likely they are to seek a second opinion, how likely they are to choose you as their specific provider in a long-term way and much, much more.

Your technology is your most critical weapon in the battle to protect that reputation at all costs. It's about more than just the inward-facing effect on your organization in that the right technology is a way to provide better, more holistic and more valuable care. It's about harnessing the raw power of that technology to create superior outcomes, ultimately creating a superior end-to-end experience and supporting that reputation you've already worked so hard to build.

About Dennis Bourn

Since 2007, Dennis Bourn and his experienced and passionate team at Bourn Technology have been helping clients all across New Orleans and the surrounding areas get the most from their technology. Those looking for more information on their offerings are encouraged to visit the Bourn Technology website to learn more.

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Therefore...as 2019 begins, we are making room for a fresh new Board. We know there are great ideas out there—so we are calling upon YOU to show your interest in becoming a LAFP Board Member!

Of course, being a Board member has its inherent perks. Be a part of LAFP history. Flex your skills in a leadership position. Help form committees and working groups. Gain access to special networking opportunities. Give valuable input and address vital topics at the forefront. Add a special facet to your resume and professional career, as each position on the Board can translate to valuable experience in the field.

Here's your opportunity to run for a position or nominate a candidate!

The LAFP Nominating Committee will select a slate of officers and directors. We encourage your input. If you are interested in serving or have recommendations for consideration of the Nominating Committee, please submit your nomination by **March 1, 2019**. The following positions are up for re-election:

- President-Elect
- Vice President
- Secretary
- AAFP Delegate
- AAFP Alt. Delegate
- Speaker
- Vice Speaker
- District 1 Director
- District 1 Alt. Director
- District 4 Director
- District 4 Alt. Director
- District 5 Director
- District 5 Alt. Director
- District 6B Director
- District 6B Alt. Director
- District 7 Director
- District 7 Alt. Director
- District 8 Director
- District 8 Alt. Director
- Resident and Resident Alt. Representative
- Student and Student Alt. Representative

For more information regarding responsibilities for a specific position or a list of parishes/cities within a certain district, please contact Ragan LeBlanc at (225) 923-3313 or by email at rleblanc@lafp.org. **Please visit us at www.lafp.org to submit your nomination online.**

ATTENTION:

Submit a Faculty Proposal to Present at the 72nd Annual Assembly & Exhibition

Application Deadline: January 1, 2019

Share Your Expertise with Your Colleagues.....

The LAFP's Committee on Education is now accepting proposals for CME sessions for the **72nd Annual Assembly and Exhibition** to be held **August 1-4, 2019 at the Roosevelt Hotel in New Orleans, LA. The deadline to receive proposals is January 1, 2019.**

Proposals submitted for course/sessions should be based on content that addresses clinical practice gaps, educational needs, content areas, and learning objectives. The session should also be at the appropriate level of rigor for practicing family physicians. Additionally, the session will be incorporated into the overall Assembly CME application that will be reviewed by AAFP. The content should be created in accordance with AAFP style and editorial guidelines and intellectual property requirements that:

- is based on the most current evidence-based recommendations and guidelines
- is clinically relevant to family medicine with appropriate level of rigor for practicing physicians
- is designed to change practice behaviors
- addresses practice barriers
- uses case-based examples for key educational messages
- includes best practices recommendations
- is free of commercial bias
- is in accordance with AAFP Intellectual Properties (IP) policies

Minimum faculty qualifications include:

1. Expertise in the specific subject area
2. Knowledge of practice issues and problems related to the subject matter
3. Credibility and high regard by the medical community at large
4. Experience in teaching methods and learning strategies
5. Appreciation for and application of adult learning theory
6. Ability to address the learning needs of the target learners
7. Ability to deliver education in compliance with current professional codes, standards, laws, or regulations governing CME, continuing professional development, and independent medical education
8. Completed Conflict of Interest Form, disclosing any relationships with industry that could pose real or perceived conflicts of interest (Please review Louisiana Academy of Family Physicians CME Policy and Procedures for Full Disclosure and Identification and Resolution of Conflicts of Interest)

The Committee on Education will review the proposals in early 2019, and notification of acceptance will follow.

Download the application from our website today. Please feel free to duplicate the application for any faculty or colleague whom you think would be interested in participating.

For additional information, contact Executive Vice President, Ragan LeBlanc at 225.923.3313 or rleblanc@lafp.org.

Got CME Questions?

We Have Answers!

Active members must report at least 150 credits of approved CME every three calendar years. This three year time period is called a re-election cycle. Once members have met the CME requirement, they are “re-elected” to AAFP membership. If re-election requirements are not met, membership is cancelled.

The 150 credits must include at least **75 AAFP Prescribed credits** and **25 credits from live activities**.

Traditional CME activities such as seminars and conferences are what one immediately thinks of for “live” credits. Don’t forget about claiming credit for “**professional enrichment activities**.”

Examples include of live credits for professional enrichment activities include:

- Medical staff meetings
- Journal clubs
- Clinical professional clubs

Examples of individual credits for professional enrichment activities include:

- Journal readings
- Other informal self-study activities
- Independent examination preparation

Credit may be claimed, commensurate with participation, for partaking in other medical educational experiences and activities, such as independent exam preparation and informal self-learning activities. These activities may or may not be documented, and are not certified by the AAFP, AMA, AOA, but are of a nature of professional enrichment to the family physician. The maximum credit allowances professional enrichment is 25 AAFP Elective credits.

