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FAMILY DOCTOR
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Spring 2018

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In This Issue

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A Message from the President

Jonathan Hunter, MD
LAFP President

Considerable recent attention was stirred by Dr. Ronny Jackson as he released details regarding the physical exam findings of his patient. Understandably, anything is noteworthy when the physician happens to be a Rear Admiral in the United States Navy, and the patient is the President. And so it was with an audience of the White House Press Corps, that Dr. Jackson lined out the results of a three-hour comprehensive evaluation that included assessments of cardiovascular, metabolic, and cognitive health among other measures. In short, President Trump was declared to be in "very, very good health." Yet despite the glowing nature of his remarks, reporters have since opted to fixate on the President's Body Mass Index of…29.5.

There is no denying that rates of obesity have risen as our society has industrialized and urbanized, and our beloved Louisiana is among the nation's leaders in this sobering trend. Our daily arch nemeses are no less sobering: hypertension, diabetes, coronary disease, and stroke—all of whom march to the beat of the same epidemiological drum. Here we are in 2018, and the leading cause of death remains the same as it was is 1921.

And yet, while mortality statistics are undeniable, much remains to be learned about the list of numbers that we measure as we evaluate our patients. It's not enough to simply evaluate a BMI as some patients are densely muscled while others are considered to suffer from sarcopenic obesity. Lipid measures that were once pronounced in a strict, patient-blind fashion are now being viewed in the context of individual risk profiles. Glycemic control that was once considered only acceptable if it flirted with hypoglycemia is now advised on the basis of age and life expectancy.

In short, physicians are now being encouraged to—astonishingly—consider each patient individually. We are no longer blindly treating families based on a list of draconian academic pronouncements. We are listening, knowing, and advising based on best evidence. I welcome the affirmation of our daily work. Indeed, the holistic, psychosocial model of our training laid out by the founders of our specialty…works.

I look forward to meeting you at our Annual Assembly in Sandestin July 5-8! The theme will be "United We Stand for Family Medicine." As always, the CME will be exciting, our comradery will be enriched, and our families will enjoy some much deserved time together. Please make every effort to attend and to support your Academy. Geaux LAFP!

A Message from the Secretary

Mary Thoesen Coleman, MD, PhD
LAFP Secretary

LAFP Members:

In my last message, we discussed the unfortunate high burnout rates among physicians and some resources to help us develop mindfulness, one of the strategies for mitigating burnout. In this issue, we are looking at system strategies that focus on the way we do our work to help us foster and nourish enjoyment. Most of us would agree that we reap many benefits and joys from caring for our patients and helping them in whatever ways we can. However, most of us would also relish the opportunity to reduce any administrative burdens that limit the time we have to focus on patient care.

We noted previously that top causes of burnout for Family Physicians included the following:

- Too many bureaucratic tasks
- Spending too many hours at work
- Increasing computerization of practice

In response to this list, it seems that we need strategies to increase the efficiency of how we do our work. Dr. Christine Sinsky and others published "In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices" (WWW.ANNFAMMED.ORG • VOL. 11, NO. 3 • MAY/JUNE 2013). In this article, the authors highlight primary care innovations designed to mitigate physician burnout and contribute to preserving and growing joy in practice.

They recommend dealing with the problem of unplanned visits with overfull agendas by doing pre-visit planning and pre-appointment laboratory tests. Tools for pre-visit planning are available at Fam Pract Manag. 2015 Nov-Dec;22(6):30-38 and also at the AMA Steps Forward website https://www.stepsforward.org/modules/pre-visit-planning.

You may want to examine your staff to physician ratio. The article states that using staff to support patient demand for care requires 2- or 3-to-1 clinical support per physician. Suggestions for garnering the support from staff include expanding roles for nurse or medical assistants in the rooming protocol, using standing orders, extending responsibility for health coaching, care coordination, and integrated behavioral health to non-physician team members, and sharing team responsibility for panel management. For example, staff members can complete medication reviews, complete forms, review health monitors, give immunizations, book appointments for mammograms and DXA scans, and administer 9-question depression screens if indicated. They can also reach out to patients whose care registry indicates gaps in meeting guideline recommendations.

To reduce the amount of time spent documenting and complying with regulatory requirements, one can hire scribes. In Family Medicine at LSU, we have been using undergraduate student workers to scribe for some of our doctors. Not only do the scribes assist in reducing documentation time, but we essentially provide students an opportunity to witness primary care first hand and consider family practice as a career option. In another effort to reduce wasted time, one can separate prescription renewal from chronic care appointment adherence by providing 12-15 month prescriptions for stable medications.

Many of us have experienced how computerized technology has pushed work previously done by staff directly to the physician. Strategies to reduce the extra work include in-box management in which electronic information is directed first to a member of your staff who filter out those things they can manage and push only those needing physician input to your attention. In some practices, frequent verbal communication leads to improved efficiency; electronic messaging is replaced by more time-efficient verbal messaging between nurse and physician.

Improving team functions can lead to a better work environment. Team skills include arranging office space so team members are co-located to improve minute to minute communications. If nurses and medical assistants do not have ready access to a physician, patient problems may not be solved quickly due to asynchronous electronic messaging moving between individuals. One solution might be to co-locate physician and medical assistant side by side in "flow stations." Another is to have team huddles and/or other regular meetings to review patient appointment schedules or registry lists and look at how patient needs can be efficiently met.

With careful planning, teams can reduce work flows around registration, rooming, lab orders, referrals, prescription refills, informing patients of results, and completing forms so that physician and staff time is optimized. Use of tools such as work flow mapping (http://cepc.ucsf.edu/workflow-mapping) can identify where there is wasted time and effort and assist in making changes to process.

I want to believe that many, if not most, of these interventions are within our reach. I suspect that we may need to take time to reflect with our staff together, on how each of us on the team can contribute best to reduce unnecessary inefficiencies that limit our joy in practice. Thanks for letting me share my thoughts with you and Happy days to all!

Executive Vice President

Ragan LeBlanc
LAFP Executive Vice President

YOUR LAFP MEMBERSHIP

The Importance of Being an LAFP Member

As we begin 2018, your membership in the LAFP has never been more important to you and your chosen profession. Between the bleak financial outlook recently presented by Governor John Bell Edwards to the continued federal regulatory burdens placed on backs of primary care physicians; running a successful practice while continuing to provide your patients access to quality and affordable health care will prove to be challenging, to say the least. The LAFP is here to help! We will continue to advocate, communicate, educate and collaborate across the state on your behalf, and for your patients as well.

Why Membership Renewals are Important

Membership is important to ensure the vitality of every professional association and the Louisiana Academy Family Physicians (LAFP) is no exception. Membership in the LAFP introduces physicians, residents, fellows and medical students to member benefits, yet membership renewals help us to determine how well we meet the needs of our members by providing relevant resources. Members remain in the LAFP because they believe their membership helps their profession

and their patients. Please help us educate members about what you do for patients, their families and within your community. It is important to have a good mix of new members and returning members; the future success of the LAFP depends on it. It also takes more effort to recruit a new member than it does to keep an existing one. A returning member who sees the value and impact of the LAFP is our best advocate for recruiting future members. Renewing members are an important part of achieving our annual membership goals as these renewals provide a solid base who in turn help us build a strong community network and future leaders within the LAFP. If you haven't already done so, please renew your membership TODAY!

