LOUISIANA FAMILY DOCTOR

An Official Publication of the Louisiana Academy of Family Physicians

Summer 2018

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Edition 34

A Message from the President

Jonathan Hunter, MD
LAFP President

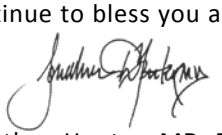
Three years have passed since our legislature passed Act 261: the ostensible welcome mat for medical marijuana in the state of Louisiana. Its wording set forth the scaffolding by which cannabis is to be manufactured and dispensed by members of the agricultural, pharmacy, and medical communities. Patients are begging. Budgets are constrained. Many other parts of the country are already far ahead of us in this effort. But we are not Colorado. Or Oregon. Or…California. Since passage, increased legislative and social momenta have begun to ratchet up the pressure on all of the involved entities to finally provide what appears to be more innocuous than previously thought—and what may be far more useful than medicine has yet to fully discover.

Shall we go ahead and acknowledge the downside—albeit a very significant downside—up front. Marijuana is an intoxicant. And not only is it an intoxicant, it is the most commonly used intoxicant in the world. It is widely considered to be the "gateway" substance to a litany of much more malicious enemies to the health of our culture. Next to alcohol, marijuana is the second most commonly found substance in drivers involved in fatal motor vehicle accidents. Its use is associated with psychomotor retardation, infertility, birth defects, and lung cancers. Its use by teens can lead to a decrease in future IQ. Patients with underlying psychiatric conditions can experience worsening of psychoses. And next to alcohol, marijuana is the second most common substance for which patients seek medical attention in emergency facilities. So then how could we possibly be taking such efforts to legitimize it?

Well there is an upside, and this is an upside that we as family physicians should dispassionately examine. The National Institutes of Health informs us anecdotally that people have been using cannabis to treat physical ailments for some 3,000 years. Clearly, it has to demonstrate some benefit. While a depth of rigorous, double-blind studies are currently lacking, medical marijuana does appear to show benefit in a cross-section of patients for whom any of us would agree represents a therapeutic challenge. Neuropathic pain secondary to the scourge of multiple sclerosis. Seizures refractory to escalating doses of sedating medications. Cachexia related to AIDS and cancer. I, for one, am weary of resigning defeat to patients and families when these enemies rear their heads in my exam room. And I am equally uncomfortable revving up doses of medications that are squarely associated with physical dependency and risk of overdose—particularly now as so many Americans are losing their lives to opioid abuse.

I will be the first to say that my mind is not made up. The fact remains that marijuana is still illegal in the eyes of the federal government regardless of what Baton Rouge has proclaimed. Louisiana's family physicians, I doubt, will break speed records to obtain the right to "recommend" medical marijuana for fear of any resulting retribution—irrespective of what we may conclude as to its efficacy. But I will also say that we should examine the data as it emerges, divorced of the stigma associated with recreational use. Indeed, we may find a therapeutic tool that our arsenal has been sorely lacking for decades.

As I write this article, my tenure as your Academy President is drawing to its finality. This has been a rewarding year, and I am honored to have served with each of you. I wish to thank you again for the work that you get up and do every day for the people of Louisiana, and I am once again proud—truly proud—to be one of you. May God continue to bless you and our LAFP!



Jonathan Hunter, MD, FAAFP
President

A Message from the Secretary

Mary Thoesen Coleman, MD, PhD
LAFP Secretary

LAFP members:

In this, issue, I am taking the opportunity to reflect on the effect of hunger on child health and things we can consider as doctors to address it.

Let us look at a few facts. More than 15 million American children live in homes plagued by hunger. 42 million Americans may be unsure where to find their next meal. In Louisiana, 17 percent of the population is food insecure --804,500 people, including 272,760 children. (Map the Meal Gap, 2017). One in four Louisiana children live in families struggling to put food on the table. One in 20 Louisiana households report skipping meals because they do not have enough money for food. In several rural Louisiana parishes, one-third of children are food insecure. Hunger affects every parish and community in Louisiana.

Louisiana ranks 45th in its ability for children to access food during the summer when students are not able to get free or reduced priced breakfast and lunch at schools. (Food Research and Action Center). Only 8.9% of students who receive meals during school year get free summer meals.

According to the USDA, Low food security manifests by reports of reduced quality, variety, or desirability of diet with little or no indication of reduced food intake. The designation of Very Low Food Security results from reports of multiple indications of disrupted eating patterns and reduced food intake. The LSU Department of Family Medicine recently surveyed a sample of families with children (approximately 300) across its clinical sites (Kenner, Bogalusa, New Orleans, Lake Charles, and Lafayette) and found that between 16.6 and 28.5 % of families reported low or very low food security.

As physicians, we are aware that hunger has health consequences. Those who suffer from hunger are sick more often, slower to recover from illness, are hospitalized more frequently, experience poorer health, and have lower bone densities. Ke and Ford-Jones reported in Pediatric Child Health, 2015 that Food insecurity and Hunger increase the risk of weakened infant attachment to parents in infants. In children, food insecurity and hunger result in poor performance on language comprehension tests and inability to follow directions, delay socioemotional, cognitive and motor development, cause higher levels of hyperactivity/inattention and poor memory, increase the frequency of chronic illnesses including childhood obesity. Youth have a higher incidence of depression and suicidal ideation as well as mood, behavior, and substance abuse disorders. Mothers are at increased risk for maternal depressive disorders, lifetime diagnosis of post-traumatic stress disorder or substance abuse and a higher likelihood of demonstrating unresponsive caregiving practices.

What can physicians do? These facts and findings raise the question of whether family physicians should screen all families to determine if they are getting enough to eat. One available screening tool is the Hunger Vital sign which asks “Are you worried about running out of food and not being able to buy more?” and “Have you actually run out of food and been unable to buy more?” Identifying the problem may lead to discussions about how to make healthy, inexpensive food choices. For example, patients may be asked to avoid added sugars, large quantities of fruit juices, colas, and diet sugars and select instead complex carbohydrates such as whole fruits and high fiber whole grains.

In addition to screening for hunger and food insecurity, physicians can collaborate with the community to address nutrition. Local examples include collaborating with community programs such as Cooking Matters. LSU medical students, enrolled in a nutrition elective sponsored by the Department of Family Medicine, assisting the School of Public Health and Dietary Science in teaching the community how to eat and cook. The LSU Department of Family Medicine is partnering with the YMCA to find ways to increase referrals from primary care to the YMCA Diabetes Prevention program which includes nutrition education. Last year, LSU Family Medicine received funds from the Humana foundation to offer nutrition and exercise programs for children at two school-based clinics at which Dr. Pamela Wiseman sees patients. There are undoubtedly many other examples of opportunities to assist our patients.

Although simplistic, “Food is medicine, food is health” reminds us to think about our patients’ nutrition needs as part of our assessment.

Mary Coleman, MD
LAFP Secretary

Executive Vice President

Ragan LeBlanc
LAFP Executive Vice President

PHYSICIAN HEALTH FIRST

Well-being Planner

Your health before all else

Health care has dominated much of the news for years. Even so, one aspect of it often goes under-acknowledged: The health care system does not just affect your patients, it affects you.

More and more, family physicians report feeling dissatisfied in their profession, and disconnected from their purpose. We know you face more challenges than ever in delivering quality patient care. Regulation burdens, documentation mandatories, operational policies, practice inefficiencies, and a culture of physician self-sacrifice all get in the way of serving the patient.

While the cause is multi-layered, the result of so much stress is clear: physician burnout and poor patient care.

Caring for your patients starts with caring for yourself. That is why the AAFP is committing its efforts to improving the health and well-being of family physicians, so you can stay passionate about your purpose: providing quality patient care.

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

Defining Burnout

"[Job burnout is] a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism, and detachment from the job, and a sense of ineffectiveness and lack of accomplishment."[1]

The subject of burnout is of critical concern to the AAFP because ***family physicians suffer from significantly higher rates of burnout than physicians in most other specialties.***[2,3]

- Nearly two-thirds of family physicians experience at least one element of burnout
- Female family physicians suffer burnout more than their male counterparts
- Early and mid-career physicians are at greatest risk

With Physician Health First, the AAFP takes a

holistic view of the factors affecting physician well-being, and addresses them from five points of entry:

Health Care System – Advocating to improve regulation and documentation burdens that impact physician well-being and quality patient care

Organization – Promoting leadership skills to help physicians succeed within organizational practices and policies

Practice – Improving efficiencies to optimize physicians' time and promote a more sustainable practice

Individual – Focusing on individual well-being habits to address physician fatigue with awareness and mindfulness techniques

Physician Culture – Addressing the mindset of physician self-sacrifice as a cultural norm and encouraging self-care and peer-to-peer support

The Next Step in Your Well-being Journey

It's time to put your health first. Prioritizing your well-being is key to a satisfying career in family medicine–one that takes you back to your purpose: providing quality patient care.

But with so many factors that affect your well-being, it can be overwhelming to know where to start.

The Well-being Planner is available to help you navigate the path to well-being.

Use the Planner to:

- Access resources to address the five major areas of the family physician ecosystem (healthcare system, organization, practice, individual, and physician culture).
- Save your favorite articles to a reading list for convenient future reference.
- Set well-being goals.
- Track and measure your progress.

Learn more about the Physicians Health First Initiative by visiting https://www.aafp.org/about/initiatives/physician-health-first.html

Ragan LeBlanc
Executive Vice President

PUT TIME ON YOUR SIDE!

Utilization of Patient Forms to Improve Physician Time Management

Anisha Turner, MD | Tammy Davis, MD | Louisiana State University Health Sciences Center Shreveport

Background

In the current practice environment, physicians face mounting demands on their time, from face-to-face patient contact to charting in electronic medical records. Yet, no matter what demands a physician faces, there are only 24 hours in a day. Since physician time has important implications on quality care, patient/physician satisfaction, malpractice suits, health care costs, and physician payments, there is reason to believe that time efficiency deserves more attention. Unfortunately, there has been very few studies of physician time as a resource to date.

Hypothesis

We examined whether new patient intake forms affect the length and efficacy of new patient visits.

- We hypothesized that patient forms will decrease the amount of time physician's spend in the room with patients
- We also hypothesized that patient forms will make the visit more efficient

Intervention

❖A balanced one-arm trial in which patients were randomized in one university hospital primary care clinic.

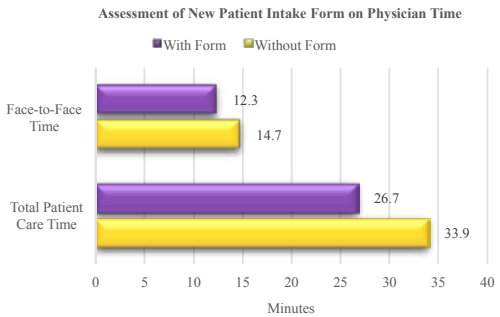
❖New patient's of one physician were assessed between the months of November 2016 – June 2017.