The LAFP staff is here to help you with understanding your transcript and reporting your CME hours. Please contact Ragan LeBlanc at 225.923.3313 or via email: rleblanc@lafp.org.

careers.lafp.org

Employers:

- **PLACE** your job in front of our highly qualified members
- **SEARCH** our CV database of qualified candidates
- **MANAGE** jobs and applicant activity right on our site
- **LIMIT** applicants only to those who are qualified
- **FILL** your jobs more quickly with great talent

Family Physicians:

- **POST** multiple CV’s and cover letters or choose an anonymous career profile that leads employers to you
- **SEARCH** and apply to hundreds of fresh jobs on the spot with robust filters
- **SET UP** efficient job alerts to deliver the latest jobs right to your inbox
- **ASK** the experts advice, get CV writing tips, utilize career assessment test services, and more

careers.lafp.org

Louisiana's Delegation Representing You

at Congress of Delegates in New Orleans

Commission meetings, debates and presentations were part of the AAFP Congress of Delegates meeting, held Oct. 7-10 in New Orleans, LA.

Louisiana's delegates were Drs. Marguerite Picou of Natchitoches and James Campbell of Kenner. The alternate delegates were Drs. Bryan Picou of Natchitoches and Wayne Graovois of Zachary.

Several of your delegates and alternates served on committees and in other capacities. Dr. Bryan Picou served as the Sergeant of Arms during the Congress of Delegates. Report from Dr. Alford, Delegate, on Actions Taken by the Congress. Dr. Marguerite Picou served on the Reference Committee on Health of the Public and Science.

Also representing Louisiana was Dr. Christopher Foret of Franklinton, President of LAFP, Ragan LeBlanc, Executive Vice President and Danielle Edmonson, Marketing and Events Coordinator.

AAFP Delegates Choose New Leaders for 2018-19

The AAFP Congress of Delegates today elected Gary LeRoy, M.D., of Dayton, Ohio, to be the Academy's president-elect. Others elected or chosen by acclamation for the following positions are:

- Speaker of the Congress -- Alan Schwartzstein, M.D., of Oregon, Wis.
- Vice Speaker -- Russell Kohl, M.D., of Stilwell, Kan.
- Directors -- James Ellzy, M.D., M.M.I., of Washington, D.C.; Dennis Gingrich, M.D., of Hershey, Pa.; and Tochi Iroku-Malize, M.D., M.P.H., M.B.A., of Islip, N.Y.
- New physician Board member -- LaTasha Seliby Perkins, M.D., of Alexandria, Va.
- Resident Board member -- Michelle Byrne, M.D., M.P.H., of Chicago
- Student Board member -- Chandler Stisher, of Brownsboro, Ala.

Moments after election results are announced in New Orleans, AAFP President-elect Gary LeRoy, M.D., of Dayton, Ohio, is escorted to the podium by sergeants-at-arms Adebowale Prest, M.D., of Silver Spring, Md., and Bryan Picou, M.D., of Natchitoches, La.

The 2019 AAFP Congress of Delegates will be held on September 23-25, 2019 in Philadelphia, PA at the Philadelphia Marriott Downtown.

Reminder: Renew Your LAFP Membership

In early October, you received your American Academy of Family Physicians and Louisiana Academy of Family Physicians 2019 dues invoice.

To continue to enjoy your AAFP and LAFP membership benefits, please visit the AAFP website to remit your payment online by Monday, December 31, 2018, or enroll in the AAFP installment plan by calling the AAFP Contact Center at 800.274.2237.

If you have any questions about your membership or need another copy of your invoice, please contact the AAFP at (800) 274-2237 or at contactcenter@aafp.org.

We appreciate your continued LAFP membership!

Nominations Sought for LAFP 2019 Family Physician of the Year

It's that time of the year again! Do you know an LAFP member who exemplifies the finer attributes of a family medicine physician? A colleague who is engaged in his or her community as well as provides compassionate, comprehensive and caring family medicine on a continual basis? If so, it's time to submit your nomination!

The Family Physician of the Year Award is one of the LAFP's highest honors. Help us bring recognition and visibility to a deserving family physician that serves and benefits the profession, the specialty, and the community. For the award criteria and to download the nomination form, please visit the LAFP website at www.lafp.org.

Selection Criteria:

1. Be an "Active" member, in good standing, of the Louisiana Academy of Family Physicians and the American Academy of Family Physicians.
2. Provides his/her patients with compassionate, comprehensive, and caring family medicine on a continuing basis.
3. Enhances the quality of his/her community by being directly and effectively involved in community affairs and activities.
4. Acts as a credible role model professionally and personally to his/her community, to other health professionals, and residents and medical students.
5. Stands out among his/her colleagues.

Judging:

The winner is determined by the Nominations Committee consisting of the Membership Committee Chair, who will serve as the Nominating Committee Chair, the President, President-Elect, Immediate Past President, and two other Board of Directors members selected by the President.

Nominations from:

Anyone can nominate a physician for the honor of LAFP Family Physician of the Year. Please confirm the physician's willingness to be honored and to serve.