Save the Date for a Little Patriotism

Assembly & Exhibition is this year's CME program in four exciting days. It's a lifetime worth of connections. It's resources and family medicine experts worth millions. This is the largest members meeting all year packed with social events, CME and time to enjoy the beautiful beaches.

This year's Annual Assembly will be held July 5th-8th at the Baytowne Conference Center at the SanDestin Golf and Beach Resort. We'll have red, white, blue and a little bit of sand too! Join us for "United We Stand for Family Medicine."

Registration opens March 1st. Visit https://www.lafp.org/cme-events/events/71st-annual-assembly-and-exhibition for the latest details.

Stay tuned for more details!

Atrial Fibrillation and Sleep Apnea: A Case Report

By Thomasz J. Kuzniar

CASE

A 57 year-old man with a prior history of hypertension, hyperlipidemia, paroxysmal atrial fibrillation and gout presented to the emergency room with shortness of breath and palpitations. Examination demonstrated obesity (body mass index of 34.6 kg/m^2), congested throat (Mallampati 4 score), irregular tachycardia, normal breath sounds, and no peripheral edema. Electrocardiogram confirmed the presence of atrial fibrillation with rapid ventricular response of 134 beats/min.

For the past 4 years prior to admission, he had recurrences of paroxysms of atrial fibrillation and has been under the care of a cardiologist. He has been taking metoprolol 25 mg BID, valsartan 160 mg, simvastatin 40 mg and aspirin 81 mg. He had previously declined systemic anticoagulation. Prior episodes were usually short-lived and were, on other occasions, triggered by stress or alcohol consumption. Diltiazem and metoprolol were used to acutely manage his symptoms; on one occasion, he required cardioversion. With recurring episodes, a catheter pulmonary vein isolation was proposed, but the patient declined. Echocardiograms showed left ventricular hypertrophy, but no valvular heart disease.

DISCUSSION

Atrial fibrillation (AF) is the most common serious arrhythmia. Its risk factors include advanced age, hypertensive heart disease, coronary artery disease and, less commonly in the United States, rheumatic heart disease. Atrial fibrillation leads to decrease in cardiac output and is associated with cardiomyopathy, heart failure, and secondary valvular changes. Also, it leads to *in situ* thrombosis within the atria, with a risk of systemic embolism including stroke.

Presence of obstructive sleep apnea (OSA) and central sleep apnea (CSA) increase the risk of atrial fibrillation and this increased risk has been documented in a number of studies. For instance, in the Sleep Heart Health Study, compared to patients without sleep-disordered breathing, patients with severe obstructive sleep apnea had a four-fold increase in risk of atrial fibrillation, after adjustment for usual confounders.[1] It is thought that repeated, intermittent episodes of hypoxia and reoxygenation are responsible for this association between sleep-disordered breathing and arrhytmogenesis.[2,3] Also, among patients <65 years of age, the risk of incident (new onset) atrial fibrillation was higher with coincident OSA, and increased with deeper desaturations at night.[4] Taken from another angle, among patients with atrial fibrillation, there is a higher of prevalence of obstructive sleep apnea, ranging from 30 to 80%.[5]

There is some evidence that treatment of OSA may reduce the risk of recurrence of atrial fibrillation. In a study by Kanagala et al., the risk of recurrence of AF over the 12 months of observation was higher in patients with untreated OSA than in matched patients with OSA controlled by continuous positive airway pressure (CPAP).[6] In another study, among sleep apnea patients who underwent a catheter pulmonary vein isolation (ablation), the risk of recurrence of atrial fibrillation was higher in those without treatment than in those on CPAP (63% versus 28%). The risk of recurrence of AF among treated OSA patients was in fact, similar to the risk of recurrence in patients without OSA.[7]

Obstructive sleep apnea may also increase the risk of other arrhythmias. Patients with OSA have a higher risk of ventricular ectopy and ventricular arrhythmias. Based on the systematic review of literature, OSA was identified as a risk factor of ventricular tachycardia, ventricular fibrillation and implantable cardioverter-defibrillator shocks in patients with and without heart failure.[1,8,9] Whether CPAP can improve this risk is an area of active investigation; at this point, there are insufficient data to demonstrate such an improvement.

In summary, OSA may be a modifiable risk factor for recurrent atrial fibrillation after cardioversion or ablation. Obstructive sleep apnea, which, if left untreated, may worsen cardiovascular outcomes. Clinical features suggestive of obstructive sleep apnea, such as history of snoring, witnessed apneas, obesity, excessive soft tissue in the upper airway should be systematically sought in patients presenting with atrial fibrillation, especially if they are accompanied by excessive daytime sleepiness and concurrent systemic hypertension. If these clinical features are present, a sleep medicine referral should be considered. In chronic care of patients with atrial fibrillation, in addition to typical rhythm- and rate-controlling therapies and anticoagulation, treatment of concurrent obstructive sleep apnea is expected to result in an improved likelihood of remaining in the sinus rhythm and possibly, prevention of complications of this arrhythmia. Board certified sleep medicine physicians can help determine the appropriate diagnostic test(s), and provide long-term management with CPAP or other appropriate treatment modalities.

CASE FOLLOW-UP

Following the control of the ventricular rate with metoprolol, the patient's AF converted spontaneously to sinus rhythm. The consulting cardiologist recommended an outpatient catheter ablation and sleep evaluation. In addition to a comprehensive sleep evaluation, his polysomnogram demonstrated severe obstructive sleep apnea with an apnea-hypopnea index of 32, nadir oxygen saturation of 77% and high sleep fragmentation. CPAP applied during the same night (split night protocol) was successful in controlling airway obstruction at 12 cmH_2O, with mild

residual central apnea that improved in the later part of the study. While it took several weeks for the patient to get used to his home CPAP unit, he is now successfully using his CPAP at home, with good symptomatic improvement and adequate control of OSA based on the adherence data monitor.

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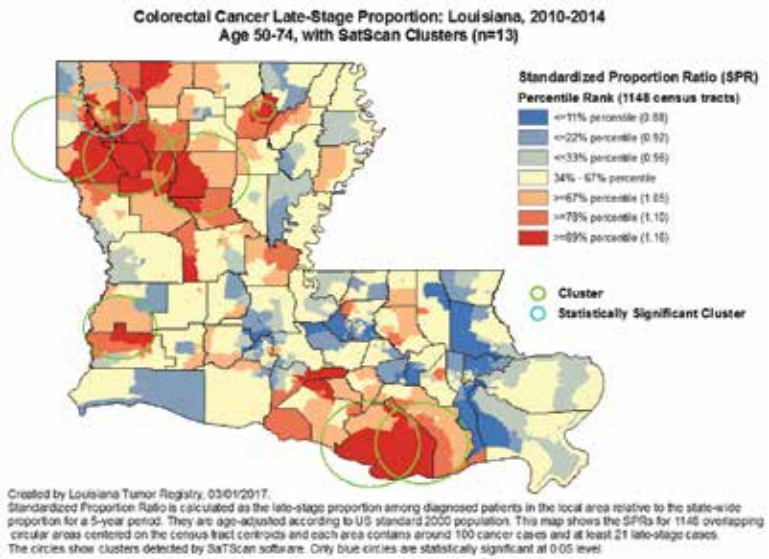
Primary Care Doctor Honored by Louisiana Colorectal Cancer Roundtable

Colorectal cancer is one of only two cancers that can be prevented through screening, and if caught early, has a 90% survival rate. Unfortunately, only 64% of eligible Louisianans are up-to-date on screening. The Louisiana Colorectal Cancer Roundtable (LCCRT) hopes to change that statistic. The LCCRT is a statewide coalition of organizations and individuals who are dedicated to reducing the incidence of and mortality from colorectal cancer in Louisiana through coordinated leadership, strategic planning, and advocacy. The mission of LCCRT will be accomplished by achieving screening rates for colorectal cancer that are equivalent to those for other cancers.