❖Patient's randomized into to groups: no form prior to visit vs new patient intake form prior to visit *(Form Detailed Below)*

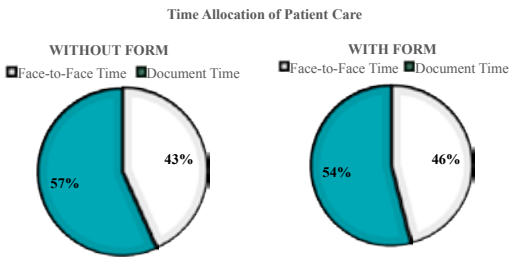
❖The work activity of physician was monitored through the patient entering the following times on a spreadsheet *(detailed below)*:

Patient #	Sex	Age	Appointment Date/Time	Pre-Visit Charting	Face-to-face Starts	Face-to-face Ends	Discharge Time	End of Charting	# of Co-morbidities

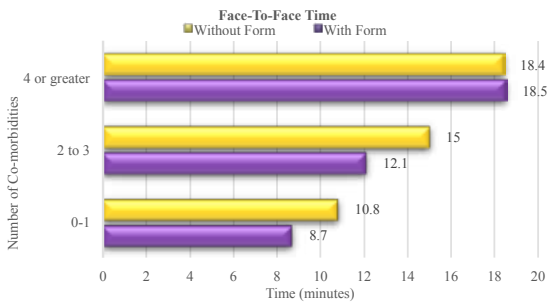
Results



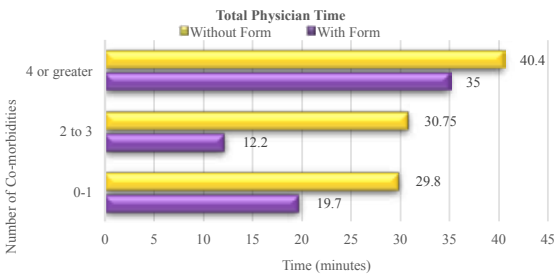
❖ Face to face time between physician and patient not statistically significant (p value 0.12)
  ❖ Average length of time: 14.7 minutes (without) vs 12.3 minutes (with)
❖ Total physician time on patient care was significantly less in the intervention group than the control group (p value 0.009)
  ❖ Average length of patient care: 33.9 minutes (without) vs 26.7 minutes (with)



❖ Documentation time was significant less in the intervention group than the control group (p value 0.032)
❖ Face to face time was 43% of physician time per patient without form and 46% with form.



❖ Face to face time increased as co-morbidities increased



❖ Total physician time increased as the number of co-morbidities increased

Patient Demographics

Demographics	Without Intake Form	With Intake Form
Number of Subjects	14	15
Age in years (range)	19-89	18-77
Age in years (mean)	48.9	37.9
Female N (%)	78.6%	73.3%
Co-Morbidities (mean)	2.9	2.3
0-1	36%	20%
2-3	29%	67%
>=4	36%	13%

Limitations

❖Only one physician's patients
❖Small study sample
❖Physician was not blinded
❖University hospital not community
❖Variable number of comorbidities in group
❖Average patient: middle-aged adult (can not be generalized to pediatrics and elderly)
❖Does not necessarily equate to financial contribution

Conclusion

❖Using a pre-visit questionnaire to increase awareness of patients' medical history appears to decrease documentation and total physician time in patient care without compromising physician-patient face-to-face time.

❖Knowledge of patient characteristics and needs could be used to schedule office visits, potentially improving patient flow through a clinic and physician efficiency.

Literature Review

❖According to literature, the average time spent with a physician during an outpatient encounter ranges from 10 – 23 minutes.(1,2)

❖The primary factors that affected the length of a visit were the patient's health needs and the type of visit - acute, chronic, or preventive care.(3)

❖New patient visits reportedly take four minutes longer than a visit with an established patient.(3)

❖Amount of topics discussed appear to have less influence, as longer time spent on major topics are typically compensated by limiting the time allocated to minor topics.(4)

❖Studies have shown that face-to-face time with both patient and physician satisfaction.(5)

❖Sinsky, MD, at the American Medical Association, found that physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work, which contributes to up to two extra hours of the workday on paperwork.(6)

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BITING AGAINST VENOM

Matthew Welch MD and Teri O'Neal, MD

Department of Family Medicine
Family Medicine Residency – UH Conway

Case Report

62 year old white female presented to ED with chief complaint of right hand swelling. Patient reports she was gardening in a flower bed, initially believing she had been pricked by a thorn, and noticing a small snake. Patient believes it was a "baby timber rattler", but could not definitively identify the snake. She reports significant hand swelling within the first 45 minutes. She presented to the emergency department by car, escorted by her brother.

Past medical history: significant for well controlled hypertension treated with lisinopril, hydrochlorothiazide, and amlodipine.
Physical exam
B/P 133/78, P72, Temp. 99.3 °F (37.4 °C), RR 18, height 1.626 m (5' 4"), weight 59 kg (130 lb), SpO2 98 %, (room Air)

Right upper extremity with 2 pinpoint sized lesions approximately 0.5 cm apart (presumed snake bite), swelling and tenderness to palpation, with increased tissue tone at wound, with decreasing tenderness moving proximally. Swelling extends proximally approximately 8 cm. Skin pen marks present denoting increased swelling from 2100 hours. Sensation intact distal to site, with cap refill <3 seconds, comparable to Left hand.
Pulses: 2+ and symmetric.

ASSESSMENT

Considering the pronounced local swelling, edema, and pain without significant systemic signs or symptoms this is most consistent with hemotoxic envenomation.

TREATMENT

Emergency room treatment consisted of contacting poison control. marking initial swelling, drawing samples for CBC, CMP, PT/INR and beginning CroFab therapy. Equine derived anti venom was once the standard therapy, but has changed in the early 2000's with the development of CroFab.

What is CroFab and when to use it?
Crotalidae polyvalent immune fab (Ovine)
Initial anti venom consisted of entire equine (Horse), or porcine (pig) derived IgG molecule. CroFab is Ovine derived (sheep) consists of only the Fab region, omitting the Fc Region, for the purpose of reducing acute reactions and delayed serum sickness.

How is it used?
Initial control is a series of 6 vials. 1 gram of powdered protein diluted and administered IV. In the first 10 minute given slowly (10 ml/hr) to monitor for allergic reaction. An allergic reaction is considered a contraindication. If no acute allergic reaction, increase rate to 250 ml/hr. Administer 2 vials at a time, over 1 hour each. Initial response is measured by observing a halt to local signs, and even reversal (at least partly) of systemic symptoms.

Complete control
After initial control, 2 more vials are administered every 6 hours for 18 hours (a total of 6 more vials) to avoid delayed venom reactions.

Different kinds of Snakes

"Pit Viper" is a common name for the Viperidae family of venomous snakes so named after an organ underneath their eyes (called a pit) which allows them to sense heat signatures of potential prey. Snakes with venom have on of two types; either hemotoxic or neurotoxic. Hemotoxic are by far the most common and these snakes belong to the subfamily Crotalidea. Reactions may range from mild local effects to severe and life threatening systemic reactions. Renal failure is a common (delayed) reaction from untreated envenomation.

Hemotoxic venoms (Most common)

An enzymatic mix of polypeptides which cause coagulation and tissue necrosis. Most usually painful, with local swelling and edema. Systemic signs and symptoms are also possible, and not uncommon; they may include thrombocytopenia, disseminated intravascular coagulation, nausea, vomiting, confusion, and dizziness.

Cane Break

Pigmy rattlesnake

Copper Head

Cotton mouth

Neurotoxic venoms (less common)

A mix of polypeptides which may be either presynaptic or post synaptic. Presynaptic work by degrading the presynaptic neuron and are not reversed with anti venom. Treatment consists of supportive care with a recovery time ranging from days to weeks. Post synaptic neurotoxins are more of the choline receptor blocker variety, and may be completely reversed with anti venom or acetylocholine esterase inhibitor (neostigmine). Typical signs of neurotoxic envenomation may include minimal pain, diaphoresis, ptosis, weakness, dysphagia, respiratory depression, paralysis. The most common local snake with neurotoxic venom is the coral snake.

Coral snake

Snake bite emergency treatment

In the Field
Avoid snakes, but if a bite occurs
Identify snake (*if* safe to do so)
DO NOT apply tourniquet
Remove all potentially constricting clothing or jewelry. A snake bite kit may not be as helpful as once considered.
Avoid physical exertion. Present to an emergency department as soon as possible.

In the Hospital
Assess ABCs
Clean wound
Keep wound in dependent position
Tdap or tetanus toxoid
Mark initial site – to monitor progression/therapy
Contact poison control
Monitor for hematology, renal, and cardiovascular change.
CroFab anti venom administration.
Initial monitoring for allergic reaction to anti venom with monitoring for initial control of local and/or systemic complications.
Continued monitoring for delayed complications.
Additional complications may include compartment syndrome (surgical intervention)

Conclusion

Patient was given a total of 12 vials of CroFab over a total of 26 hours of wound, with PT/INR, and creatinine remaining within normal range.

Over the next day patient exhibited some dependent edema in the affected limb with decreased swelling and was discharged home the next evening without complication.

Patient was seen for follow up at the family practice clinic 8 days after discharge, and again 15 days after discharge with no signs of swelling, cyanosis, or edema of the affected limb (right hand). Patients seems to have made full recovery from the event.

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Bordetella Pertussis: When a cough is more than a cough

Shawnna Ogden, MD; Advisors: Euil Luther, MD;
Chezhiyan Murugesan, MD; and Umashankar Kandasamy, MD

Department of Family Medicine Family Medicine Residency – Monroe

Case Report

Nine month old male with no significant PMH presented to a local pediatric clinic with a cough, rhinorrhea, nasal congestion, and sneezing that started about three weeks prior. Patient's mother was treating his symptoms with OTC allergy and cough medication, which provided only mild relief. His cough started out as a dry cough that became productive with thick whitish sputum over time. Patient's mother was instructed to take the patient to the ED due to an oxygen saturation of 87%. At a local hospital, the patient presented with a severe cough, mild wheezing, tachypnea, and a mild fever of 100.9 °F. Patient was transferred to UH Monroe due to hypoxemia and findings of left lower lobe pneumonia on a chest x-ray.

Sick Contacts: Two siblings with fever & URI symptoms

Immunization Hx: **No vaccinations up to date or initiated**.

Physical Exam:
pulse 139, temperature 97.9 °F (36.6 °C), temperature source Axillary, resp. rate 31, height 0.65 m (2' 1.6"), weight 9.78 kg (21 lb 9 oz), SpO2 95 %.

General: alert, in mild distress, coughing, fussy but easily consolable in mother's arm

HEENT: sclera white, ecchymosis is noted around the eyes, right eye crusting, mild subconjunctival hemorrhage of right eye. TM bulging in both ears, tonsils are non erythematous, no exudates noted.

Lungs: mild crackles are audible on the left with minimal expiratory wheezing. Accessory muscle use of respiration and coughing profusely. (paroxysmal coughing)

Heart: regular rate and rhythm, S1, S2 normal, no murmurs

Abdomen: soft, non-tender; bowel sounds normal

Extremities: extremities normal, no edema cap refill < 2 sec

Neuro: alert, moves all extremities spontaneously & grossly intact

Clinical and Diagnostic Criteria

Pertussis can be diagnosed without laboratory findings in patients with a cough illness lasting more than 2 weeks and at least one symptom of either paroxysmal coughing, inspiratory whoop, posttussive vomiting, or apnea with or without cyanosis

The predominant laboratory indication of B. pertussis is leukocytosis resulting from lymphocytosis. In infants, the WBC count and lymphocyte count are directly correlated with disease severity.

Classic Pertussis, a.k.a. 100 days of cough, is divided into 3 stages.

- Catarrhal stage: Similar to a viral URI with mild cough and coryza lasting one to two weeks. Risk of transmission is greatest at this stage.
- Paroxysmal stage: Coughing spells increase in severity. This stage can last two to eight weeks. Child may gag, develop cyanosis, or struggle to breath.
- Convalescent stage: The cough subsides over several weeks to months. Episodic coughing may recur or worsen during convalescence with interval upper respiratory tract infections.

For confirmation, patients under 3 months should be diagnosed with PCR and culture of nasopharyngeal specimens. At 3 months and older, use PCR and serology for diagnosis of cough less than 3 weeks. Serology only for cough over 3 weeks.

Nasopharyngeal specimens must be collected by swab or aspiration from the ciliated respiratory epithelium of the posterior pharynx where B. pertussis resides. Person obtaining the specimen should wear gloves and a protective face mask.

Figure 1: Collection of a clinical specimen by swabbing the posterior nasopharynx.