Nomination requirements:

The nomination packet must contain the following:

1. Completed nomination form.
2. Current curriculum vitae (limited to three pages).
3. Maximum of eight pages of supporting documentation. Please note the following rules:
   a. If more than eight pages are received, only the first eight pages will be used. Note: supporting documentation does not include the nomination form or curriculum vitae.
   b. No double-sided pages will be accepted.
   c. Please do not reduce more than two letters to a page. Nomination packets with more than two letters per page will not be accepted.
   d. All pages must be photocopy-ready and of reproducible quality. Newspaper articles, odd-sized pieces of paper, etc., must be copied onto an unfolded, 8 1/2 x 11 sheet of paper. Anything that is not photocopy-ready will not be used.

Electronic and hard copy nominations will be accepted. If submitting electronically, please scan the nomination form and all supporting documentation to one PDF file. Hard copy submissions also will be accepted. If mailing, please do not fold the materials. The packet should be mailed flat with no staples. No two-sided copies, please.

Nominations due:

Nominations and supporting documents are due to the Academy office no later than March 1, 2019. Nominations, along with all supporting materials and documentation, can be emailed or mailed to:

Ragan LeBlanc
rleblanc@lafp.org
Executive Vice President
Louisiana Academy of Family Physicians
919 Tara Boulevard
Baton Rouge, LA 70806

Presented At:

The LAFP Family Physician of the Year Award will be presented to the winner at the Installation & Awards Ceremony, during the LAFP Annual Assembly.

Please contact the LAFP office at 225.923.3313 or email at rleblanc@lafp.org if you have any questions.

LAFP Calendar

SAVE THESE DATES

2019

April 25-27, 2019
AAFP Annual Chapter Leadership Forum/National Conference Constituency Leaders
Sheraton
Kansas City, MO

August 1-4, 2019
72nd Annual Assembly & Exhibition
The Roosevelt
New Orleans, LA

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LAFP Brings Update to North Louisiana and Honors 2018 Legislators

The LAFP hosted membership socials in North Louisiana in September with Allergan Pharmaceuticals. The District Socials were held on Wednesday, September 12th in Shreveport and Thursday, September 13th in Monroe at 6:30 pm.

During the Shreveport social, Danielle Edmonson, Marketing and Events Coordinator welcomed everyone on behalf of the LAFP Board of Directors and staff and provided an update from LAFP, LAFP Foundation updates and took questions from LAFP members. There was an educational presentation titled, **"***Diagnosing Bi-polar Disorder and Treatment Options***,"** featuring Marty Bennett, MD. Joe Mapes, LAFP Lobbyist also provided and an update on the 2018 Legislative Session and future planning.

During the Monroe social, Tahir Qayyum, MD, LAFP President-Elect welcomed everyone on behalf of the LAFP Board of Directors. Ragan LeBlanc, Executive Vice President with LAFP, provided an update from LAFP and the LAFP Foundation. Joe Mapes, LAFP Lobbyist provided and an update on the 2018 Legislative Session and future planning. An educational presentation by Francisco Marrero, MD was offered on the **"***Current Treatments for IBS-C and IBS-D***."**

A special presentation was held during the social, where the LAFP presented awards and honored two legislative champions. These legislators were vital to the LAFP during the 2018 legislative session. Representative Katrina Jackson and Senator Francis Thompson both received the LAFP Legislative Champion Award, due to their continued support of family physicians and their patients.

Thanking them for their continued support of the LAFP, President-elect, Tahir Qayyum, MD stated "These legislators have remained dedicated to the LAFP and to the physicians and patients of Louisiana. As they continue to serve in the legislature, Senator Thompson and Representatives Jackson understand the importance of having family physicians in their communities and protecting scope of practice from being expanded to other allied health professionals. The LAFP appreciates their support."

The LAFP thanks Allergan Pharmaceuticals for sponsoring these socials. Additional dates and locations for LAFP socials will be planned in 2019. Please check LAFP communications for more information as dates are added.

The LAFP and MAFP Hosts Welcome Social at FMX

LAFP and MAFP hosted a Welcome Social for member registrants attending the AAFP FMX in New Orleans on October 9th at The Chicory. Dozens of Louisiana and Mississippi family physicians networked and had fun. Goodie bags and prizes were awarded and the entire group 'let the good times roll!'

This event was courtesy of our generous sponsors Ochsner Health System, Merrill Lynch and United HealthCare.

Michael Madden, MD, FAAFP

Receives AAFP Award for Distinguished & Meritorious Service to Family Medicine

The LAFP honored Michael L. Madden, M.D. with the AAFP Award for Distinguished and Meritorious Service to Family Medicine during the FMX Welcome Social on Tuesday, October 9th. This award recognizes members, nonmembers, chapter executives with 25-year service, and entities for long-time dedication to advancing, contributing, and supporting to the AAFP and the specialty of family medicine. It is intended to recognize long-time dedication, rather than through a single, significant contribution and effective leadership within their chapter or nationally in furthering the development of family medicine.

In the popular 70s television show, actor James Young portrayed the wise and mild mannered physician, Marcus Welby. Everyone wanted their doctor to be like him because he treated patients while taking an interest in their lives, realistically dealing with a variety of medical maladies, one episode at a time. Over forty years later the Welby practice lives on, not in syndication - but embodied through the real life medical practice and care philosophies of Michael L. Madden, M.D. He's the old fashioned cradle-to-grave kind of physician who still sees patients in clinic, does hospital rounds, personally makes follow-up calls and regularly makes nursing home and home-bound patient visits and has done so for the past fifty years.