Despite being a screening-amenable cancer, colorectal cancer remains a concern for Louisiana. Louisiana ranks third in the nation for colorectal cancer incidence and mortality from 2010-2014 for all races, both sexes, and all ages combined (State Cancer Profiles). Colorectal cancer accounted for 9.9% of all new cancer diagnoses and 9.4% of all cancer deaths from 2010 through 2014 in Louisiana.

Thus, as part of the Louisiana Tumor Registry's (LTR) collaboration with LCCRT, the LTR worked with geospatial experts from the National Cancer Institute and Temple University to identify areas within Louisiana that may benefit the most from screening interventions.

The map above depicts the late-stage proportion of colorectal cancer within Louisiana from 2010-2014. The late-stage proportion is the number of late-stage colorectal cancer cases (regional and distant) over the total number of colorectal cancer cases in the area (all stages including in situ). The standardized proportion ratio is the local-area late-stage proportion divided by the state-wide late-

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stage proportion for the 5-yr period.

The yellow areas have a late-stage proportion closest to that of the state, the areas in red have a higher late-stage proportion when compared to the state, and the blue areas are lower than the state in terms of late-stage proportion.

The only statistically significant cluster identified through this analysis is in the Shreveport area. With this information, cancer control programs and the LCCRT are now able to direct resources to the areas' most in need of screening interventions.

LCCRT and Blue Cross and Blue Shield of Louisiana co-sponsored a friendly competition among Quality Blue Primary Care providers with the goal to screen 80 percent of their eligible population for colorectal cancer. Quality Blue Primary Care is a patient-centered program that focuses on achieving better health outcomes.

The Louisiana Colorectal Cancer Roundtable is excited to join Blue Cross in giving special recognition to these 22 primary care doctors who reached this goal of 80 percent or more screened in the last year as part of this competition.

Sally Ball	Willis-Knighton Physician Network
Jennifer Bertsch	WJPQA-Touro-Crescent City Physicians
Gayle Beyl	North Oaks Physician Group
Theodore Borgman	WJPQA-Touro-Crescent City Physicians
Mark Brown	Shreveport Internal Medicine
Todd Burstain	Ochsner
Michael Casey	Northshore Family Medical Center
Marion Cash	The Family Doctors
Wartelle Castille	Health Leaders Network
Jewell Crockett	Baton Rouge Clinic
Bertha Daniels	WJPQA-WJMC-West Jeff Employed Clinics
Eugenia Gary	Ochsner
Ashley Guy	Health Leaders Network
Charles Haliburton	Health Leaders Network
Ricky Jones	The Family Doctors
John Kokemor	WJPQA-Touro-Louapre; Kokemor, Sarrat & Braedt
Meredith Maxwell	WJPQA-Touro-Crescent City Physicians
Aarti Pais	WJPQA-Touro-Crescent City Physicians
Theresa Rinderle	The Family Doctors
Andrew Siegel	WJPQA-Touro-Crescent City Physicians
Vincent Tumminello	Baton Rouge Clinic
J. David West	Baton Rouge Clinic

Stroke and Obstructive Sleep Apnea

By Cathy Goldstein, MD, MS

CASE

A 72 year old male with a past medical history of hypertension and obesity is admitted to the hospital after acute onset of right sided facial droop and difficulty lifting the right arm and leg. Physical examination confirmed right face, arm, and leg weakness and MRI revealed a lacunar infarct of the left internal capsule. The patient had an uneventful hospital and rehabilitation course with the exception of a nocturnal oxygen requirement not explained by any pulmonary pathology. He presented to your clinic 4 weeks later reporting that he's always been told he snored loudly but he sleeps just fine. In addition to right sided weakness, physical examination revealed a BMI of 34.7 kg/m,^{2} a neck circumference of 17.5 inches, and class 3 modified Mallampati.

DISCUSSION

Sleep-disordered breathing (SDB) is common among individuals who have experienced stroke or transient ischemic attack (TIA) with prevalence of approximately 70%.[1] Obstructive sleep apnea (OSA) makes up the vast majority of SDB in this patient group, although central sleep apnea (CSA) is also seen in a small percentage.[1] The similar prevalence of OSA in stroke and TIA patients[2] suggests that OSA is likely present prior to the stroke or TIA, as opposed to a direct result of neurological compromise.

Importantly, OSA can increase the risk of incident stroke or TIA. Meta-analysis of prospective cohort studies demonstrated an approximately two-fold increase in the odds of subsequent ischemic cerebrovascular events in those with OSA.[3] OSA is an independent risk factor that persists despite control for other relevant vascular comorbidities[3-7] including atrial fibrillation.[3] Initially, the risk appeared isolated to men;[3] however, more recent work that targeted female populations confirms this finding in women.[6,7] Greater risk is seen with higher degrees of OSA severity.[8,9]

Conversely, treatment of OSA may ameliorate the risk of future stroke.[6] However, randomized controlled trials to determine the effect of continuous positive airway pressure (CPAP) for primary prevention of stroke in OSA patients are limited and have reported negative results.[10,11] Insufficient sample size and poor CPAP adherence noted during these studies may be the

driving factor behind similar incident cardiovascular events in individuals randomized to CPAP compared to controls.[10,11]

In patients who have already experienced stroke or TIA, treatment of OSA can improve outcomes; therefore rapid diagnosis is crucial. Symptoms suggestive of OSA in general also apply to this population and include: snoring, choking, gasping, witnessed apneas, poor sleep quality, excessive daytime sleepiness, and fatigue.[12] Clinical characteristics such as male gender, obesity, upper airway anatomy that may predispose to obstruction, atrial fibrillation, and hypertension should increase the index of suspicion.[1,12-14] Features specific to stroke patients such as recurrent stroke and unknown etiology of stroke increase the likelihood of OSA.[1] In the acute inpatient setting, unexplained hypoxia may be the result of OSA.[15] Given the poor predictive value of tools using signs and symptoms, suspected OSA must be confirmed by diagnostic testing. Especially given that stroke patients with OSA may not report excessive daytime sleepiness and are more likely to be female and non-obese.

Diagnostic testing may be conducted even in the acute post-stroke setting as soon as the patient is able to tolerate the evaluation and can be performed with polysomnogram (PSG) or split-night PSG. In a split-night PSG, CPAP therapy is started if OSA of sufficient severity is seen during the initial diagnostic segment (often 2-3 hours). The potential for comorbid CSA in stroke patients makes home sleep apnea testing less desirable than gold-standard PSG.[16] OSA is defined as 5 or more obstructive respiratory events per hour of sleep on PSG or 5 or more respiratory events per hour of recording time on home sleep apnea testing, as these limited sensor devices often lack a sleep measure such as electroencephalography.