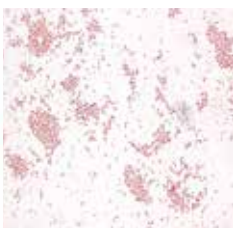
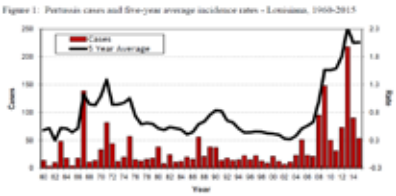


Figure 2: Gram stain of Bordetella Pertussis. Rod shaped, aerobic, gram negative bacteria.

Key Facts

Before Pertussis vaccine worldwide availability in 1940's, there were about 200,000 pediatric cases each year in US and about 9,000 deaths from the infection. Today, about 10,000 to 40,000 cases are reported each year with up to 20 deaths. In Louisiana, there are only six recorded deaths that have been attributed to pertussis. The latest mortalities were two one month old males in 2005.



Potential causes for the elevated rate of cases over the past decades include awareness, reporting, improved diagnostic tests, genetic changes to pertussis bacteria strains, and waning immunity. Unvaccinated children are at least 8 times more likely to get pertussis than fully vaccinated children. Vaccinated patients with pertussis infection are less likely to have a serious infection and duration of cough is usually reduced.

Post-exposure Prophylaxis (PEP) is a part of management to prevent asymptomatic contacts from progressing to symptomatic cases and prevent serious complications in high risk individuals. PEP is recommended to all household and close contacts. Most effective within 21 days of onset of cough in the index patient. Antibiotic regimens for PEP are identical to those used for treatment.

SUMMARY

- Pertussis can be diagnosed with or without laboratory testing in patients with a cough over 2 weeks and a symptom of either paroxysms of coughing, inspiratory whoop, posttussive vomiting, or apnea.
- A diagnosis is confirmed with PCR, serology, or culture studies with posterior nasopharyngeal specimens.
- Both probable and confirmed cases should be reported to public health authorities
- PEP is recommended for all household and close contacts of the patient.
- Routine immunization at all ages is the best preventive strategy.

ASSESSMENT

Nine month old non-immunized male with worsening cough for about three weeks, wheezing, hypoxemia, tachypnea, mild fever, and subconjunctival hemorrhage of right eye.

Initial Laboratory Findings:

- Leukocytosis of 28.7 with 34% lymphocytes
- CRP of 7.18.
- Influenza antigen and RSV antibody testing –negative.
- Chest x-ray showed focal opacification of the lingula consistent with pneumonia.

Bordetella Pertussis was diagnosed based on the above mentioned findings. The diagnosis was confirmed with a positive serology with a high IgG and IgM antibody count. PCR results were negative. After confirmation, the case was reported to public health authorities.

Treatment

Patient's initial antibiotic treatment was IV Rocephin for one dose. However, the WBC, lymphocyte count, and CRP increased the following morning. Once B. pertussis was suspected, patient was immediately placed in contact and droplet precautions. IV Azithromycin was added to his antibiotic therapy. The child's treatment regimen also included IV fluids, Tylenol, nasal cannula or blow by oxygen, and albuterol nebulizer treatments.

The child completed a 5 day course of antimicrobial therapy and symptoms improved while maintaining oxygen saturation on room air. Mother encouraged to reconsider vaccination at discharge but refused.

Antimicrobial treatment should be administered during the catarrhal stage with a clinical diagnosis. After this stage, treatment is recommended to limit the spread of infection to others. The preferred antimicrobial therapy are macrolides such as azithromycin and erythromycin. Azithromycin is preferred for infants under one month of age.

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Septic Pulmonary Embolism
in an intravenous drug user

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Abstract

Septic pulmonary embolism (SPE) is an uncommon disease that presents with a wide array of presenting symptoms, including chest pain, hemoptysis, dyspnea, cough, and fever. Intravenous drug abuse (IVDA) is one of the risk factors that should increase the physician's suspicion of the diagnosis of SPE. Other risk factors for SPE include tricuspid valve bacterial endocarditis, thrombophlebitis, Lemierre syndrome, indwelling catheters or devices. Combinations of any of the symptoms with these risk factors in conjunction with characteristic radiographic findings of multiple peripheral lung nodules with or without cavitation make the diagnosis highly likely. In our case study, a 36-year-old male with current IV drug abuse presented with left-sided chest pain and a right arm wound. During his hospital course, he was noted to have cellulitis of the right arm, methicillin-resistant Staphylococcus aureus (MRSA) bacteremia, and a chest radiograph showing peripheral nodules with early cavitary changes. A diagnosis of SPE was made and the patient treated appropriately. We present this case with discussion of diagnosis and recommendations for treatment of SPE. Early diagnosis plus appropriate antimicrobial therapy with source control can result in the resolution of the illness and reduction of complications in SPE.

BACKGROUND: Septic pulmonary embolus (SPE) is an uncommon disease with a wide array of presenting symptoms that can mimic other pathologies. The incidence of this disease has been increasing over time due to factors discussed below. Early suspicion and diagnosis are crucial for adequate treatment.

CASE PRESENTATION: We present a patient that came to our emergency room with an ongoing history of IV and inhalation drug abuse, symptoms suggestive of, and with eventual diagnosis of septic pulmonary emboli.

MANAGEMENT/OUTCOME: A 36 year old male with history of IV drug use, left sided chest pain and right arm cellulitis underwent work up including CT scan of the chest and cultures eventually growing MRSA. A diagnosis of SPE was made, the patient treated with appropriate IV antibiotic coverage and was discharged. We discuss the diagnosis and treatment of SPE.

DISCUSSION: SPE is a relatively uncommon disease process that carries a significant mortality rate with it, and should be included in the differential diagnosis in patients presenting with chest pain, fever with associated history of IV drug use or other risk factors. Appropriate antibiotic treatment and addressing underlying causes are necessary for adequate treatment.

BACKGROUND:

Septic pulmonary embolism (SPE) is an uncommon disease yet can be fatal if left undiagnosed. Mortality rates range from 12% to 20%.[12,13] SPE presents with an array of symptoms, including chest pain (characterized as pleuritic), hemoptysis, dyspnea, tachypnea, cough and fever. Intravenous drug abuse (IVDA) is a common risk factor also associated with septic embolism. Bacterial endocarditis, septic thrombophlebitis, central venous catheter and periodontal infections constitutes a group of primary disorders also frequently associated with septic embolism.[1-3,11] The implantation of long term vascular access devices, pacemakers, defibrillators, and ventricular-assisted devices, is becoming more common and as a result is placing more patients at risk for this condition. Although quite heterogeneous in character, all of the above-listed factors have the potential of association with and or become causative agents in producing SPE. [11]

Septic embolism is usually the result of two insults: an early embolic and ischemic insult due to vascular occlusion combined with infectious insult from a deep-seated nidus of infection that has become dislodged systemically into the venous vasculature.[11]

Understanding risk factors and having a high index of suspicion in patients that present with associated symptoms is important in recognizing SPE and adequately treating this disease process.

CASE PRESENTATION:

The patient we are presenting is a 36 year-old male who is currently an active intravenous drug user, has Hepatitis C, mild intermittent asthma, as well as a history of depression. He presented to the emergency department with a chief complaint of left-sided chest pain. The patient reported that he had been experiencing this pain for several days. He described it as an aching, non-radiating pain that was associated with some shortness of breath that he felt was secondary to discomfort upon deep inspiration. He denied any fevers, chills, nausea, vomiting, myalgias, or arthralgias. The patient also reported that his asthma was not under adequate control, and was experiencing some increase in wheezing and shortness of breath recently.

The patient admitted to primarily abusing methamphetamines as his illicit drug of choice. He stated that his asthma began to worsen whenever he would inhale crystal methamphetamine, so he began injecting it into his arms intravenously. He admits to injecting crystal methamphetamine multiple times daily. Other findings and results from a review of systems were not contributory.

While in the emergency department, the patient's vitals were as listed: temperature of 97.9°F, a heart rate of 92, blood pressure of 121/60 mmHg, a respiratory rate of 18, and oxygen saturation of 100% on room air. On physical exam, pertinent positives were left-sided chest wall tenderness to palpation, and an erythematous, warm, 2 x 2 cm area of induration with clear distinct borders on the right posterior forearm, suggestive of cellulitis and or abscess.

His laboratory studies showed a WBC 12,600 Cell/mm^3 and a normal chemistry panel. Given his shortness of breath, a chest radiograph was ordered, which found no evidence of any acute cardiopulmonary processes such as an effusion or consolidation. Also because of his shortness of breath, a D-dimer was obtained in order to evaluate him for possible thromboembolic

disease. His D-dimer was elevated at 0.64 mg/L. As a result a computed tomography angiography of the chest was ordered, which showed multiple peripheral nodules with ground glass halo and possible early cavitary changes. There were also nodules within the left lower lobe that were consistent with septic emboli. Figure A. Figure B.

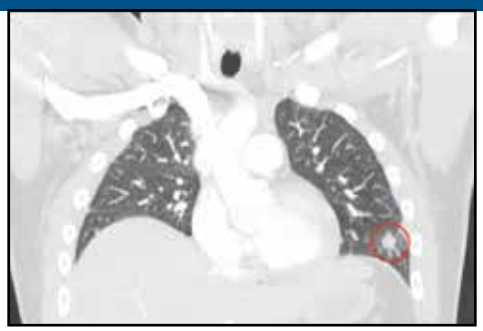

Fig. A. Computed tomography of chest shows peripheral nodules

Fig. B. Peripheral wedge-shape infiltration and with cavitary change

While in the emergency department, two sets of blood cultures were obtained and the patient was empirically begun on intravenous Vancomycin. Both sets of blood cultures eventually grew out methicillin-resistant staph aureus (MRSA), the primary source most likely being the areas of cellulitis on his arm where he self-injected the amphetamines.

Because of concerns also for cardiac complications as a result of his history of IV drug use, a transthoracic echocardiogram as well as transesophageal echocardiogram was ordered. The studies did not reveal any valvular vegetations or evidence of endocarditis.

Given his preference of engaging in high-risk behavior, a Quantiferon gold and HIV tests were also obtained. Both Quaniferon and HIV tests were found to be negative.

The patient had repeat blood cultures that were positive for MRSA bacteremia for two subsequent days. Sensitivities of the cultures demonstrated Vancomycin as being the drug that was suitable for treatment for his MRSA bacteremia. On Day 3 of his admission, the patient's repeat blood cultures were negative for bacteremia indicating a good response to treatment of his MRSA. His clinical course was one of gradual improvement in symptoms. He was scheduled to complete a 4-week course of intravenous Vancomycin.

Discussion:

Clinicians should have a low threshold of suspicion for SPE in individuals who present with associated risk factors, fever, chest pain, dyspnea, or radiographic evidence of pulmonary infiltrates. [3] In a retrospective study of fourteen subjects diagnosed with SPE, it was concluded that clinical presentations (risk factors, chest symptoms, and fever), plus radiologic imaging that showed multiple, nodular lung infiltrates with or without cavitary lesions are sufficient to diagnose a patient with SPE.[2]

The management of patients with SPE must include a thorough evaluation for the source of the emboli which includes a cardiac workup in the form of an echocardiogram. Transesophageal echocardiogram in this instance is the study of choice. Although this is not needed to diagnose SPE, it can help identify potential sources of the emboli. This is especially important in cases of patients with a history of IVDA as they are at increased risk for infective endocarditis.

Infective endocarditis (IE) is a disease commonly seen in patients with a history of IVDA. However IE is also seen in patients without a history of engaging in high-risk behaviors. According to an article published in the European Heart Journal, the epidemiology and incidence of IE are evolving.[6] As a result of increasing numbers of invasive procedures, we are now seeing infective endocarditis develop more and more as a result of health-care related interventions in patients with no known prior valvular disease and not just in patients with prosthetic valves.[6] This article reports also an increase in the rate of staphylococcal IE within the United States. In a retrospective study, Cook and colleagues reported that the epidemiology of patients with SPE has changed over the past 30 years with their study showing that SPE cases were more often associated with catheter/device-related and soft-tissue infections. [2]

Another confounding factor associated with SPE and IE is the rising number of patients with end-stage renal disease who are requiring some form of dialysis, with associated diabetes mellitus, and intravascular devices.