Dr. Madden has been a member of the American Academy of Family Physicians, the Louisiana Academy of Family Physicians since 1978. He is also a member of the Louisiana State Medical Society and the American Medical Association. He has served as chair / active member on many hospital committees at Rapides Regional Medical Center and has maintained support of the Louisiana Academy of Family Physicians serving on various committees through the years, served as an AAFP delegate, as well as serving as LAFP President in 1989-1990. Dr. Madden is the recipient of numerous awards including the 2009 LAFP Family Physician of the Year and was a finalist for the 2010 AAFP Family Physician of the Year.

Dr. Madden has served in many capacities, including Program Director at LSUHSC-S Alexandria Family Medicine Residency Program since 1998. He has remained very dedicated to training residents and has been voted as the Outstanding Faculty Member of the Year eight times. The LAFP has remained confident in his leadership abilities and is shown with all the various honors that he has received.

Without intention Dr. Madden has given countless hours of dedication to Family Medicine. He has provided education primarily by example, complemented by gentle guidance and firm support. Dr. Madden has supervised in a variety of clinical settings including hospital-based adult and pediatric in-patient services, emergency medicine's night float rotations, labor and delivery, nursing home and home-bound patient care and continuity clinics. He has taught Residency to Reality and leads the Balint group monthly, teaching how emotional response affects the physician's attitude and actions towards fulfilling professional obligations to the patient.

Family Medicine's spirit is enveloped through his example of practice, lifestyle and values. Dr. Madden regularly teaches senior medical students and physician assistant students who rotate from four to eight weeks at the residency program where he is employed and has mentored pre-med students from the Louisiana medical schools. In each Intern, he instills the unique opportunity they have to care for the whole patient population, stressing the importance of working closely with their patients, getting to know them and their stories as those patients get to know and entrust their doctor. His success at accomplishing these relationships is evidenced by the relationships that last far beyond residency graduation dates. He is considered as an adopted father and grandfather to the many residents that he has mentored over the years and staff members who admire him. His solid reputation is founded on his good works - communicated truthfully and delivered with diplomacy.

In his spare time, he volunteers countless hours of medical care to the indigent and uninsured, conducts life-saving health screenings at community health fairs, serves as team physician during school football games and provides physicals for the athletes. As an avid hiker, he swallows his own prescription for a healthy lifestyle, and often takes a group of residents hiking with him. Married for fifty years, he is a doting father and grandfather and his devotion to his family is an example for all.

Dr. Madden's compassion and dedication to family medicine over the years exemplifies that he is more than deserving of this award.

Congratulations Dr. Madden!

Represent Louisiana
at the AAFP National Conference of Constituency Leaders

The Louisiana Academy of Family Physicians is seeking physicians to serve as delegates to the American Academy of Family Physicians National Conference of Constituency Leaders (NCCL).

NCCL will be held Thursday-Saturday, April 25-27, 2019, in Kansas City, MO.

The LAFP is looking for physician members who can represent the following five recognized special constituencies:

- **Minority family physicians—**an active member of the AAFP who is Black, Asian, Hawaiian Islander, American Indian, Eskimo, or Hispanic
- **New physicians—**an active member of the AAFP who has been in practice less than seven years
- **Women physicians—**an active member of the AAFP who is a woman
- **International medical graduate (IMG) physicians—**an active member of the AAFP who graduated from medical school outside the United States, Canada, or Puerto Rico
- **Lesbian, gay, bisexual, and transgender (LGBT) physicians—**an active member of the AAFP who self-identifies as LGBT or who is supportive of LGBT issues

During NCCL you will meet similar family physicians from across the United States, discuss and develop resolutions that shape AAFP policies, and have the chance to be elected for various leadership positions for the next NCCL or as a delegate to the annual AAFP Congress of Delegates.

LAFP delegates to NCCL are reimbursed for eligible expenses (with the submission of a delegate report and receipts) according to the LAFP reimbursement policy.

If you are interested in serving as an NCCL delegate, please email a short statement of interest to Ragan LeBlanc no later than **Friday, January 5, 2019.**

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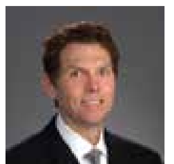
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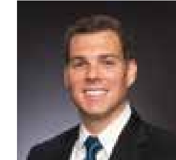
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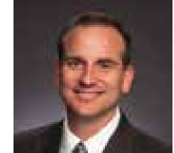
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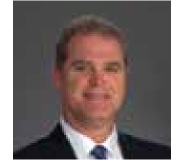
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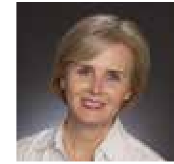
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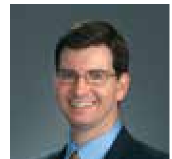
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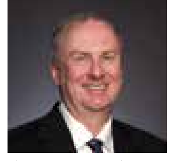
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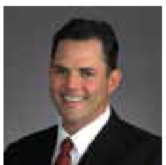
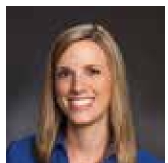
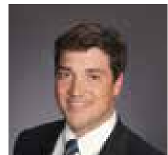

Ryan N. Majoria, M.D.

Jonathan C. Malone, M.D.