In stroke patients, OSA has the potential to delay neurological recovery, prolong hospitalization, and increase the risk of recurrent stroke or death, while treatment with CPAP may improve neurological recovery and cognition, reduce subsequent vascular events, and decrease sleepiness and depression.[17-19] The benefits of treating OSA in general, and the possibility of specific gains in this population, warrant the initiation of CPAP. CPAP is the gold-standard of treatment for OSA and uses positive pressure to overcome recurrent airway obstruction.[20] The clinician may initiate CPAP even in the acute post-stroke setting and most investigations demonstrate adequate patient adherence to therapy.[17] CPAP titration, either full night or during the second portion of a split-night polysomnogram, is indicated to determine the optimal pressure setting to resolve obstructive respiratory events.[20] The patient should undergo a CPAP titration as soon as possible after stroke to guide therapy; however, given many centers lack the ability to conduct inpatient CPAP titration studies, auto-titrating CPAP is a promising therapy that requires further investigation.[18,21] Many sleep centers are open-access sleep centers, which allows primary care clinicians to order sleep studies without the patient undergoing a consultation by a sleep medicine physician. However, patients with multiple medical problems may benefit from the care of a board certified sleep medicine physician to guide the evaluation, diagnosis and treatment for sleep problems within an American Academy of Sleep Medicine (AASM) accredited sleep center (clinics and sleep lab).

Stroke patients may possess characteristics that pose a challenge to effective treatment of OSA. Neglect and greater stroke severity reduce CPAP adherence.[22] Additionally, cognitive difficulties, apathy, upper extremity weakness, facial droop, and increased oral secretions may lead to difficulty operating the CPAP machine and wearing the CPAP mask interface. Patient and caregiver education and support is critical to ensure successful OSA treatment.

Lifestyle modifications such as weight loss, avoidance of alcohol and other sedatives, and non-supine sleeping positions are recommended in addition to CPAP, but are not typically successful as sole therapy in the general SDB population.[20] Alternatives to CPAP such as mandibular advancement devices, surgical interventions, and hypoglossal nerve stimulation, which are effective treatments for OSA, have not been investigated specifically in stroke patients.

In summary, OSA is common in patients who have experienced stroke or TIA and may increase the risk of future stroke or TIA. Given the high prevalence and negative association with desirable outcomes, clinicians should have a low threshold to order diagnostic testing for OSA in this patient population. Treatment of OSA with positive airway pressure (CPAP, BPAP, or other indicated modalities) is both feasible and effective in individuals with stroke and TIA. Positive airway pressure should be initiated at the earliest opportunity to reduce symptoms attributable to sleep-disordered breathing and possibly improve recovery after stroke.

CASE FOLLOW-UP

The patient was referred to a local sleep center. After a thorough clinical sleep consultation, he underwent a split-night polysomnogram. He was found to have an apnea-hypopnea index of 43 events/hour during the diagnostic portion of the study with oxygen desaturations to a nadir of 76%. CPAP set at 14 cm of water was found to effectively treat his OSA and therapy was initiated for home use.

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This article was developed through the National Healthy Sleep Awareness Project, a joint effort of the Centers for Disease Control and Prevention (CDC), American Academy of Sleep Medicine (AASM) and the Sleep Research Society (SRS). Visit www.sleepeducation.org for more information. This article was supported by the cooperative agreement number 1U50DP004930-04 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

This Skin I'm In:

Subcorneal Pustular Dermatosis Diagnosis and Treatment

Anisha Turner, MD and Tammy Davis, MD

Case Report

History of Present Illness
38 year old male presents to skin clinic for evaluation of rash. He reports that he has been having random pustules appear on his body over the course of 15-20 years. Over the past ten years, the appearance of pustules ha been more frequent and occasionally coalesce. They are pruritic but never painful. Upon scratching the pustules de-roof and come scaly hyperpigmented areas. He noticed that a short course of steroids improved the symptoms temporarily. He denies other symptoms.

Past Medical History
Brain surgery 2/2 unknown brain tumor type, CVA

Pertinent Physical Examination
Skin: Various crops of flaccid pustules measuring approximately 1-2 millimeters in diameter involving the flexural areas of the trunk and proximal extremities, some ruptured/de-roofed; various pustules coalesce and often form circinate and bizarre serpiginous patterns of scale/crust surrounding hyperpigmented skin. No mucosal, facial, scalp, or palmar involvement.

Differential

- Subcorneal Pustular Dermatosis
- Pustular Psoriasis
- IgA Pemphigus
- Bullous Impetigo
- Eosinophilic Pustular Folliculitis
- Dermatitis herpetiformis
- Pustular Drug Eruption

Work-Up

- Skin Bacterial Culture: sterile eruption unless secondary bacterial infection is present
- Skin scraping/fungal culture: sterile unless superimposed fungal infection is present
- Skin Biopsy: Subcorneal vesicles filled with numerous neutrophil with occasional eosinophils extending to epidermis and upper dermis.

Treatment

Prior to treatment, one should collect the following:
- Serum protein electrophoresis (association is well documented)
- CBC (evaluate polycythemia, neutropenia, or lymphopenia seen with rheumatological conditions associated with SPD)

Treatment: There are multiple treatment options:
Dapsone (treatment of choice)
Acitretin (alternative treatment)
Treatments from anecdotal case reports (infliximab, tacalcitol, minocycline, tetracycline, vitamin E, cyclosporine, azithromycin, colchicine, adalimumab)

Prognosis

- It is chronic and relapsing but benign.
- Because relapse is common on withdrawal of therapy, the drug is usually continued long term, with gradual decrease to the lowest required dose after control of symptoms.

Patient Course

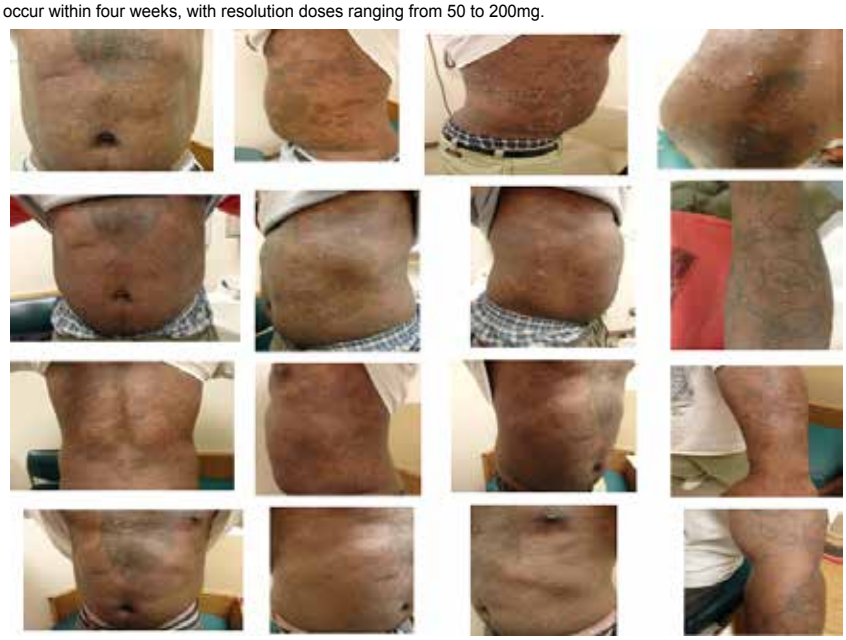
According to literature, Resolution of cutaneous manifestations often occur within four weeks, with resolution doses ranging from 50 to 200mg.