IE is characterized by bacterial colonization of the endothelial layer of heart valves. The tricuspid valve is the most commonly affected valve in patients with a history of IVDA.[10] Bacterial colonization can lead to development of vegetations, which may embolize, resulting in SPE. Staphylococcal aureus is the most common organism isolated in such cases. These patients may be asymptomatic. Cardiac murmur may or may not be present on physical exam; therefore echocardiogram is crucial for diagnosis of IE. Patients suspected of having IE should be started on appropriate antimicrobial therapy as soon as possible in order to reduce risk of complications such as SPE.

The annual incidence of IE ranges from 3-10 cases per 100,000 annually.[7] IE is the fourth most common life-threatening infectious disease after sepsis, pneumonia and intra-abdominal abscess.[9]

The organisms themselves also seem to play an important role in the development of SPE. Experience from patients with Lemierre's Syndrome, which is thrombophlebitis of the internal jugular vein which is often caused by Fusobacterium necrophorum demonstrates the importance that the organism plays in the development of thrombus.

The organism produces a heat stable leucocidin that exhibits thrombogenic properties as a result of indirect inflammatory mechanisms, including formation of reactive oxygen species and release of secondary inflammatory mediators, thus causing endothelial dysfunction.[14] Staphylococcus aureus exhibits similar properties. Skin and soft tissue infections, such as cellulitis or osteomyelitis, are commonly the result of methicillin-resistant Staphylococcus aureus

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(MRSA) and thus can be a common source for the bacteremia.[4]

Location of the MRSA bacteremia source must be aggressively sought after in order to adequately control it. MRSA has been classified into two types: healthcare-associated (HA-MRSA) and community-acquired (CA-MRSA).[5] In the case of our patient, he presented with CA-MRSA. CA-MRSA occurs without exposure to healthcare personnel. CA-MRSA is usually associated with young adults that have skin and soft tissue infections, as was seen in our patient.

In a report conducted by the United States Active Bacterial Surveillance network in 2005, they projected that there would be 94,360 cases of invasive MRSA, 14 percent (or 13,210 patients) being positive for CA-MRSA. They also concluded that risk factors for MRSA bacteremia included intravenous drug use, sharing needles/razors, recent antibiotic use, long-term catheter use, men having sex with men (MSM), patients with HIV (CD4 count <50 cells/µL or HIV RNA >100,000 copies/µL) and Type-2 diabetes mellitus.[5] All of these concerns should be included in history taking in patients suspected of having MRSA and SPE.

Thrombophlebitis can be another possible source of SPE. SPE due to thrombophlebitis should be suspected in patients with persistent bacteremia after 72-hours of appropriate antimicrobial therapy.[10] This condition is commonly seen in hospitalized patients with peripheral intravenous catheterization and in individuals who are at risk of developing venous thrombus. Patients having thrombophlebitis with a high risk for SPE may present with fever, erythema, tenderness or purulent discharge at the infected site. Similar to IE, the most common pathogen is Staphylococcus aureus, therefore management of these patients requires high index of suspicion followed by early diagnosis and treatment. Diagnosis is usually confirmed with positive blood cultures and or cultures of infected sites along with ultrasound identification of venous thrombus. Treatment consists of removal of the infected source along with empiric antibiotic therapy and anticoagulation.

As in any patient with pulmonary emboli, anticoagulation plays an integral part in the treatment of SPE. The role of anticoagulation is mainly to reduce propagation of the clot and it does not "dissolve" the emboli that are already present. Concerns for conversion of metastatic septic lesions into a hemorrhagic site as a result of anticoagulation, and or increasing the rates of embolic lesions have not played out.[14] So control of the pathogen, source of emboli and anticoagulation for prevention of propagation of the already present thrombus are mainstays of treatment.

Conclusions:

Because of the varied causes of SPE, adequate management of patients consists of early suspicion of SPE in patients with identified risk factors along with early initiation of appropriate antimicrobial therapy. Removal of an infected source is indicated in cases of SPE due to related catheters or devices. Similar to cases of IE and thrombophlebitis, Staphylococcus aureus and Gram negative species are commonly isolated organisms in cases of SPE.[2] Therefore, initial empiric therapy should include coverage for these organisms, and the antimicrobial therapy should be modified based on final cultures and sensitivities. IV antibiotic therapy should be continued for at least 4-6 weeks from the time of sterile cultures for adequate treatment of this disease.[7] Anticoagulation plays an important role in management of patients with SPE as well. A recent exhaustive systematic review[15] analyzed 14 case series consisting of a total of 216 patients to determine the role of intravenous heparin in combination with antibiotics for the treatment of septic thrombophlebitis. The authors found that the use of heparin was associated with a low mortality and few reported serious adverse effects.

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OCULAR SYPHILIS

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CASE REPORT

Mr X - a 61 year old white male with a past medical history of HIV (diagnosed in July 2015) presented to the eye clinic for follow up of uveitis. He had decreased vision in his right eye. He has a history of blindness in the left eye since September 2015. He was placed on anti-retroviral medication for HIV but Mr X had not been taking his medications except Morphine, for about a month as he was having difficulty swallowing pills.
On evaluation and work up of his uveitis, RPR was found to be positive with a titre of > 1:152. His CD4 cell count was 619.

SLIT LAMP EXAM:

EYE STRUCTURE	RIGHT	LEFT
Lids / lashes	Normal	Normal
Conjunctiva / Sclera	1+ injection	White and quiet
Cornea	Scattered small and medium keratic precipitates	Large mutton fat keratic precipitates (central and inferior)
Anterior chamber	Trace flair, occasional cell, deep	2+ flair, deep, 1+ cell
Iris	Round	Numerous posterior synechiae, small, irregular pupil
Lens	3+ nuclear sclerosis, pigment on surface, cortical cataract	2+ nuclear sclerosis, cortical cataract
Vitreous	Very hazy view	Hazy view

Other investigations included: lumbar puncture which showed Fluorescent Treponemal antibody absorption test was reactive, with a quantitative VDRL of 1:4
He was admitted for management of his ocular syphilis with Rocephin 2 grams IV on a daily basis. The patient was started on Rocephin as there was a concern of Penicillin allergy.

TREATMENT

The CDC guidelines recommend to manage ocular syphilis according to treatment recommendations for neurosyphilis [1,2]:

- Aqueous crystalline Penicillin G 18-24 million units intravenously (IV) administered as 3-4 million units IV every 4 hours or Procaine Penicillin 2.4 million units intramuscularly (IM) with Probenecid 500mg od po for 10-14 days.

Alternatively:

- Benzathine Penicillin (2.4 million units IM once per week for up to 3 weeks) can be considered for cases staged as late-latent or unknown duration, after completion of neurosyphilis treatment regimens.

Options for patients with Penicillin Allergy:

- several therapeutic alternatives are available including Tetracycline, Doxycycline, Chloramphenicol, Ceftriaxone and the macrolide antibiotics.

Mr X was admitted with the intention of treating him with Rocephin (Ceftriaxone) 2g IV for 21 days. He was also treated with injection of intravitreal Triescence with significant improvement in vision.
He was advised to continue on Pred Forte one drop every 2 hours while awake, Atropine three times a day to both eyes as outpatient. He was also started on 40mg of oral steroid to continue as outpatient treatment.

EPIDEMIOLOGY OF OCULAR SYPHILIS

Between December 2014 and March 2015, 12 cases of ocular syphilis were reported from two major cities, San Francisco and Seattle. Subsequent case finding indicated more than 200 cases reported over the past 2 years from 20 states. The majority of cases have been among HIV-infected men who have sex with men (MSM); a few cases have occurred among HIV-uninfected persons including heterosexual men and women. Several of the cases have resulted in significant sequelae including blindness.[1]

CASE DEFINITION OF OCULAR SYPHILIS

A person with clinical symptoms or signs consistent with ocular disease (i.e. uveitis, panuveitis, diminished visual acuity, blindness, optic neuropathy, interstitial keratitis, anterior uveitis, and retinal vasculitis) with syphilis of any stage.
FOUR STAGES OF SYPHILIS [5]:

- **Primary syphilis** - painless ulcer or chancre, 2-6 weeks of exposure
- **Secondary syphilis** - chronic stage, skin rash and brown sores 3-6 weeks after initial ulcer, mild fever, fatigue, headache, sore throat, hair loss, swollen lymph glands occur over 1-2 years
- **Latent syphilis**
- **Tertiary syphilis** - final stage, spreads to many body systems (heart, eye, brain, nerve system, bone and joint), mental illness, blindness, neurological problem, heart problems, death.

SYMPTOMS OF OCULAR SYPHILIS [2]

Loss of vision, redness of the eye, eye pain, floaters, a blue tinge in vision, flashing lights & blurring of vision.

SIGNS OF OCULAR SYPHILIS [3]

LIDS:
Chancre
Gumma
Tarsitis
Ulcerative blepharitis

CONJUNCTIVA:
Chancre
Papular syphilides
Gumma

ORBIT:
Periostitis
Gumma

CORNEA:
Interstitial keratitis
Ulcers
Deep, punctate keratitis
Keratitis profunda
Keratitis pustuliformis
Keratitis linearis migrans
Gumma

SCLERA:
Episcleritis
Scleritis
Gumma

ANTERIOR CHAMBER
Hypopyon

IRIS AND CILIARY BODY
Roseolae
Papules
Gumma

PUPILS:
Light-near dissociation

LENS:
Capsular rupture and necrotizing cortical inflammation - congenital syphilis

OPTIC NERVE:
Neuritis
Perineuritis
Neuroretinitis
Gumma

MOTILITY DYSFUNCTION:
Oculomotor, adbucens, trochlear paresis - associated with basilar meningitis
Periodic alternating nystagmus

RETINA AND VITREOUS
Chorioretinitis - pseudoretinitis pigmentosa, salt & pepper fundus
Perivasculitis
Central retinal artery / vein occlusion
Cystoid macular edema
Vitritis

LABORATORY TESTS[4]

- Non-treponemal assay: RPR, VDRL (less sensitive & specific)
- Treponemal assays:TP-PA, FTA-ABS (more sensitive & specific), but remain positive for life even despite treatment.
- Lumbar puncture for VDRL testing of cerebrospinal fluid - this is highly specific and positive results confirms neurosyphilis. If CSF VDRL is positive in someone with eye symptoms, DEFINITIVE diagnosis of ocular syphilis can be made.
- Due to high co-infection rate, patients should also be tested for HIV

DIFFERENTIAL DIAGNOSIS OF OCULAR SYPILIS[4]

Infectious diseases such as tuberculosis, non-infectious diseases such as sarcoidosis, hereditary retinal disorders, diabetes mellitus, radiation, corticosteroid use, vitreous inflammation, pigmentary retinopathy, neurofibromatosis type 2, and myotonic dystrophy.

Photos [2]

DISCUSSION

Syphilis is on the rise over the recent years. Few causes may be associated with the rise in rate of syphilis, like lack of public awareness and according to the CDC, syphilis rates have risen more rapidly in states that have underfunded syphilis prevention efforts.

By educating and increasing awareness among healthcare providers and general public, syphilis and ocular syphilis can be detected and treated early before complications arise.

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Impact of Tax Reform on Equipment Financing Solutions

Andrew Necaise

Bank of America Leasing
Merrill Lynch

In late December 2017, Congress passed the "Tax Cuts & Jobs Act." This Bill introduced a number of significant interrelated changes impacting the U.S. equipment finance market. Given the breadth of this legislation, the market is expected to take an extended period of time to fully absorb and reflect all of the changes.