Laura S. Miller, M.D.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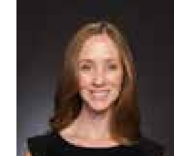
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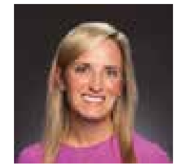
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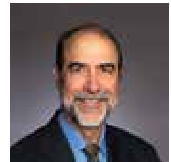
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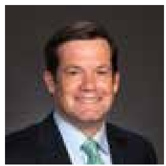
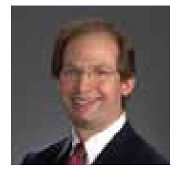

Scott B. Schuber, M.D.

Steven C. Sotile, M.D.

Brandon S. St. Amant, M.D.

Matthew A. Stair, M.D.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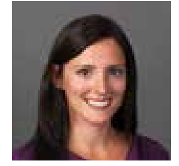
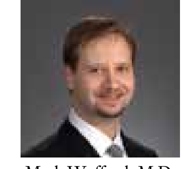

Allison S. Vitter, M.D.

E. Gay Winters, M.D.


Mark Wofford, M.D.

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Want a Voice in the AAFP?

Join A Member Interest Group Today!

As a growing organization with an increasingly diverse membership, the American Academy of Family Physicians is committed to allowing all members to have a voice in the organization. To support this ongoing effort, the AAFP Board of Directors established AAFP member interest groups to define, recognize, and engage groups of AAFP active members who have shared professional interests.

What are MIGs?

MIGs provide a forum for AAFP members with shared professional interests. Group members have the opportunity to do the following:

- Network with fellow AAFP members
- Participate in interest-specific continuing professional development activities
- Deliver a unified message to AAFP leadership
- Suggest AAFP policy
- Provide input on AAFP policies and positions (upon request)
- Pursue professional leadership development within the AAFP
- Connect to existing AAFP resources
- Meet face-to-face at AAFP Family Medicine Experience (formerly AAFP Assembly)
- Participate in an online community forum for discussion and idea-sharing

Connect with a Member Interest Group (MIG)

Learn about objectives and long-term goals for each AAFP MIG, or join a group. Each group offers an online community for connection and conversation.

Note: As a first-time visitor to an online community, you will be asked to affirm a Code of Conduct prior to access.

Current Board-approved member interest groups include:

Academic Mentorship MIG

Foster mentorship, collaboration, communication, and support among AAFP members with careers and interests in academic family medicine.

Adolescent Health MIG

Foster collaboration, communication, and support among family physicians engaged in adolescent health. Strengthen the perception and integration of family medicine into the larger adolescent health discipline.

Breastfeeding Medicine MIG

Enhance AAFP member knowledge of breastfeeding medicine and provide ongoing support for AAFP members taking care of breastfeeding families.

Community Health MIG

Participate in a forum for providers interested in the intersection of primary care and public health, highlighting the work of family physicians and family medicine residents in the community.

Direct Primary Care MIG

Increase awareness of the DPC model among family physicians and advocate for AAFP members who are currently practicing in this model or anticipate transitioning to it. Create resources, education, and a supportive community within the AAFP for physicians interested in direct care relationships with patients.

Emergency Medicine / Urgent Care MIG

Promote workforce policies, educational goals, and credentialing standards that are consistent with the AAFP policy on family physicians in emergency medicine.

Global Health MIG

Foster support for AAFP member interest in global health activities, networking, and collaboration. Facilitate professional development in the area of global health and opportunities for engagement in the broader global health movement.

Hospital Medicine MIG

Serve as a voice for family physicians that practice hospital medicine. Advocate for educational resources specific to hospital medicine.

Independent Solo / Small Group Practice MIG

Represent the interests of AAFP members who practice in independent solo and small group practices. Advocate policies that enable independent solo and small

group practices to deliver the highest quality of care while remaining financially viable.

Lifestyle Medicine MIG

Increase networking opportunities for members who have a passion to improve health through the focus on healthy lifestyle and foster communication and dialogue on debates in nutrition, fitness and other self-care areas.

Oral Health MIG

Increase awareness of oral health resources for AAFP members so that they might serve their patients better and improve their overall wellness. Provide AAFP members with oral health resources that can be used with patients at point of care.

Point-of-Care Ultrasound MIG

Work to improve access to education and resources to help incorporate Point-of-Care Ultrasound (POCUS) into family physicians' practices and advocate for related education in medical school and family medicine graduate medical education.

Reproductive Health Care MIG

Promote evidence-based reproductive health care in family medicine. Help AAFP members integrate comprehensive reproductive health care into their practices.

Rural Health MIG

Grow connections among American Academy of Family Physicians (AAFP) members with a distinct interest in rural health, inclusive of rural practice topics and rural medical education issues related to producing family physicians prepared for rural practice.

Single Payer Health Care MIG

Investigate the current outlook on single payer financed health care among AAFP members. Educate AAFP members on the ability of single payer financed health care to streamline and simplify patient care and improve family physicians' professional satisfaction by greatly decreasing administrative complexities and burdens.

Telehealth MIG

Provide education and support for the family medicine community on the many facets of Telehealth with a view toward enriching the practice of medicine and patient care. Better understand the views of AAFP members on Telehealth and identify questions, areas of concern, topics of interest, and create a forum for research, review, and discussion.

Interested in joining a member interest group? Visit the individual webpage for a specific member interest group and click on the "Visit the Community" button located on the right side of the webpage. Members will be redirected to the online community for the group. Upon reaching that page, click "Join Group."

We Want to Get to Know You.....