WEEK 0
- Prior to treatment
- Started on Dapsone 25mg

WEEK 2
- Result on Dapsone 25mg
- CBC stable
- Increased to Dapsone 50mg

WEEK 4
- Result of Dapsone 50mg
- CBC stable
- Increased to Dapsone 75mg

WEEK 8
- Patient had self-increased medication to Dapsone 100mg
- CBC stable
- Continued on Dapsone 100mg



Dapsone Key Features

Prior to dapsone initiation, the following tests should be performed:
- G6PD (assess for G6PD deficiency whish is a contraindication to dapsone therapy)
- CBC (to assess hematologic tolerance)
- LFTs (as dapsone can result in abnormal liver function)

After initiation, patient should have the following:
- Monthly CBC and LFTs for the first six months
- Periodic CBC and LFTs after first six months

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Money Sense: Four Big Retirement Risks and How to Prepare for Them

The Lovell Group
Merrill Lynch

Andrew Necaise

You cannot control unexpected events in your life and the markets, but these tips from Merrill Lynch Wealth Management can help you limit their impact.

Some common retirement mistakes—like overspending, investing too conservatively or veering away from your plan—are easy to avoid with a little discipline and forethought. Other risks—like a health crisis or a market downturn—cannot be avoided, but they can be managed. Here are four of the most common dangers to your retirement strategy, and steps you can take to prepare for them.

1. OUTLIVING YOUR MONEY
Thanks to medical advances and healthier lifestyles, Americans are living longer than ever. That is great news, but it also creates the very real possibility that you might outlive your retirement assets—especially when 37% of retirees underestimate their own likely lifespan by five years or more, according to a 2015 study by the Society of Actuaries.

"People look at how long their parents or relatives lived. But life expectancies have grown markedly from one generation to the next," says Nevenka Vrdoljak, director of Retirement Strategies at Bank of America Merrill Lynch.

What You Can Do:
Think about delaying the age at which you claim Social Security. "By claiming at age 70 as opposed to 62, your monthly income goes up by 76%," says Vrdoljak. Though you sacrifice income early on, knowing you will have higher Social Security payments in your seventies and beyond is like having "longevity insurance," she adds.

Find out whether an annuity might be appropriate for you. Investing in a lifetime income annuity could help you avoid the risk of outliving your retirement savings by providing a path to income for as long as you live. Because annuities come with certain costs and risks, be sure to talk to your advisor about all the pros and cons before making a decision.

2. CHANGES IN MARKETS
If there is a significant market drop shortly before or early in your retirement—just as you are starting to tap into your assets—the value of your investments could shrink to an extent that undermines your retirement security. Even if the market subsequently improves, "If the first four or five years of your retirement are bad, it can be difficult to recover," Vrdoljak says.

What You Can Do:
Take a second look at the way you invest. As you near retirement, shifting to a more conservative investment approach may help protect against market downturns. At the same time, it is important to maintain some exposure to stocks to create a suitable balance.

3. INFLATION
Although quite low in recent years, inflation—even a modest percentage—reduces your spending power over time. People living in retirement are especially vulnerable. Over a 25-year period—probably a reasonable expectation for the length of your retirement—a relatively low inflation rate of 2.5% can bring the value of every $100,000 saved down to about $54,000, according to calculations by Merrill Lynch.

What You Can Do:
Consider investments that could grow along with inflation. "That might be real estate or shares of stocks," Vrdoljak says. If you have bond holdings, you may want to consider adding some Treasury Inflation-Protected Securities (TIPS). These government bonds offer returns that vary with the inflation rate. When interest rates go up, bond prices typically drop, and vice versa. "If inflation accelerates for whatever reason, you get compensated for that," Vrdoljak notes.

4. RISING MEDICAL EXPENSES
"When it comes to financial planning, people do not systematically plan for health care risks," Vrdoljak says. According to the U.S. Department of Health and Human Services, almost 70% of Americans over 65 will at some point need long-term care—which can include not just residence in a care facility, but help with daily activities like bathing or assistance with household chores. Even without such costs, it is likely that your health spending will increase as you age—and it is important to note that Medicare does not fully cover these costs.

What You Can Do:
Plan early for long-term care. Some people may be able to pay for out-of-pocket long-term care or are able to rely upon grown children or a relative for assistance. But for many others, long-term care insurance may be the answer. If you do choose long-term care insurance, try to purchase it in your fifties or early sixties—well before you need it. The cost rises as you age and may not be available if you develop certain medical conditions.

Best wishes in your practice's continued success,
Andy Lovell, Drew Necaise and Michael Minvielle
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Scholarships Available to Attend the National Conference for Family Medicine Residents and Medical Students

August 2-4, 2018
Kansas City, Missouri

Application Deadline: May 1st

The 2018 AAFP National Conference of Family Medicine Residents and Medical Students will take place August 2–4 in Kansas City, MO. Past attendees consistently rate this event as an invaluable opportunity because of the practical sessions, networking, and chance to learn more about family medicine.

The AAFP Foundation offers awards to help students and residents attend National Conference and improve their leadership skills. Family Medicine Leads Scholarships provide 220 awards valued at $600 each. This financial assistance helps offset expenses such as registration, travel, lodging, and meals. **The application deadline is May 1.** Note: The categories have changed. Please review carefully.

Eligibility Requirements

- You must be a member of the American Academy of Family Physicians (AAFP) to apply. New or lapsed memberships may require a minimum of two business days to process. Please plan accordingly as late applications will not be accepted.
- You may only apply to one scholarship category each year (i.e. if you apply for Student Primary Care Champion this year, you may not also apply for FMIG Leader this year).
- You are not eligible to apply if you previously received a National Conference scholarship from the AAFP Foundation (excluding Emerging Leader Institute).
- Scholarships are based on your status during the 2018-19 academic year. Please apply to scholarship categories accordingly.
- You must be able to attend the entire National Conference (defined as arriving no later than noon on Thursday, August 2, and leaving no earlier than noon on Saturday, August 4).
- You must agree to the *Family Medicine Leads Scholarship* Agreement.

The required online application must be completed and submitted to the AAFP by May 1, 2018. Winners will be notified by May 31.

Scholarship Categories

- Early Career Student (Rising M1-M3)
  You must be a M1-M3 student during the 2018-19 academic year to apply. You are not eligible if you will graduate before July 1, 2019.
- Student (Rising M4) or Resident Primary Care Champion
  To apply for the student scholarship, you must be a M4 student during the 2018-19 academic year. You are not eligible if you will graduate before July 1, 2018.
- **Family Medicine Interest Group (FMIG) Leaders**
  You must be a medical student during the 2018-19 academic year to apply. You are not eligible if you will graduate before July 1, 2018.

Do you have a LinkedIn account? Import your profile on the LAFP Career Center!

You can now upload your LinkedIn profile on the LAFP Career Center! Save your time and energy for something else, like searching for your next career from the number of open jobs posted on the LAFP Career Center. Here's what to do:

1. Register for a job seeker account on the LAFP Career Center. If you are already registered, log in using your current career center credentials.
2. Click on "Manage Resumes."
3. Under "Create a new resume," click "Sign in with LinkedIn."
4. Sign in with your LinkedIn credentials when prompted.
5. Review the information imported into your resume profile on LAFP Career Center and save!

Make sure you set your resume as "public" to increase your chances of landing your dream job. Employers search the Resume Bank daily for candidates like you. Don't worry, your contact information will not be given to employers unless you release it.