Key changes impacting the equipment finance market

- Reduced top Corporate Tax Rate from 35% to 21%
- Provided for 100% Bonus Depreciation for new and (most) used equipment with careful consideration required for existing contracts, historical ownership and select ineligible industries
- Limited Net Business Interest Deductions to 30% of taxpayer's adjusted taxable income (the definition of the cap will become more restrictive in 2023)
- Repealed the prior Corporate Alternative Minimum Tax (AMT) regime
- Created the BEATs (Base Erosion Anti-Abuse Tax) regime
- Repealed Like Kind Exchange (Section 1031) for personal property and equipment (now limited to real estate property only)
- Restricted the ability to utilize and carry-back NOLs
- Permanently increased Section 179 Expensing Limits and indexed them to inflation
- Provided that farm and agriculture equipment is no longer subject to the special 150% DB rule for depreciation and will now follow normal MACRS (200% DB), and permanently established that most farm equipment is subject to a 5 year recovery
- Created new 20% deduction (up to 20%, subject to a number of complex caps) for pass-thru business income, intended to adjust the effective tax rate on that income

Many benefits of equipment financing are not impacted by tax reform:

- Competitive fixed rate financing
- Usage flexibility with transfer of asset risk (options to buy, extend or return)
- 100% financing
- Accounting statement treatment
- Diversification of financing base
- Cash flow management
- Security, compliance and tracking for technology assets

If you have any questions about equipment financing solutions, please don't hesitate to reach out. Best wishes in your practice's continued success,

Drew Necaise and Michael Minvielle
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The Lovell Group, Merrill Lynch
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Population Health: *Making the Invisible, Visible*

Evelyn Cayson, Southeast Clinical Workflow Coordinator

When a patient enters your clinic, you undoubtedly take the best possible care of them. Your front office clerk likely welcomes them with a smile, followed by a compassionate nurse that triages and rooms the patient. You, the provider, then enter the room and address your patient's needs. But what happens after the patient checks out and leaves your office?

Population Health addresses this question. How can you take care of patients when they are not physically in your office, sitting in front of you? How do you care for the patient who went to the Emergency Department last week for swelling and shortness of breath? How do you care for the patient who was just discharged home from the hospital after a COPD exacerbation?

How do you care for your "flock"-all of your patients- not only when they are in your office, but when they are at home?

Starting in 2015, Aledade began working with the Louisiana Academy of Family Physicians to bring together a group of like minded, independent physicians, to start transforming health care in our state.

By implementing these population health approaches to care in our Aledade Louisiana ACO, we've seen great results like: an increase in primary care services by primary care physicians by 15%, decreased hospital admissions by 6%, and a decrease in hospital readmissions by 6%. All of these things help improve the health of your patients, while helping your practice see the value of population health management.

Annual Wellness Visits (AWV): An Annual Wellness Visit is a great way to touch base with your patients at minimum, annually, to ensure they have the best chance at staying healthy and home. This visit gives you the opportunity to address most of their preventative needs, including cancer screenings, immunizations, falls risk, and depression risk.

Someone in your office should call the patient to schedule this visit. Not simply "adding the visit on to an already scheduled appointment". Someone should call this patient or mail them a postcard reminder (maybe on their birthday) to let them know you care about their wellness and would like to see them in the office. While it's certainly fine to add on an AWV to a normally scheduled appointment, those are the patients that are already coming in to see you! Population health

Continued on page 16

Continued from page 15

is thinking more about those patients who don't come in very often. Drive your focus to those patients who are out seeking care elsewhere - the Emergency Department for example.

Emergency Department Follow Up. Did your patient recently visit the emergency department? Did you know about the visit? If you're thinking about the best way to care for all of your patients, you first have to know when they seek care elsewhere.

Do you have a good relationship with your local hospital/emergency department? Could you request they alert you when your patient arrives for care via fax or daily phone call?

These are great ways to be aware of what your patient is doing when they're not in your office! Call the patient, let them know you care about them and ask them to come in for a follow up visit so you can check in and answer any questions.

Transitions of Care After Hospital or Facility Discharge. Was your patient recently discharged from a hospital or facility? Again, did you know they were there? Even if your practice does not have access to a Health Information Exchange, there are still ways to work locally to find out what's happening to your patients outside of your practice's four walls. Yes, it's a bit of a lift; however, it's worth it when you can provide a smooth transition for your patient back into their home and help reduce preventable readmissions.

Do you round at the local hospital? If so, make sure someone in your office is aware that the patient is being discharged home. Have someone in your office call the patient with in two business days to check in on them and make sure they have a follow up appointment. Even if you miss this two day window required by Medicare to bill "Transitional Care Management", it is still worth reaching out to the patient and ensure they have a follow up appointment with you.

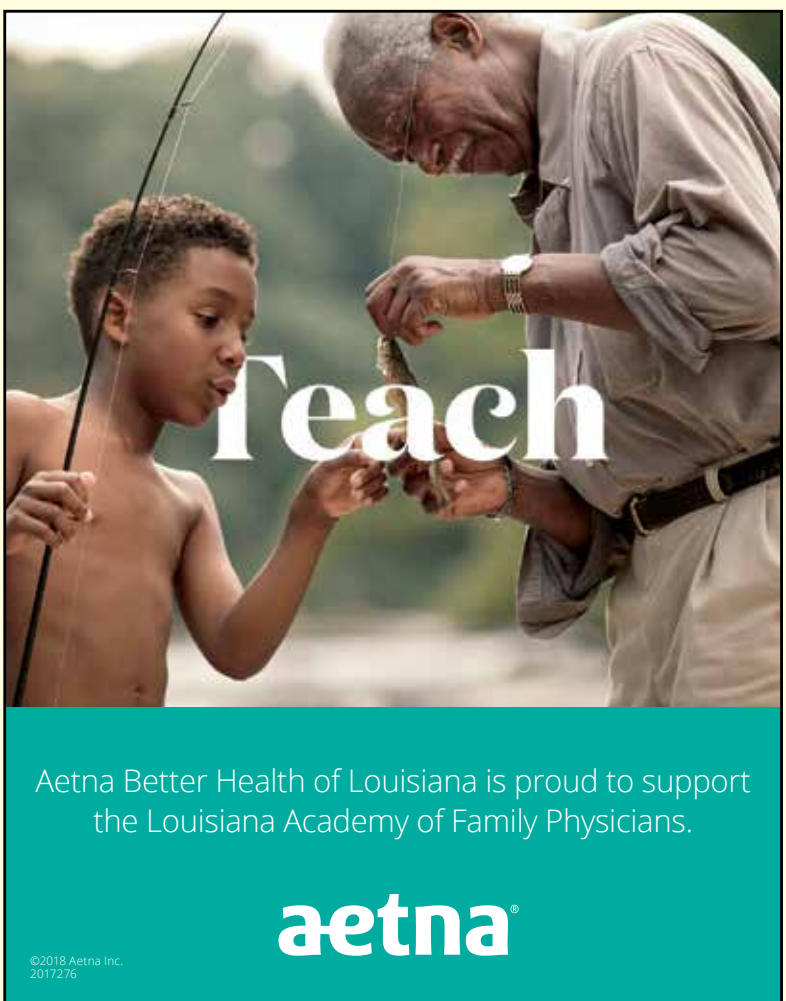
Maybe you have a great relationship with the hospitalist group in town? Or maybe you don't - and this is an area you could reach out to them to let them know that you care about ensuring your patients have a smooth follow up and you'd like to be alerted when your patients are discharged.

Care Management. Maybe you've heard about chronic care management and even implemented a program in your own clinic. Care management is a great way to have visibility into what's going on inside the patient's home. Care management can be the link to making patient's needs and concerns visible to you.

To make care management most effective, we often see one assigned person to the task of care management. We see this person making frequent outreach to the patients, not just the required twenty minute interaction once per month. A care manager can follow up on Transitions of Care, they can keep track of outgoing referrals, they could call and schedule AWVs, and follow up with patients after a trip to the Emergency Department. While this most frequently works best with a designated person doing this full time, we see many creative ways to implement population health even when a full time person is not feasible. Maybe the care manager works on some of these tasks during your half day in the office? Or maybe one day of the week, you tend to be a bit slower seeing patients-could someone be tasked with some of this work in the down time?

Population Health is one of the key values of Aledade ACOs. We pride ourselves on working with independent providers as a physician-led ACO. We work hard to help your practice transform into a value based care setting with visibility to technology and tools to make population health easier to implement in your office. If you're interested in learning if an Aledade ACO may be right for your clinic, contact Nadine Robin, our local Executive Director, at nrobin@aledade.com.

Aledade



4 Reasons to Attend FMX....YOU In?

This year's AAFP Family Medicine Experience (FMX) will be held in New Orleans, October 9-13. If you've never attended, take the opportunity to experience FMX in your own backyard.

FMX is the AAFP's largest annual meeting, and it's like no other family medicine event.

Like No Other Education: Expand your knowledge through evidence-based, family medicine CME.

- Plan to earn the **28 CME credits** included in your base registration.
- Take home **25 additional credits** with ***FMX On Demand***, a digital library of FMX courses, also included with your base registration.

Like No Other Speakers: Get inspired at three main stage sessions:

- Zubin Damania, MD, internist and founder of Turntable Health, will educate and entertain while satirizing our dysfunctional health care system under the pseudonym ZDoggMD.
- A panel will discuss opioid use and misuse risks for chronic pain management (CME credit available).
- Highly rated FMX speaker Frank J. Domino, MD will share his top 10 updates in evidence-based medicine (CME credit available).

Like No Other Network: Make connections with people like you, who know family medicine is like no other specialty, with special networking events including the Expo Hall Grand Opening and Member Interest Group receptions. Plus you can unwind at the end of the week at the FMX Celebration at the National WWII Museum.

Like No Other Solutions: Access the latest technologies and patient care tools in the Expo Hall.

- Visit the Office of the Future exhibit to explore new technology and practice innovation concepts.
- Access the latest information on high-priority family medicine topics.
- Get resources and tools that can help simplify administrative burdens.

Don't miss out on this opportunity to experience FMX in Louisiana.

Register by July 27 to save $200.* One-day registration will be available on site.

**This offer includes the $200 early bird discount. This offer does not apply to students, residents, inactive, or life members.*

The LAFP Remembers Dr. Walter Birdsall (Jan 4, 1954 – Apr 20, 2018)

The LAFP wishes to express our sincere condolences regarding the sudden death of Dr. Walter "Walt" Birdsall, Jr. while travelling with his wife and two of his children in Barcelona, Spain. He was born in his favorite city, New Orleans, LA, on January 4, 1954. As the beloved husband of Jane Angelette Birdsall for 42 years, he became the adoring father of Dr. Lisa Fort, Dr. Emily Bui, Allison, William and Alexander. Recent years blessed him as a proud grandfather of Sophia and Sabrina Fort as well as Oliver and Simon Bui. He was the oldest son of Walter Birdsall, Sr. and Betty. He is survived by his sisters Brenda Klazynzki and Dr. Maria Cruse and his brothers Dr. Gary Birdsall and Thomas Birdsall. He was preceded in death by his brother James.

Walter graduated from LSU medical school in New Orleans in 1981. His involvement with LAFP was in the 1990's after serving on the LAFP Board of Directors where he became President of the LAFP in 1994. A gifted family physician, he spent many years in practice in his hometown in Cut Off, Louisiana. He continued his practice through Ochsner at St. Charles Parish hospital until the time of his death. He remained active in education and mentorship of young physicians throughout his career. Walter will be remembered as a dynamic, generous family man who made the most of every moment of life for himself and all those around him. He shared his lifelong love of music with friends and family during holidays and gatherings as "Dr. DJ."

LAFP Leaders and Staff Attend National Meeting

Louisiana Academy of Family Physicians chapter leaders met in Kansas City, MO, April 25-28 for the American Academy of Family Physicians (AAFP) Annual Chapter Leader Forum (ACLF) and the National Conference of Constituency Leaders (NCCL).