The LAFP would like to profile our physicians throughout Louisiana. We want to get to know what you are doing in your practices and communities. It doesn't matter if you have held a leadership role, been a member for 1 month or 30+ years, we want to hear more about you! You can help! Let us know if you have a colleague who should be recognized. Contact Ragan LeBlanc, Executive Vice President, at 225.923.3313 or via email: rleblanc@lafp.org.

Welcome to the following active, resident and student members who joined the Academy during the months of August through October 2018.

New Active Members

Jennifer Bakar, MD
Lauren Denise Bartholomew, MD
Becky Marie Batiste, MD
Ruth Guadalupe Darg Quinones, MD
Mathew Clark Erickson, MD
Catherine D Garner-Kuada, MD
Jeffrey Allen German, MD
Steven Bennett Kitchings, MD
Mai Truc Lam, MD
David Leslie, DO
Jayesh Madrecha, DO
Dennis Jeffrey Morris, MD
John B Pope, MD, FAAFP
Maria Dolores Abascal Roberts, MD
John H Smith, MD
Thomas Wesley Strain, MD
Joshua Paul Vallelungo, MD
David Ira Wartenberg, MD
Jennifer Renae Williams, MD

New Student Members

Melissa Ada
Naseem Alammar
Edward Alpaugh
Mark Alvarez
Kyle Arnold
Arash Ataei
Joy Ayemoba
Brett Barrilleaux
Sydney Beatty
Shannon Beermann
Jon Beker
Emilie Claire Bourgeois
Lauren Broussard
Nolan Broussard
Ben Brown
Spencer Brown, MS
Theodore Brown
Madison Buras
Katherine Carsky
Alana Carstens
Haley Cart
Kristin Champagne
Leland Chan
Tiffany Chang
Lynne O Chapman
David Chernobylsky
Erika Chow
Jay Cliffe
Aaron Cusato
Tucker Cushing, BA
Rebekah LeAnn Bennett Daggett
Laura DeLatin
Blake Denley
Andrea Dousdebes
Nichole Downing
Steven Eastlack
Olivia Rose Fankuchen, BS
Chenchen Feng
Peter Ferrin
Hannah Winthrop Fiske
Joseph Fitz-Gerald
Bailli Sage Fontenot
Jake Foote
Rebekah Frazier
Mackenzie Anne Fredricks, BA
William Gensler
Angellica O Gordon
Seth Guilbeau, BS
Laura Gulotta-Parrish
Hannah Hansen
Justin Harrell
Adam Haydel
Shaun Hayden
Victoria Hayes Robert
Tara Henagan
Stephen Hightower
Taylor Hill
melanie hotz
Daniel Hyneman, DDS
Ibrahim Ibrahim
Jonathan J Bennett
Nicholas J Gates
Alexander Jahncke, BA
George Jeha
Kathleen Annie Jenkins
Brittany Katherine Karlay
Emily Keegan
Joseph Kim
Austin Labbe
Madeline Lebar
Landon Lingenfelter
Mallory Lowe
Tony Lum
Michelle E McCarthy
Ben Melancon
Carlie Melanion
Celina Mercer, BS
Lucy Meyer
Abenet Michael
Blake Milson
Youmna Elena Moufarrej
Andrew Paul Mullet
Jacob Neary
Linh Nguyen
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Michelle Nguyen
Reginald K Nkansah
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Stephen Patin
Rod Paulsen MS
Ellen Pham
Anthony Pham
Evan Powers
Paul Alexander Ramirez
Tierra Range
Sabby Reed
Anna Rees
Natasha Rezvani
Nathan Rinehouse
Evan Rivere
Madison Robert
Tyler Rooney
Ryan Connor Rougelot
Bryce Rushing
Brett Salomon
Joseph Sansone
Mary Sauce
Karen Schaeffer
Samuel Schneider
Zachary Schwartz
Daniel Mark Seeser
Ruby Simmasalam
Alyssa Simon
Miranda Smith
Haley Stephens
Samuel B Stevenson
Taylor Stiegler
Halen Sumner
Malia Tarpley
Stephanie Terhoeve
Elsa Thomas
Collette Tilly
Ronni Tilmon
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Legislative Report

Joe Mapes
LAFP Lobbyist

A new year is upon us, which means another Louisiana legislative session is around the corner. This year is also an election year, so we can bet it will be an eventful year for the State and LAFP.

Throughout the year we ask you to connect with your legislators to let them know you are a resource when is comes to the practice of medicine, this year is no different. The 2019 fiscal session of the Louisiana legislature begins April 8th and adjourns June 6th. Although this session is primarily focused on the state budget, each legislator is allowed five bills on any subject matter. Between now and the start of the session, make sure that you reach out to your legislators to let them that know you are available to help when they are presented with tough decisions. Because there will be tough decisions to make this session. We can expect that some of the term-limited legislators will sponsor bills that are controversial. Some of them may hope to go out with a bang! LAFP must rally together now to prepare for potentially dangerous legislation.

Every session, LAFP provides a few different ways each of you can get involved at the State Capitol. Make sure to volunteer some of your time in the LAFP First Aid Station located in the Senate Committee Hall. Not only are you offering your services to the legislators, Capitol staff and visitors, but it is also a great way to mingle with those individuals. You can sit in on a committee hearing to get a better understand of the legislative process. Also, LAFP "White Coat Day" is a very important event to show our strength in numbers. The more "white coats" at the Capitol on this day, the better. Get involved and get your peers involved!!