Do you have big ideas for the LAFP? Want to help get the momentum going?

Don't be a bored member.
Become a Board Member.

For many years, the LAFP has continued its mission in promoting and supporting the specialty of Family Medicine as well as fostering philanthropic and educational goals. The objective of the LAFP Board of Directors is to not only keep this mission alive—but to keep up with the changing times, and to maximize the potential of our incredible membership upon which the organization was founded.

Therefore...as 2018 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 **April 1, 2018**. The following positions are up for re-election:

- President-Elect
- Vice President
- Secretary
- AAFP Delegate
- AAFP Alt. Delegate
- Speaker
- Vice Speaker
- District 2 Director
- District 2 Alt. Director
- District 3A Director
- District 3A Alt. Director
- District 3B Director
- District 3B Alt. Director
- District 6A Director
- District 6A Alt. Director
- District Director At Large
- Alt. District Director At Large

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.**

Mark your calendars to join us this summer at the beach for our 71st Annual Assembly and Exhibition. Details are underway as we plan our annual in state members meeting.

Registration
The full registration fee covers CME offerings, daily continental breakfasts and coffee breaks, as well as one complimentary ticket to the social events. Registration rates include a member discount and non-members rates. There is also an optional fee for guests and daily registrations to attend the CME.

CME sessions will begin at 8:00 am every day and last until lunch or right after. Breakfast will be served in the exhibit hall each day beginning at 7:00 am. Daily breaks are offered as well as lunch on Thursday and Friday. And you don't want to miss the "Boot Scootin' Boogie" Foundation Auction & President's Party on Friday.

Registration Fees

Member Type	THU	FRI	SAT	SUN	FULL
LAFP/AAFP ACTIVE MEMBER	$125	$125	$125	$125	$500
NON-MEMBER	$150	$150	$150	$150	$550
LAFP/AAFP LIFE MEMBERS	$75	$75	$75	$75	$275

NOTE: Refunds, less a $100 Administrative Fee will be made upon receipt of written request until May 5, 2018.

Accreditation:
This program is being reviewed for Prescribed Credits by the American Academy of Family Physicians. This includes evidence based credit. AAFP Prescribed Credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA Category 1 Credit toward the AMA Physician's Recognition Award. When applying for the AMA PRA, prescribed credit earned must be reported as prescribed credit not as Category 1.

Program Objectives:
This activity is designed for the specialty of family medicine, but may also be of educational interest to the specialties of internal medicine, pediatrics, and other primary care fields. It is designed to introduce providers to the latest information, techniques, and technology applicable to office-based patient care through didactic lectures and interactive discussions. Upon completion of this program, participants should have a working and applicable comprehension of these topics. Specific objectives for each topic will be included in the participant syllabus.

Accommodations:

We are proud to designate SanDestin Baytowne Conference Center as our conference headquarters. A block of guest rooms is being held for the conference until **June 2, 2018** or until the guest room block is full. Studio accommodations start at $216/night plus tax and up to 3 bedroom condos are offered.

Reservations may be made by calling (800) 320-8115 or online at www.SanDestin.com and enter group code 23K17C. Guests may also reserve by fax at (850) 267-8221. The reservation code is: 23K17C, Louisiana Academy of Family Physicians 2018.

Questions:
Visit www.lafp.org for additional information or contact the LAFP at info@lafp.org or (225) 923-3313.

The LAFP Hosts the CONNECT FamMed Spring Summit in New Orleans

LAFP brought back a mid-season CME conference this year that was held at the Westin Canal Place in New Orleans. The small-scale conference was kicked off with the New Orleans Area Grand Rounds Crawfish Boil, which also served as the Welcome Reception. The crawfish, shrimp and accompaniments were overflowing. Guests enjoyed a cool evening out on the terrace watching the moon reflect on the Mississippi River and boats passing by.

The sessions kicked off the next morning with Dr. Burton Brodsky on behalf of a grant from Myriad Genetics. This lecture was so well-received, we're having him back for the Annual Assembly! Other topics were centered around what a family physician needs to know – diabetes, opioid use, cancer-focus, cardiovascular update, Inflammatory Bowel Disease, HIV prevention, pharmacotherapy and more. Great feedback was received from all the sessions!

The residents and students also had their own track for Saturday. These sessions focused on what medical school students with a focus on Family Medicine and Family Medicine residents find pertinent in their up-and-coming careers. Lectures included creating their own practice, networking, the matching process, personal and professional finances and more and were topped off by two hours filled with hands-on workshops. Special thanks to the Family Medicine Residency Programs that hosted these workshops that included, joint injections, continuous glucose monitoring, video otoscopy, suture workshop, splinting and shoulder exams.

The Career Fair & Expo served as a great location for networking with Family Medicine Residency Programs as well as medical industry leaders. Exhibitors and attendees chatted during breakfast, lunch and an evening reception along with breaks throughout the day on Saturday. The smaller scale proved to be a productive atmosphere.

Thank you to all that attended the Spring Summit. We hope to bring more opportunities for continuing medical education to you along with opportunities to network with companies that span the wide field of family medicine.







Make Plans to Attend LAFP's 2018 General Assembly

General Assembly

Louisiana Academy Family Physicians

As a member of the LAFP, you are encouraged to, attend and participate in the LAFP's 2018 General Assembly, which will convene on Friday, July 6, 2018. The General Assembly will be held in conjunction with LAFP's 71st Annual Assembly and Exhibition at the Sandestin Golf and Beach Resort in Destin, FL.

2018 CALL FOR RESOLUTIONS

LAFP members may present resolutions for debate, which set the direction for the Academy in the coming year. Any LAFP member can submit a resolution for vote. If you wish to submit a resolution, it must be submitted, in writing, to Ragan LeBlanc, Executive Vice President of the LAFP at least thirty (30) days prior to the General Assembly (No later than June 6, 2018).

Resolutions cannot be submitted from the floor except by an affirmative vote of two-thirds of the members of the General Assembly present and voting.

Any resolution submitted from the floor and accepted for presentation must be submitted in writing to the Speaker of the General Assembly, Dr. Derek Anderson. To learn more about writing a resolution, or to complete form, please visit the LAFP website at www.lafp.org . **Remember, the deadline to submit resolutions to the LAFP is no later than June 6, 2018.**

Bylaws and Amendments to Bylaws

Any five or more members may propose bylaws or amendments of bylaws. Such proposals must be submitted to Ragan LeBlanc, LAFP's Executive Vice President, at least sixty (60) days prior to any regular or special meeting of the General Assembly, and notice shall be given to all members at least thirty (30) days prior to the meeting at which the proposals are to be voted upon.

An affirmative vote of at least two-thirds of the members present and voting shall constitute adoption. Amendments shall take effect immediately upon adoption unless otherwise specified. For more information, please contact Ragan LeBlanc at rleblanc@lafp.org or call 225.923.3313.

Please visit the LAFP website, www.lafp.org, for more information and continued updates.

Have You Reported Your CME???

The 2018 CME Re-election deadline is 12/31/2018 and will be here before you know it! To determine your re-election cycle or to view/update your transcript, please visit www.aafp.org/mycme. Remember – only CME hours earned during your three-year cycle are applicable and consists of earning at least 150 credits with a minimum of 75 Prescribed credits and 25 credits from live learning activities.