ACLF is the AAFP's leadership development program for chapter-elected leaders, aspiring leaders, and chapter staff. Louisiana members attending included Christopher Foret, MD. Staff members in attendance included Coordinator of Events and Marketing Danielle Edmonson, and Director of Membership and Education Stacy Barbay.

NCCL is the AAFP's premier policy development event for underrepresented constituencies, including women; minorities; new physicians; international medical graduates (IMG); and lesbian, gay, bisexual, and transgender (LGBT) physicians or physicians who support LGBT issues. Louisiana's official delegates to NCCL included Richard E. Bridges, MD (new physician representative); Vincent L. Shaw, MD (minority physicians representative); Lisa A. Casey, MD (women physician representative); and Jody R. George, MD (IMG physician representative). Dr. Keisha Harvey also attended the conference.

In addition to participating in leadership sessions, NCCL delegates write, debate, and vote on resolutions related to medical practice and patient health.

Twenty-four chapters sent full delegations to the 2018 NCCL, meaning all five member constituencies were represented by a chapter delegate. NCCL had 44 chapters represented with 172 chapter delegates. The total of 228 registrants included 136 new physicians and 102 first-time attendees.

ACLF/NCCL conference highlights included:

- An opening session and plenary with AAFP President Michael Munger MD, FAAFP, who gave an update on the AAFP's activities including the Advanced Primary Care Alternative Payment Model, the benefit of increasing the national primary care "spend" from approximately 7% to 12%, and results from a recent study that recognized the AAFP as one of the most effective, influential, and impactful advocacy organizations in Washington, D.C.
- Breakout sessions that covered governance, communications, advocacy, media relations, and membership issues
- An inspirational presentation by Derrick Kayongo, a Ugandan refugee turned successful entrepreneur and renowned human rights activist. Mr. Kayongo is the founder of the Global Soap Project, which recycles used hotel soap and redistributes it to impoverished populations around the world. In creating this global humanitarian initiative, he demonstrated that a simple, yet novel idea has the power to transform lives.
- During the lunch program on April 27, the LAFP was recognized for 100% Resident Membership. Dr. Sevilla, chair of the AAFP's Commission on Membership and Member Services, presented the chapter awards.

In 2019, the conference will be held Thursday-Saturday, April 24-27, in Kansas City. If you are interested in serving as a Louisiana delegate to the 2019 NCCL Conference, please contact Ragan LeBlanc at (225) 923-3313 or email rleblanc@lafp.org for more information.

LAFP Calendar

SAVE THESE DATES

July 4, 2018
LAFP Board of Directors Meetings
Fleming's Steakhouse
Destin, FL

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

July 6, 2018
General Assembly
Sandestin Golf & Beach Resort
Destin, FL

July 27, 2018
Early Bird FMX Registration Deadline

July 27, 2018
General Assembly
Sandestin Golf & Beach Resort
Destin, FL

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

August 4, 2018
Family Medicine Leads Emerging Leaders Institute
Kansas City, MO

August 14, 2018
Application Deadline for the Annals of Family Medicine Editorial Board and AMA positions

September 5, 2018
Advance FMX Registration Deadline

September 8, 2018
AAFP COD Resolutions Deadline

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 10-12, 2018
2018 Chief Resident Leadership Development Program (Sessions 1 & 2)
New Orleans, LA

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

November, 2018
LAFP Board of Directors Meeting
TBD

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

Stay Connected with the LAFP

Are you receiving your LAFP Newsletter?

The Louisiana Academy of Family Physicians newsletter is distributed via email every Tuesday. If the newsletter is not arriving to your inbox, check to see if it is being routed to junk mail and/or allow info@lafp.org to be listed as a safe sender.

We are dedicated to making it a valuable resource with information you won't want to miss! Check your inbox today and adjust your settings so you can receive regular LAFP member updates and event information.

Are You Following the LAFP?

The LAFP is on Facebook to provide its members and others with up-to-date information about LAFP news and events and other family medicine information.

The LAFP uses twitter to provide urgent Academy news and official statements quickly and easily to members, Louisiana media, and legislative individuals. Follow us @lafp_familydocs

LAFP Elects 2018-2019 Resident *and* Student Leaders

The Louisiana Academy of Family Physicians is proud to announce the 2018-2019 elected student and resident delegates! Each year the Resident Student Leadership Committee begins as election process to select our resident and student delegate positions. The LAFP values our resident and student members. We are one of the few professional membership organizations that actively recruits and involves our resident and student members to leadership roles. This represents the future of Family Medicine and the LAFP.

Delegate to LAFP Board of Directors:

Resident Delegate: Rachael Kermis, MD- Baton Rouge General Family Medicine Program

Rachael Kermis, MD, was born in Buffalo, New York. She attended Cornell University where she received her undergraduate degree in Human Biology, Health and Society. Dr. Kermis received her doctorate degree from Ross University. She is a second year resident in the Baton Rouge General Family Medicine Residency Program. She enjoys reading, watching classic movies, baking people cupcakes and making friends with any dog she sees.

Resident Delegate: Drew Parks, MD Baton Rouge General Family Medicine Program

Andrew Parks, MD, was born in Baton Rouge and grew up in New Roads. Dr. Parks received his doctorate degree from Louisiana State University Health Sciences Center in Shreveport. He is a third-year resident in the Baton Rouge General Family Medicine Residency Program. His hobbies including obsessing/attending all LSU athletic events, golf, bowling, and soccer.

Student Delegate: Travis Phipps - LSUHSC New Orleans

Travis Phipps is a rising fourth year medical student at LSUHSC New Orleans. Born and raised in Sulphur, LA, he graduated from LSU as a first-generation college student with a degree in Spanish in 2009. Soon after, he relocated to Buenos Aires, Argentina, where he taught English as a foreign language in various language schools and for private clients in settings including the Buenos Aires Stock Exchange and Lacoste Argentina. Upon moving to New Orleans in early 2011, he continued his work teaching English to Spanish speakers and also expanded into teaching Medical Spanish at a local career college. It was during this time he decided to pursue a career in medicine. Phipps first became interested in Family Medicine after his first year of medical school during a summer preceptorship with his family's physician in his hometown. He is excited to represent his fellow medical students as Student Delegate to the LAFP Board of Directors and to help impact his future specialty within his home state.

Student Delegate: Rose Marie Tusa - LSUHSC New Orleans

Rose Marie Tusa was born and raised in Louisiana. She attended the Louisiana Scholars' College at Northwestern State University, where she received her BA in Liberal Arts with a concentration in Scientific Inquiry and a minor in Spanish. Ms. Tusa is currently in her second year at LSUHSC School of Medicine in New Orleans. She will be serving as the Vice President of FMIG for the 2018-2019 academic year.

Delegate to National Conference:

Resident Delegate: Mark Andrew Carreras, MD - LSU Lafayette

Mark Andrew Carreras, MD s a First Year Resident at LSU New Orleans at Lafayette Family Medicine Residency Program. Dr. Carreras is a graduate of the Medical University of the Americas (Nevis).

Resident Delegate: Anisha Turner, MD - LSU Shreveport

Anisha Turner, MD is a Fourth Year Resident at LSU Shreveport Emergency Medicine/ Family Medicine Residency Program where she is currently serving as the Chief Resident. Dr. Turner is from Houston, Texas and is a graduate of University of Texas Southwestern.

Student Delegate: James McAllister - Tulane Medical School

James McAllister grew up on Bainbridge Island in Washington state and got his bachelor's degree from the University of Washington in Seattle. He worked in the federal government in Washington, DC, before deciding to go to medical school at the Tulane University School of Medicine in 2015. He is the former president of Tulane's family medicine interest group and has worked to promote family medicine at Tulane and been involved in student mental health and wellness efforts. He plans to practice full spectrum family medicine back in the Pacific Northwest.

Student Delegate: Caitlin Sisson - Tulane Medical School

Caitlin Sisson is a 2015 graduate of the University of Southern California with a Bachelor of Arts in Psychology. She is currently a third year MD/MPH candidate at Tulane University School of Medicine and Tulane University School of Public Health and Tropical Medicine. Outside of her interest in primary care she enjoys bowling, spending time with her family, golfing and watching the Winnipeg Jets make a Stanley Cup run.

Delegate to General Assembly:

Resident Delegate: Candice Weiner-Johnson, MD - LSU Shreveport

Candice Weiner-Johnson, MD is a Fourth Year Resident at LSU Shreveport Family Medicine Residency Program. Dr. Weiner-Johnson is from Luling, Texas and is a graduate of University of Texas Health Science Center at Houston.

Resident Delegate: John M. Yager, MD - LSU Shreveport

John M. Yager, MD is a second year Resident at LSU Shreveport Family Medicine Residency Program. Dr. Yager is from East Greenbush, New York and is a graduate of Ross University.

Student Delegate: Caitlin Sisson - Tulane Medical School

Caitlin Sisson is a 2015 graduate of the University of Southern California with a Bachelor of Arts in Psychology. She is currently a third year MD/MPH candidate at Tulane University School of Medicine and Tulane University School of Public Health and Tropical Medicine. Outside of her interest in primary care she enjoys bowling, spending time with her family, golfing and watching the Winnipeg Jets make a Stanley Cup run.

LAFP is one of the only professional medical associations that actively promotes our resident and student members to hold leadership positions. For more information on how to become involved with the Academy, visit www.lafp.org or contact Stacy Barbay for more details.

Congratulations to all of the winners!

Are You Ready for the
Transformation
of Healthcare?

HEALTHSYNC
OF LOUISIANA

The physician-led health information exchange.

To learn more or begin participating in the HealthSYNC of Louisiana statewide health information exchange call Jeff Williams at 844.424.4371 or email to jeff@lsms.org.

In partnership with the Louisiana State Medical Society

A Member of the KAMMCO Network

Human Papillomavirus (HPV) Vaccination Report: Louisiana

May 2018

Working Together to Reach National Goals for HPV Vaccination

In collaboration with CDC's Division of Cancer Prevention and Control, this quarter's report highlights your jurisdiction's HPV–associated cancer burden. In addition, please see your jurisdiction's human papillomavirus (HPV) vaccine distribution trend for 2017 below.

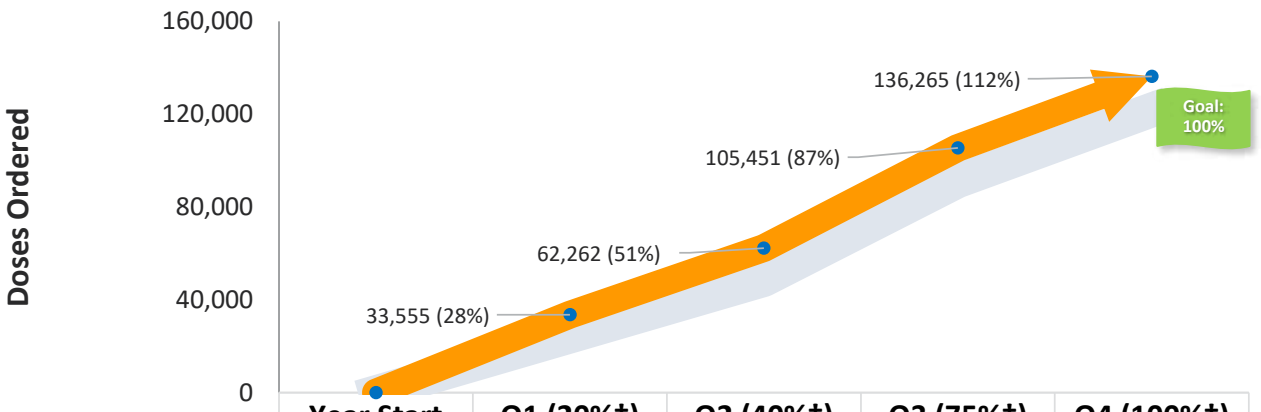
Every year in the United States, it is estimated that >30,000 people are diagnosed with a cancer caused by HPV infection. A large proportion of these cancers could be prevented with vaccination. See the second page of this report for data on HPV–associated cancers in your state or city.