Staying involved is vital this year. Not only because of the issues we may face at the State legislature, but it is also an election year. There will be a large turnover in both the House of Representatives and the Senate. Pay close attention to candidates in your area and support those candidates that are friends of Family Medicine. Make sure to ask potential candidates their thoughts on medical issues important to you and your patients. All too often we have different allied health professionals elected to the legislature, but we do not currently have a medical doctor serving in the House or Senate at the state level. We need to make sure that we elect individuals that are open to our issues and open to working with us to better medicine in the state of Louisiana. Get involved and support your future leaders. If you don't choose your new legislator, someone else will choose for you and it may not be the result you wanted.

As always, please contact Ragan or myself with any questions or concerns. Have a great New Year!

Thank you to our 2018 LaFamPac Donors!

The LAFP Political Action Committee (LaFamPac) would like to thank the following individual contributors:

Derek J. Anderson MD
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Kenneth Brown, MD
James Campbell, MD
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Mary Coleman, MD
Christopher Foret MD
Jody George, MD
Wayne Gravois, MD
Jack Heidenreich, MD
Karrie Kilgore, MD
Darrin Menard, MD
Brandon Page, MD
Bryan Picou, Jr., MD
James Smith, MD
James A. Taylor, Jr. MD

If you would like to contribute to LaFamPac, visit the LAFP website at www.lafp.org or contact Ragan LeBlanc at rleblanc@lafp.org or 225.923.3313.

LAFP Presents Legislative Champion Award to Senator Claitor

LAFP President Christopher Foret, MD presented one of the LAFP's Legislative Champion Awards to Senator Dan Claitor on Thursday, November 1, 2018. Claitor was unable to attend the LAFP Annual Assembly & Exhibition in Destin, Florida over the summer, so President Foret took a trip to Sen. Claitor's law office in Baton Rouge to present him with his award.

Senator Claitor has been a long-term friend of the LAFP representing medicine and healthcare at the State Capitol.

Representative Katrina Jackson and Senator Francis Thompson also received Legislative Champion Awards earlier this year.

Thanking them for their continued support of the LAFP, Legislative Chair Richard Bridges, MD has stated "These legislators have remained dedicated to the LAFP and to the physicians and patients of Louisiana. As they continue to serve in the legislature, these Legislative Champions understand the needs of physicians by filing resolutions to better patient care. The LAFP appreciates their support."

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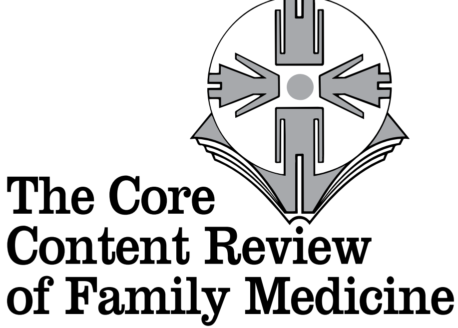

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WHY SUPPORT YOUR PAC?

What is LaFamPac?

LaFamPac is the state political action committee of the Louisiana Academy of Family Physicians. The PAC is a special organization set up to collect contributions from a large number of people, pool those funds and make contributions to state election campaigns.

Where does my donation go?

LAFP Political Action Committee (LaFamPac) contributions go directly to support legislators who are informed and committed to Family Medicine's business and practice management issues. And the results....Family Medicine interests are much more likely to receive greater attention among the many competing interests and constant stream of proposals put forward for consideration.

I Already Pay My Dues – Isn't That Enough?

Election laws prohibit the use of membership dues for donations to political candidates. Funds to be used for donations to candidates must be raised separately from membership dues. Voluntary LaFamPac donations are what will enhance LAFP's clout in the elections and with elected members of the Legislature.

Contribute Today!

Your contributions help keep the voice of Family Medicine heard on topics such as:

- **Scope of Practice Issues**
- **Managed Care Issues**
- **Protecting Provider Rates**
- **The LA Medicaid Program**

LaFamPac Donation Form

Please return this form, along with your contribution to:
LaFamPac, 919 Tara Boulevard, Baton Rouge, LA 70806 or Fax to (225) 923-2909.

Questions? Please contact the Executive Vice President of the LAFP, Ragan LeBlanc at (225) 923-3313.

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HELP THE LAFP PREPARE FOR THE UPCOMING 2019 LEGISLATIVE SESSION

As a subject matter expert and a valued constituent, elected officials need – and, in fact, count on – expert opinions like yours to make effective legislative decisions.

Of the 144 representatives and senators in the LA Legislature, there is not a physician who serves currently. Your members of the legislature have some medical knowledge but are more likely to be a former mayor, attorney, business owner, educator, or even a farmer than a healthcare professional.

While e-mails, social media outreach, and phone calls are valued ways of communicating, nothing compares to in-person visits with your legislators. It can be very difficult to find time to meet personally with your legislators while they are in session. However, over the next few months, meeting with your own representative and senator is an important goal of the LAFP as we begin preparing for the legislative session in 2019.

The LAFP needs your help in our efforts and are asking that as a member that you begin making contacts. We have developed a timeline for you as a guide leading up to when session starts.

- Make your first contact before January 2019 by stopping by your legislators' office and drop off your business card or contact information.
- Month of February – make a phone call to your legislators and follow-up.
- Month of March – make an in person visit to your legislators' office. Ask your legislators for a meeting to explain the real implications of health care policy for you, your practice, and your patients.p

Reaching out to your legislator is easier than you might think, and can increase the visibility and importance of family medicine to those in the legislature. Resources are available on the LAFP website to help make the invitation to your legislator, direct the conversation, and inform the local media of your meeting.