If you are in the 2017 re-election cycle, you have till March 31st to report your CME at www.aafp.org/mycme for continued access to these benefits:

- Exclusive CME reporting, tracking, and planning
- Access to evidence-based clinical practice guidelines, coding and privileging tools, and practice support consultations
- Significant discounts on high-quality, specialty-specific CME
- Advocacy for your specialty at the state and national levels

Remember to report your CME to the AAFP. They will automatically inform the ABFM once you meet its CME requirements. It's one less thing to worry about, and it's one of the reasons CME reporting is the AAFP's top-rated services.

Please email us at contactcenter@aafp.org or call us at (800) 274-2237 with your questions. Thank you for your ongoing membership, it is our pleasure to serve you!

Types of Credit

Prescribed Credits include completing a fellowship, teaching*, participation in a research study, most life support courses, and most activities produced by the AAFP including online quizzes from American Family Physician and Family Practice Management, and CME Bulletin products.

Elective Credits include activities approved for the American Medical Association (AMA) Physician's Recognition Award (PRA) Category 1 CreditTM or American Osteopathic Association (AOA) credit, taking a Board certification exam, or even attending medical staff or medical society meetings.

Live Activities take place in real time, involve two or more physicians, and are either Prescribed or Elective credits such as medical seminars or conferences including the AAFP Scientific Assembly, lecture series, or life support activities (ACLS, ATLS, BLS, NALS, PALS, etc).

Other activities that may be eligible for CME credit include advanced training, clinical research, scholarly work, or medical writing or editing (there may be some limits on the number of credits from these types of activities applied to each re-election cycle.)

*A maximum of 60 Prescribed credits can be applied during a three-year re-election cycle for teaching medical students, residents, physicians, physician assistant students, physician assistants, nurse practitioner students, nurse practitioners, nursing students, or nurses in formal individual or live educational formats. Teaching is also considered a live activity.

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LOUISIANA HOSPITAL ASSOCIATION

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LAFP Calendar

SAVE THESE DATES

March 12, 2018
Louisiana Legislative Session Convenes

April 26-28, 2018
AAFP Annual Chapter Leadership Forum/National Conference of Constituency Leaders
Sheraton Kansas City at Crowne Center
Kansas City, MO

May 2, 2018
White Coat Day at the Capitol
State Capitol
Baton Rouge, LA

May 21-22, 2018
Family Medicine Congressional Conference
Washington Court Hotel
Washington, DC

June 4, 2018
Louisiana Legislative Session Adjourns

August 2-4, 2018
AAFP National Conference of FM Residents & Medical Students
Kansas City Convention Center
Kansas City, MO

July 3, 2018
LAFP Board Meeting
TBD
Destin, FL

July 5-8, 2018
71st Annual Assembly and Exhibition
Sandestin Golf & Beach Resort
Destin, FL

July 6, 2018
General AssemblySandestin Golf & Beach Resort
Destin, FL

October 8-10, 2018
AAFP Congress of Delegates
Hilton New Orleans Riverside
New Orleans, LA

October 9–13, 2018
AAFP FMX
Hilton New Orleans Riverside
New Orleans, LA

October 25-27, 2018
AAFP State Legislative Conference
TBD
Fort Lauderdale, FL

The LAFP Honors E. Edward Martin, Jr., MD, MS During the New Orleans Area Grand Rounds

Almost 20 years ago, E. Ed Martin, Jr, MD, MS, helped start a regular forum of local Family Medicine physicians, Medical School Departments of Family Medicine and Family Medicine Residency Programs to promote unity and camaraderie in the Family Medicine community around the state. This Spring has brought the first meetings of the Baton Rouge/Lafayette and New Orleans areas since Dr. Ed Martin's passing late last year. Both districts have been successful in these quarterly socials for many years due to the initiative and dedication of Dr. Martin.

His involvement with LAFP was birthed in the 1990's soon after his return to Louisiana. From President of the LAFP and recipient of the Family Physician of the Year Award, Dr. Martin's excellence in Family Medicine and proven leadership advanced the role of the family physician in today's healthcare landscape. Martin also was a longtime Board Member for the LAFP Foundation.

Now, his legacy will live on with an award in his name given annually to a deserving Ochsner Queensland student who is on the path to becoming a Family Physician. This award was named the E. Edward Martin, Jr., MD Family Medicine Award as approved by the LAFP Foundation Board of Directors prior to his passing and was given to its first recipient at the graduation this past fall.

It was an honor to pay tribute to Dr. Ed Martin—a friend, colleague, teacher, husband, father and wonderful physician. In whatever role we knew him, from whatever vantage point, he stood apart as someone special.

Eligible Primary Care Provider Types

- ✓ *Family Medicine*
- ✓ *Internal Medicine*
- ✓ *General Practice*
- ✓ *Geriatrics*

Hundreds of primary care doctors are discovering the value of Quality Blue Primary Care. This program offers primary care doctors tools, data and resources to help improve patient outcomes. Physicians enrolled in the program are rewarded for these improvements—and are paid a monthly care management fee on top of their usual fee-for-service amount.

Quality Blue is making measurable improvements in the lives of Louisianians – while keeping costs in line.

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Louisiana | Quality Blue PRIMARY CARE

Legislative Report

Joe Mapes
LAFP Lobbyist

Just days before spring officially comes, the Louisiana legislature meets for its annual session. Being an even-numbered year, it's a regular session and not a fiscal session. That means bills can be filed related to any issue, not just the state's fisc as is allegedly the case in a fiscal session. Each legislator can pre-file as many bills on any subject that they want to file, up to the pre-filing deadline. After that, each legislator can file 5 more bills during the session. There are 144 legislators, so there will be several thousand bills filed during the session.

Some of these bills will be good for the practice of family medicine in Louisiana, and some bills will be bad for family medicine. Some of you may remember Senate bill 75 from last year's session authored by Senate Health and Welfare Chairman Fred Mills. The bill would have abolished many healthcare boards, including the LSBME, and merged them into one, giant board of governance at the state Department of Health and Hospitals. DHH would then act as the regulator over the practice of medicine in Louisiana. This is a horrible scenario, and it makes one curious as to why such a law would even be pursued. Well, to the victor go the spoils, i.e., all those boards' budgets also get swept into DHH, just at a time when they are being asked to cut their budget. So, LAFP will be waiting in the gap for this bill to be filed again this year, as we fully expect. Another issue that could rear its ugly head is independent practice for NP's. If this happens LAFP, and the entire doctor lobby, will have to join in and help. We've done this before with great success, but only due to your participation. So, stay alert. When you are asked to hit a submit button in an email or a text during the legislative session to influence your legislators, just hit the button. If you're asked to call your legislator, do it with no questions asked. Trust that your association professionals have done the research at the Capitol needed to promote and protect family medicine, and know that. if you're asleep at the switch, you can lose your profession.

Sincerely,
Joe Mapes
LAFP Lobbyist

2018 White Coat Day at the Capitol

Wednesday, May 2nd – 9:00 a.m. to 4:00 p.m.

Louisiana State Capitol Rotunda

The LAFP invites you to participate in the Annual White Coat Day at the Capitol in Baton Rouge on Wednesday, May 2, 2018.

This opportunity will allow you to join colleagues at the state capitol, gain information about the issues affecting family medicine and your patients and dialogue with state legislators and administration officials.