Examining the percentage of HPV vaccine doses distributed while accounting for your jurisdiction's estimated 11-year-old* population provides a yardstick for measuring progress toward vaccinating this cohort. Nationally, HPV vaccine has been distributed as follows:

- 20% in the first quarter
- 20% in the second quarter
- 35% in the third quarter
- 25% in the fourth quarter

We used these percentages to measure progress toward vaccinating 11-year-olds for each quarter of 2017. Check the graph below to see how your jurisdiction did last year.

Year-to-date total of HPV vaccine doses ordered† in Louisiana, compared with doses needed to fully vaccinate 11-year-olds* in Louisiana, 2017



	Year Start	Q1 (20%‡)	Q2 (40%‡)	Q3 (75%‡)	Q4 (100%‡)
2017 Estimated	0	24,364	48,727	91,364	121,818
2017 Actual	0	33,555	62,262	105,451	136,265

Based on an estimated 60,909* 11-year-olds in Louisiana, your jurisdiction ordered **112%** of the estimated total annual doses of HPV vaccine needed to vaccinate all 11-year-olds. If all the ordered doses were used for 11-year-olds, Louisiana ordered a sufficient amount of vaccine for this age group in 2017 including extra doses for catch-up vaccination of older adolescents and young adults.

*The 11-year-old population estimate was obtained from the U.S. Census: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPSYASEX&prodType=table.
†These data represent an estimate of all HPV vaccine doses distributed in Louisiana. The 9-valent HPV vaccine is currently the only HPV vaccine available in the United States.
‡Estimated percentages of vaccine orders are based on the 11-year-old population estimate and national HPV vaccine ordering patterns over the last several years.

Have questions? Contact us at hpvquarterlyreport@cdc.gov.

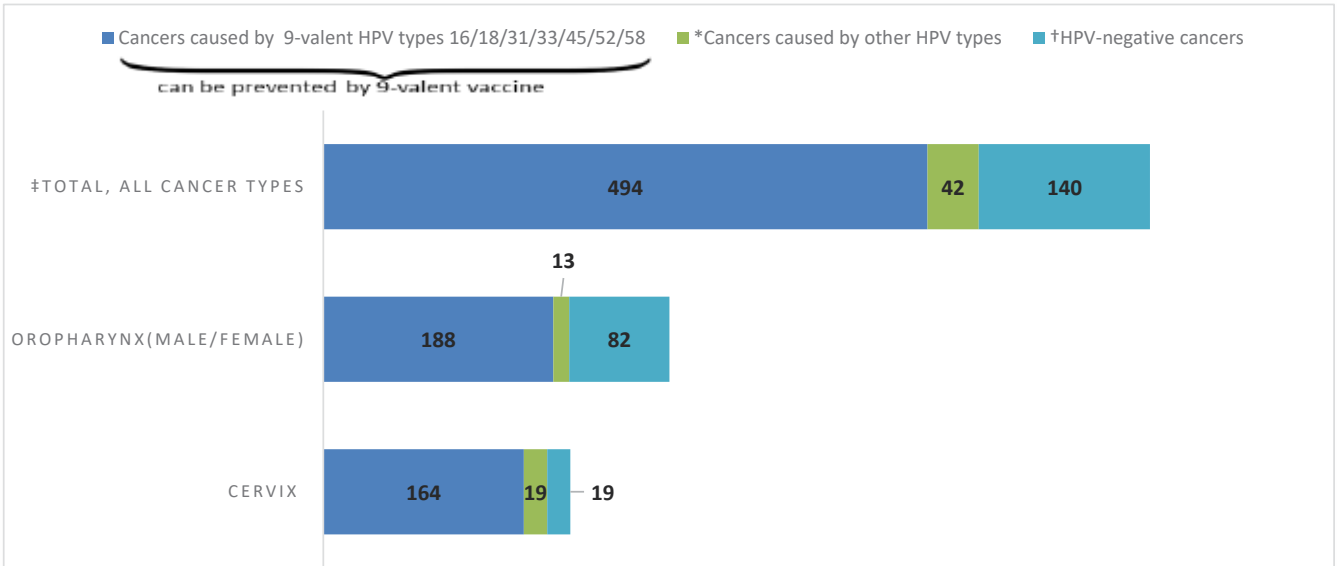
HPV VACCINE IS CANCER PREVENTION

Human Papillomavirus (HPV) Vaccination Report: Louisiana

May 2018

Working Together to Reach National Goals for HPV Vaccination

Estimated number of HPV-associated cancers by cancer type and HPV type, Louisiana, 2010–2014



Source: Data are from population-based cancer registries participating in the CDC National Program of Cancer Registries and/or the NCI Surveillance, Epidemiology, and End Results Program, meeting criteria for high data quality for all years 2010 to 2014, (all registries except Nevada, covering about 99% of the U.S. population).

* "Cancers caused by other HPV types" are cancers caused by HPV types not included in the 9-valent HPV vaccine.

†"HPV-negative cancers" are those that occur at anatomic sites in which HPV-associated cancers are often found, but HPV DNA was not detected.

‡"Total, all cancer types" includes HPV-associated cervical carcinomas as well as squamous cell carcinomas at other anatomic sites, including the vagina, vulva, penis, anus (including rectal squamous cell carcinomas), and oropharynx. However, due to small numbers, data points for the following sites are not displayed in the graph above: vagina, vulva, penis, anus, and rectum.

- **In Louisiana, an estimated total of 676 HPV-associated cancers were reported each year during 2010–2014. Of these, around 79% (536/676) were HPV-attributable and around 92% (494/536) could have been prevented with the 9-valent HPV vaccine, including 188 oropharyngeal and 164 cervical cancers. Of note, the majority (83%) of these oropharyngeal cancers occurred among males.**
- Nationally, an estimated total of 41,000 HPV-associated cancers occurred in the United States each year during 2010–2014. Of these, around 79% (32,500/41,000) were attributable to HPV and of these, around 92% (30,000/32,500) could have been prevented by the 9-valent HPV vaccine, including 11,500 oropharyngeal and 9,400 cervical cancers *(data not shown in chart above)*.

HPV-associated cancers are defined as invasive cancers at anatomic sites with cell types in which HPV DNA is frequently found. These anatomic sites include the cervix, vagina, vulva, penis, anus, rectum, and oropharynx (back of the throat, including the base of the tongue and tonsils). These cell types include carcinomas of the cervix and squamous cell carcinomas of the vagina, vulva, penis, anus (including rectal squamous cell carcinomas), and oropharynx.

HPV-attributable cancers refers to the proportion of HPV-associated cancers probably caused by HPV. These cancers are estimated by multiplying the number of HPV-associated cancers by the percentage attributable to HPV.[1] Based on a CDC study[2] that used population-based data and determined HPV types in cancer tissue, about 90% of cervical cancers and 70% of oropharyngeal cancers are attributable to HPV.

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Resources

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Have questions? Contact us at hpvquarterlyreport@cdc.gov.

HPV VACCINE IS CANCER PREVENTION

Legislative Report

Joe Mapes
LAFP Lobbyist

As this is being written, LAFP is in the throes of another contentious legislative session with multiple issues that could negatively affect Family Medicine. The 2018 Regular Session of the Louisiana Legislature will adjourn sine die at 6 p.m. on June 4, 2018. Over one thousand bills have been introduced in the 2018 Legislative Session and the LAFP is following more than 100 bills.

The LAFP hosted the Legislative and Advocacy Training and White Coat Day at the Capitol on May 2nd where your governmental relations team took part in providing training to those attending. Attendees learned the tools necessary to successfully and effectively communicate with their legislators about issues affecting the specialty of Family Medicine. Attendees also gained insight into the 2018 federal and state legislative agenda and put those skills to use in the afternoon by speaking with their legislators.

As usual, we fought the nurse practitioners who wanted to expand their scope of practice so that they could be independent practitioners. This is called certification through legislation. Senate Bill 435, authored by Senator Fred Mills, would have allowed for the removal of the collaborative practice agreement in the hospital and nursing home settings. It was the camel's head under the tent. As soon as they author got the bill on the floor, an amendment was made to expand the scope even further. A few weeks later, in the house Health & Welfare Committee hearing, the nurse practitioners brought forth a companion bill, but it was killed, as well. However, the NP's stated that they would come back to this Capitol every year until they got independent practice. In working with the other doctor lobbyist groups, we were able to defeat this legislation in its House of origin, i.e., the Senate floor. The bill only got 10 favorable votes to pass it. Thanks, and good job to those doctors that participated by contacting their legislators on this most important issue.

Another bill would have increased the medical malpractice cap dramatically, and a third major issue for us was balanced billing. We have been successful in all measures so far, but the session isn't completely over. Regardless, as we head towards the LAFP 2018 annual conference, you should solicit as many of your colleagues to attend as possible. It's always a good time, but we need to work together as a group and prepare for next year. Doctors must contact legislators to establish and maintain relationships in order to promote and protect Family Medicine. If this cannot be accomplished, Family Medicine will not be at the table, and we all know that means that Family Medicine will be on the menu.

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!

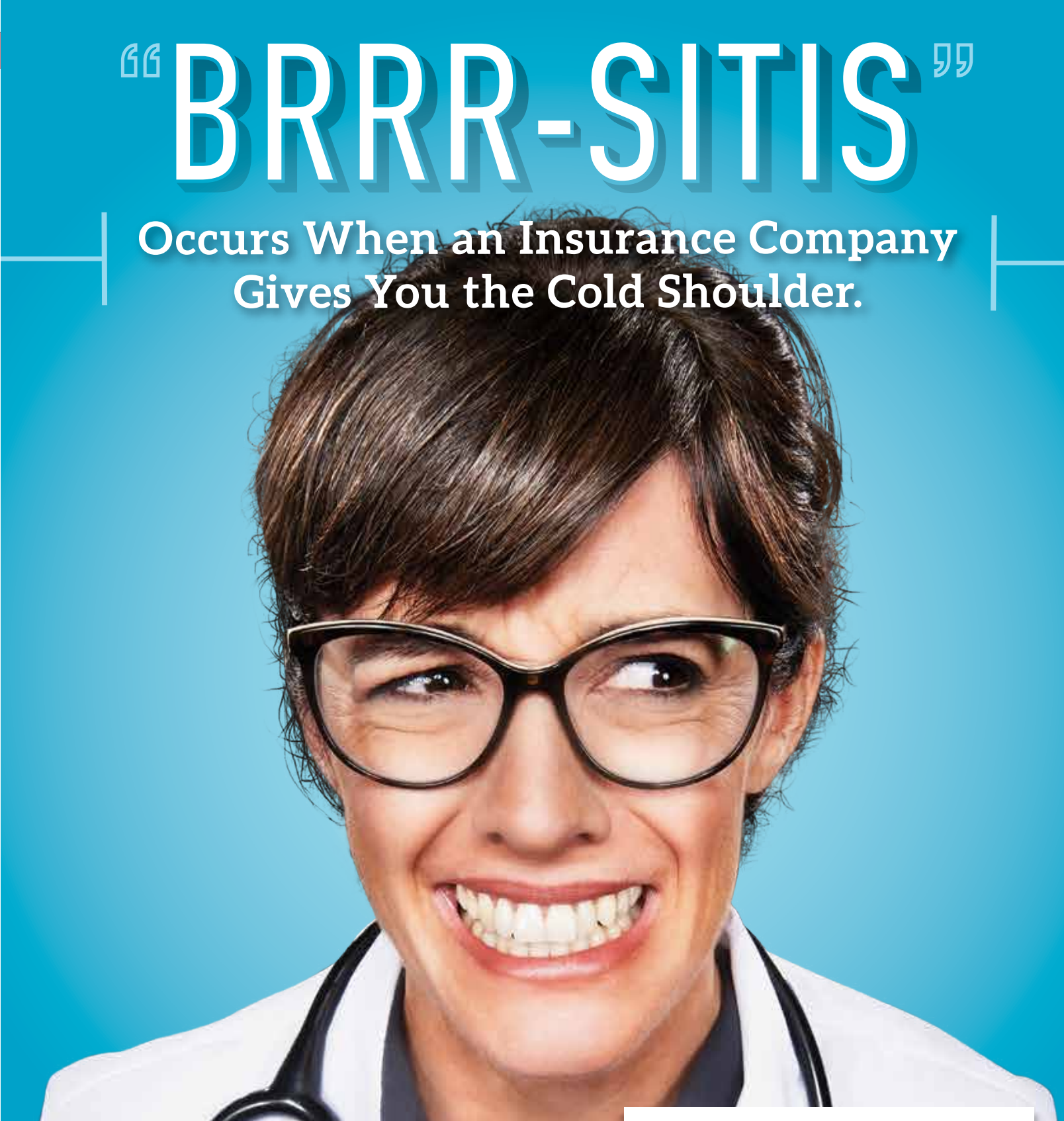
The LAFP Political Action Committee (LaFamPac) would like to thank the following individual contributors:

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.