April is just around the corner. Start making contacts, establishing a relationship and ask your member of the LA Legislature now for a meeting. Email Ragan LeBlanc, Executive Vice President at rleblanc@lafp.org with your questions and let her know when you make contacts or your meeting is scheduled.

Thank You to Our Foundation Donors

The Louisiana Academy of Family Physicians (LAFP) Foundation would like to thank the following individual contributors over the past year. The following individuals helped support Tar Wars, various awards and scholarships, and contributed to the LAFP Foundation General Fund.

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The Foundation would also like to extend a thank you to all of the LAFP membership that helped support individual fundraising activities such as the golf tournament and auction in the past. While the Foundation applies for grants to help support costs, we still rely on donations to fund our residency program and community outreaches. Thank you for helping support us and we look forward to supporting family physician initiatives in 2019!

Build the Future of Family Medicine
with Your Donation to the LAFP Foundation

As 2018 comes to an end, we hope that you will consider ***"Building the Future of Family Medicine"*** with the LAFP Foundation in your charitable giving. The Foundation provides and supports education and scientific initiatives of family medicine to improve the health of all Louisianans. Generous financial contributions ensure the continuation of the Foundation's programs to identify and cultivate future family physicians such as:

- Encouraging medical students to pursue Family Medicine
- Educational programming targeting Students and Residents annually with unique speakers and hands-on workshops
- Supporting Family Medicine Interest Groups (FMIGs) that promote the future of Family Medicine
- Providing financial assistance for delegates to attend the AAFP National Conference for Students and Residents, which is an opportunity to be involved, collaborate and understand processes that impact the future of family medicine
- Recognizing outstanding Students and Residents with awards and scholarships to further their educational growth

Please consider joining your fellow family physicians in supporting the work of the Foundation to help us better serve those who wish to stay and practice Family Medicine in Louisiana. Consider providing a small monthly gift, as donating over time provides continual support to these important programs and enables us to better plan the future of the Foundation. While we apply for grants to help support costs, we still rely on donations to fund our residency programs and community outreach. The Foundation is a 501(c)3 tax-exempt corporation and is the only charitable organization in Louisiana that exists to improve and increase access to health care by investing in the specialty of family medicine. Thank you for supporting the LAFP Foundation in continuing its mission of ***"Building the Future of Family Medicine"*** as we look forward to ongoing student and resident initiatives in 2019! You can make your gift online at www.lafp.org/foundation.

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More Than Medical Care:

A COLLABORATIVE APPROACH TO THE SOCIAL DETERMINANTS OF HEALTH

Efforts to address social determinants of health (SDOH) are gaining steam in Louisiana, and our state's physicians and payers have the opportunity to play an important role in how our healthcare system addresses SDOH for some of our most vulnerable patient populations.

DATA THAT MAKES A DIFFERENCE

The digitalization of healthcare that has occurred over the past two decades has produced a tremendous amount of data that enables payers and physicians to partner in the development of programs and services that track, measure and support efforts to address SDOH among vulnerable patient populations.

Through predictive analytics and risk stratification tools, payers are using this data to enhance member engagement, to reduce non-emergent ED utilization and hospital readmissions, and to close gaps in care. And perhaps most importantly of all, this data serves as the foundation of efforts to link members across the transitions of care with the non-clinical services necessary to achieve improved outcomes.

The need for increased accuracy in data around SDOH in Louisiana is critical, and can be achieved through the use of the Z55-65 codes in ICD-10's Chapter 21, "Factors influencing health status and contact with health services." Each of these codes has sub-codes providing a more specific description of the socioeconomic factors that are negatively influencing health outcomes.

Using these codes in a clinical setting, for example, physicians have the opportunity to indicate whether a patient is non-compliant with medications due to a financial problem, or whether a patient is not adhering to an appropriate diet because of food insecurity in the home. When those codes appear on a claims submission, they serve as a flag to payers, letting them know that a member is in need of targeted outreach for a social determinant of health issue.

In addition to supporting data-driven strategies to address SDOH at the point of care, the use of Z codes improves claims accuracy and specificity, and helps to establish medical necessity for treatment in some cases, leading to an endorsement of Z codes earlier this year by the American Hospital Association (AHA). In its April 2018 guide, "ICD-10-CM Coding for Social Determinants of Health," the AHA encouraged hospitals and health systems to educate physicians, non-physician providers and coding professionals on "the important need to collect data on the social determinants of health."

"Utilizing these codes will allow hospitals and health systems to better track patient needs and identify solutions to improve the health of their communities," the AHA wrote.

A HEALTHY PARTNERSHIP

Payers have strong internal teams of care managers, clinical social workers and community health coaches trained in identifying and addressing SDOH. They invest in academic partnerships that yield geo-specific data around the factors that influence health for their members, and they partner with community-level organizations that address those factors.

Together, physicians and payers can connect vulnerable patients with the resources, tools and support services they need to overcome SDOH and improve their health. And as a result, quality of care, care coordination and access to care will improve for the patients who need it most.

Code	Description
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Chapter 21 of ICD-10, "Factors influencing health status and contact with health services," includes a series of Z codes that help to identify social determinants of health (SDOH) that may negatively impact a patient's health outcomes. Each of these codes has sub-codes that provide a more specific description of the problem.

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