White Coat Day allows family physicians to discuss salient healthcare issues with Louisiana legislators and relay the issues that affect their patients on a daily basis. You'll spend the day hearing from legislators, agency heads and the Governor's staff about relevant issues. YOU are the voice for your patients: **the LAFP is calling on you to make a difference.** Register today at www.lafp.org.

Event Details:
White Coat Day is designed to provide free health screenings to legislators while discussing important issues and concerns affecting the health of your patients.

Participants in White Coat Day will:

- Make a difference for the future of family medicine
- Learn about the challenges health care issues face today
- Inform legislators about the issues important to you and your patients
- Attend committee hearings and House and Senate sessions

Lunch will also be provided.

*Schedule is subject to change and will be updated as the event approaches.

Why Support Your PAC?

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.

Visit **www.lafp.org** today to DONATE!

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**

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
Richard Bridges MD
Kenneth Brown, MD
Christopher Foret MD
Jody George, MD
Wayne Gravois, MD
Jonathan Hunter, MD
Daniel Jens, MD
Alan LeBato, MD
Brandon Page, MD
Bryan Picou, MD
Marguerite Picou, 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.

The Foundation for the Future of Family Medicine

Towards the end of last year, the LAFP Foundation sent out a donation campaign requesting donations for some upcoming initiatives for 2018. Your donation to the LAFP Foundation has a purpose! It's ***"Building the Future of Family Medicine"*** with every dollar collected.

Resident & Student Conference

The Resident and Student Track at the CONNECT FamMed Spring Summit held March 3rd, 2018 was a day full of education sessions, hands-on workshops and networking with industry leaders for those that are the future of the medical industry. Leadership opportunities, practice management, interviewing skills and contract negotiation were just a few of the topics discussed. This annual conference cannot be held without the generous support of our membership.

Annual Raffle

The LAFP Foundation is bringing back the raffle again this year…. except we cut the ticket price and added MORE prizes! Can you believe it?!?! Tickets are just $50 this year. Top prize will be $1,500 CASH. You can also grab a 7-day cruise on the Carnival Dream out of New Orleans, 50" Samsung Ultra HD SmartTV, Beats by Dre Headphones, iPad and more! There are only 500 tickets up for sale so be sure to get your tickets before they sell out! Call the LAFP Office to purchase your tickets at (225) 923-3313 or visit www.LAFP.org/Foundation to purchase online and tickets will be mailed to you. Winners will be announced at the Foundation Auction & President's Party on Friday July 6th, 2018. Need not be present to win!

Live Auction

We will also be hosting the Live Auction at the Foundation Auction & President's Party on Friday evening of the Annual Assembly, July 6th. Join us for a "Boot Scootin' Boogie" and bid on your favorite items to take home. If you have an item you would like to donate, please contact Emily at the LAFP office at (225) 923-3313 or e-mail efink@lafp.org. You can see what items are up for bid at www.LAFP.org/Foundation.

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 a successful 2018!

Investing In Care Pays Off

QUALITY THAT PAYS IN PRACTICE

In February 2015, Louisiana Healthcare Connections, one of the state's largest Medicaid Managed Care Organizations with over 475,000 members, launched an incentive program for network Primary Care Physicians (PCPs). The program incentivizes improvements in key quality areas such access to preventive care services for the state's most vulnerable patients.

A MODEL THAT WORKS

Using the feedback of Louisiana's PCPs, Louisiana Healthcare Connections built its incentive model on clearly defined quality measures and financial incentives. Every targeted measure is data-driven and based on the specific healthcare needs of Louisiana's complex Medicaid population.

One component of the program is centered on achieving improvements in Healthcare Effectiveness Data and Information Set (HEDIS) measures such as adolescent well care, chlamydia screenings and comprehensive diabetes care - all areas in which Louisiana has historically ranked poorly. For meeting the designated targets, PCPs receive a Per Member Per Month (PMPM) incentive.

Another component enables PCPs to earn increased rates for providing after-hours care, and rewards physicians for tasks such as notifying the health plan when a member becomes pregnant and performing key health screenings for members.

To support providers in achieving quality targets and closing care gaps, Louisiana Healthcare Connections provides a comprehensive set of tools and resources, including access to timely, actionable data reports related to Emergency Department (ED) utilization, HEDIS measures and incentive targets.

Further, the health plan employs a statewide team of provider consultants who work one-on-one with physicians to provide support for quality improvement efforts and education about resources for both providers and members.

In addition, the health plan conducts free provider education and training opportunities throughout the year, across the state, to increase program awareness and engagement.

RESULTS THAT MATTER

The results of the investment in Louisiana's physicians are clear. Since 2015, adolescent well care visits and chlamydia screenings have each increased by nearly six percent. Well child visits for children ages three-six and adult access to preventive care have increased by three percent each.

These quality improvements were achieved while simultaneously supporting providers in delivering care to a Medicaid Expansion population that includes hundreds of thousands of residents who previously lacked access to preventive services and continuity of care.

Partner with the plan that pays for quality.
LaHealth.cc/earnmore

These achievements contributed to Louisiana Healthcare Connections being awarded Commendable Accreditation status from the National Committee for Quality Assurance (NCQA) in 2017 for demonstrating outstanding operations and clinical performance, and scoring near perfect in member satisfaction.

INCENTIVES WORK

Louisiana Healthcare Connections has demonstrated that a data-driven incentive model yields quality improvements, better outcomes for patients, and significant savings for the state.

One of the most critical components in transforming the health of Louisiana is a strong partnership with the state's physicians. An investment in quality-focused physicians is an investment in the health of Louisiana—and it's clearly a sound investment.

QUALITY MEASURE	2015	2017
Chlamydia Screenings	57.5%	63.3%
Adolescent Well Care Visits	39.4%	45.2%
Well Child (3-6 years)	57.5%	60.4%
Adult Access	81.3%	84.2%

TABLE 1: Louisiana Healthcare Connections invests in primary care physicians to achieve key quality improvements for the state's Medicaid population.

louisiana healthcare connections™

LouisianaHealthConnect.com

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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Rachel Wissner, MD
Jami Zachary

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 2018!

THE STRENGTH TO HEAL

and focus on what's really important: my patient.

As a family practice physician on the U.S. Army Health Care Team, you don't have to worry about operational burdens such as overhead costs, malpractice premiums or patient billing. Instead, our physicians get to focus on what they were educated to do – treat patients to the very best of their abilities.

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VITAMIN D
Helps build and maintain strong bones and teeth

VITAMIN B_3 (NIACIN)
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VITAMIN A
Helps keep skin and eyes healthy; helps promote growth

VITAMIN B_5 (PANTOTHENIC ACID)
Helps your body use carbohydrates, fats, and protein for fuel

VITAMIN B_{12} (COBALAMIN)
Helps with normal blood functions; helps keep the nervous system healthy

VITAMIN B_2 (RIBOFLAVIN)
Helps your body use carbohydrates, fats, and protein for fuel

PHOSPHORUS
Helps build and maintain strong bones and teeth; supports tissue growth

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Highest Achievement in DIABETES CARE:
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Highest Achievement in HYPERTENSION CARE:
East Jefferson Primary Care

Highest Achievement in VASCULAR CARE:
Bossier Family Medicine

Highest Achievement in KIDNEY CARE:
The Family Doctors *(Shreveport)*

To see the full list of top-performers, including more than 275 individual primary care doctors, visit **www.bcbsla.com/QBPC**.

Louisiana | Quality Blue PRIMARY CARE

Together, we are improving the health and lives of Louisianians.