"BRRR-SITIS"

Occurs When an Insurance Company Gives You the Cold Shoulder.



An insurance rep who's impossible to reach is usually a symptom of a larger issue. Warm up to the proactive professionals at LHA Trust Funds, where members get full access to an experienced customer service team, ready to return your call within 24 hours.

Think you might be suffering from BRRR-sitis?

Get Diagnosed at FreeRiskCheckup.com

LOUISIANA HOSPITAL ASSOCIATION
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Insurance Solutions for Louisiana Healthcare Providers

Family Physicians Engage Legislators *at the Capitol*

On Wednesday, May 2nd the LAFP held the 2018 Legislative and Advocacy Training and White Coat Day at the Capitol. Attendees took part in a full-day of learning the tools necessary to successfully and effectively communicate with their legislators about issues affecting the specialty of family medicine. Attendees also gained insight into the 2018 federal and state legislative agenda and put those skills to use that afternoon while speaking to their legislators. This event was a valuable and successful day for the LAFP.

The residency programs from around the state set up various screening booths for the White Coat Day Health Fair in the State Capitol Rotunda. Including:

- Blood Pressure Screening
  Bogalusa Family Medicine Residency Program
- Glucose Screening
  Baton Rouge General Family Medicine Residency Program
  East Jefferson Family Medicine Residency
- Sleep Apnea Screening
  Kenner Family Medicine Residency Program -
- Concussion Evaluation
  Monroe Family Medicine Residency Program

Here, our physicians could put their advocacy skills into practice. Legislators were seen throughout the afternoon by our residents and physicians while hearing concerns and feeling the presence of Family Medicine as a solidified unit.

The day as a whole was a great success, and we greatly appreciate all of our members who took the time to participate and help strengthen the voice of Family Physicians in Louisiana. If you were unable to attend this year, be on the lookout for 2019 dates!

Improve the Health of Your Patients and Earn Rewards with Our Quality Blue Primary Care Program

Our Quality Blue Primary Care program offers our network 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. Best of all, they're making a measurable difference in the health of their patients.

Learn more about how our Quality Blue Primary Care program can benefit your patients and your practice!

Call: 1-800-376-7765
Email: ClinicalPartnerships@bcbsla.com

Louisiana | Quality Blue PRIMARY CARE

LEARN MORE!

Look for our display at the LAFP 71st Annual Assembly and Exhibition.

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Radiology Associates is committed to providing the highest quality, state-of-the-art imaging and intervention for you, our patient, and to work closely with your referring physician for optimal communication and care.

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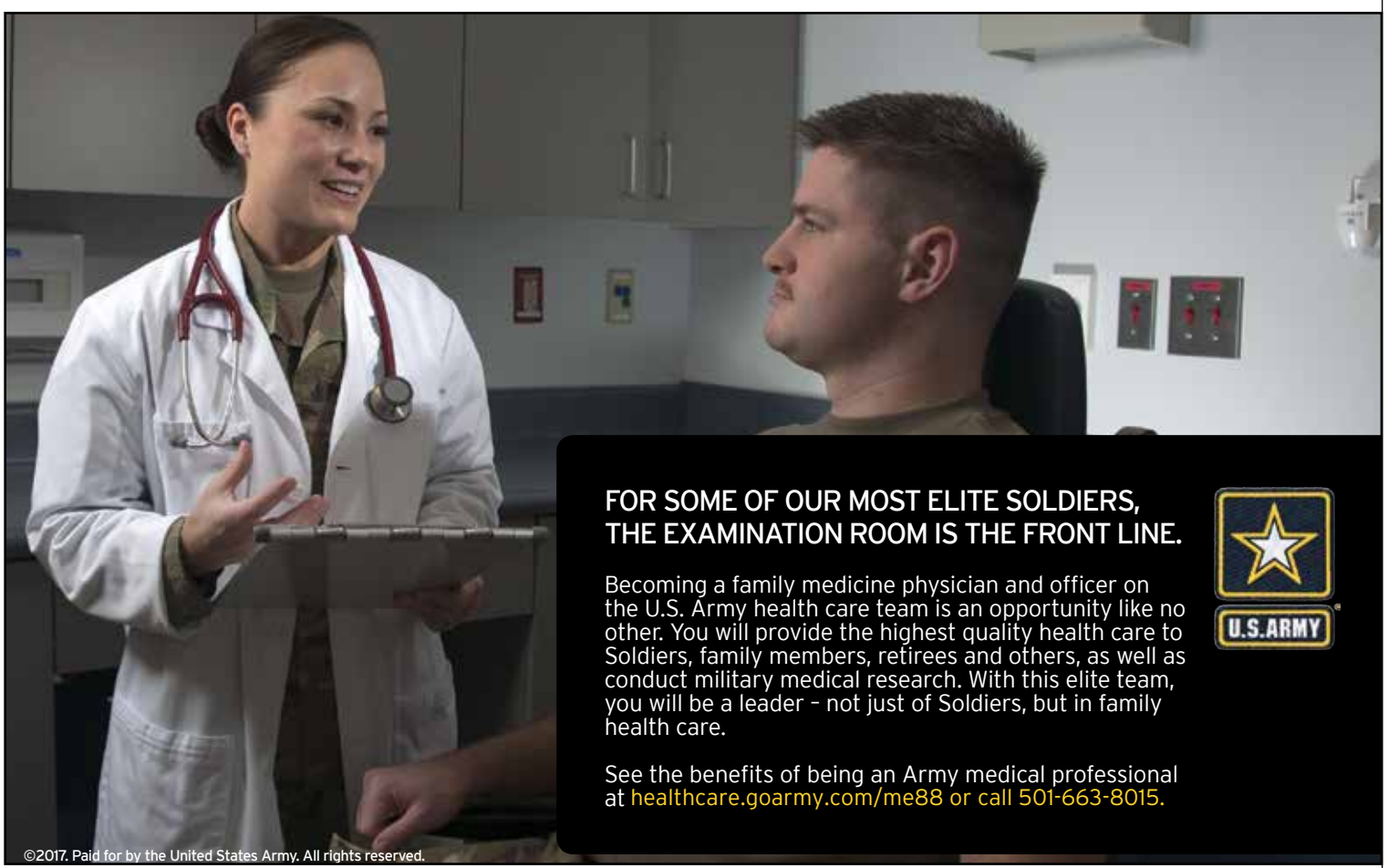

FOR SOME OF OUR MOST ELITE SOLDIERS, THE EXAMINATION ROOM IS THE FRONT LINE.

Becoming a family medicine physician and officer on the U.S. Army health care team is an opportunity like no other. You will provide the highest quality health care to Soldiers, family members, retirees and others, as well as conduct military medical research. With this elite team, you will be a leader – not just of Soldiers, but in family health care.

See the benefits of being an Army medical professional at healthcare.goarmy.com/me88 or call 501-663-8015.

U.S.ARMY

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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.

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 at 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 2018! You can make your gift online at www.lafp.org/foundation.

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.

Chuckie Albert
Michael Arcuri, MD
Gerald Barber, MD
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Melvin G. Bourgeois, MD
Richard Bridges, MD
Donald Brignac, M.D.
Janet Brignac
Kenneth Brown, MD
Elderidge Burns, MD
James Campbell, MD
Lisa Casey, MD
Mary Coleman, MD
Russell Cummings, MD
Tom Curtis, MD
Nicholas Daigle
Thomas Davis, MD
Eddie Denard, MD
Eileen Dominguez
Rosa Folgar
Thomas Fontenot, MD
Christopher Foret, MD
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Wayne Gravois, M.D.
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Teri Barr O'Neal
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Richard Streiffer, MD
Leonard Treanor, MD
Roland Waguespack, MD
John Walker, MD
Hugh Washburn, MD
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!


Theodore Borgman


John Kokemor


Mark Brown


Sally Ball


Ricky Jones


Vincent Tumminello


Gayle Beyl


Theresa Rinderle


Marion Cash


Michael Casey

Congrats!

These Louisiana Blue Cross doctors have reached over 80% screening rate for colorectal cancer screening!


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BE A LEADER In Preventive Care

As a healthcare provider, keeping your patients healthy is the goal.

1.27 million adults in Louisiana have prediabetes and 90% of them don't know it. Ignoring prediabetes increases the risk of:

- TYPE 2 DIABETES
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Help your patients determine their risk and take action today.

TEST your at-risk patients for prediabetes.

REFER your patients to a **National Diabetes Prevention Program**.

The National Diabetes Prevention Program is a lifestyle change program that provides:

- A Trained Lifestyle Coach
- Group Support
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Research shows structured lifestyle interventions can cut the risk of type 2 diabetes in

HALF

Your patients will learn to make small, smart lifestyle changes like:

- EATING HEALTHY
- MOVING MORE
- MANAGING STRESS

To find a National Diabetes Prevention Program near you, visit:
www.wellaheadla.com/programs/diabetes

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The Medicaid Fee Schedule and Access to Care: *Building A Healthy Louisiana*

According to national data from the Kaiser Family Foundation (KFF), about 70 percent of office-based physicians accept new Medicaid patients. Louisiana, at just under 57 percent, is one of only five states that fall significantly below that national average. Recent research has found a direct correlation between higher Medicaid fees and higher rates of Medicaid participation among physicians, making Louisiana's Medicaid fee schedule, and its impact on access to care, issues of critical importance.

THE IMPACT OF THE FEE SCHEDULE

Each state establishes its own Medicaid provider payment rates, or fee schedule. Here in Louisiana, the Medicaid fee schedule is 67 percent of Medicare, meaning a physician providing services to a Medicare patient is reimbursed 33 percent more than when he or she provides the same services to a Medicaid patient. As a point of comparison, the Medicaid fee schedule is significantly higher in neighboring Mississippi.

To date, no study has been conducted in Louisiana to determine the full impact of the Medicaid fee schedule on access to care, but extensive research has been done at the national level.

In 2017, Princeton University examined variations in Medicaid reimbursement rates after the Affordable Care Act mandated that states raise Medicaid payments to match Medicare rates for primary care visits in 2013 and 2014.The study found that increasing Medicaid payments to primary care physicians resulted in improved access to care, better self-reported health and fewer school days missed among Medicaid beneficiaries.

THE LOUISIANA LANDSCAPE

In addition to higher rates of heart disease, diabetes, HIV, drug mortality, and cancer diagnoses and deaths than most other states, Louisiana also suffers from disparities in access to care, with significant percentages of the population reporting a lack of a personal doctor. These poor health ratings were largely attributed to the state's high numbers of residents without health insurance.

However, with the expansion of Medicaid in 2016, the state made significant strides in overcoming its high uninsured rate. By the end of the first year, more than 430,000 Louisiana residents had enrolled, giving Louisiana one of the best reductions in uninsured rates in the nation, and generating $199 million in savings for the state.

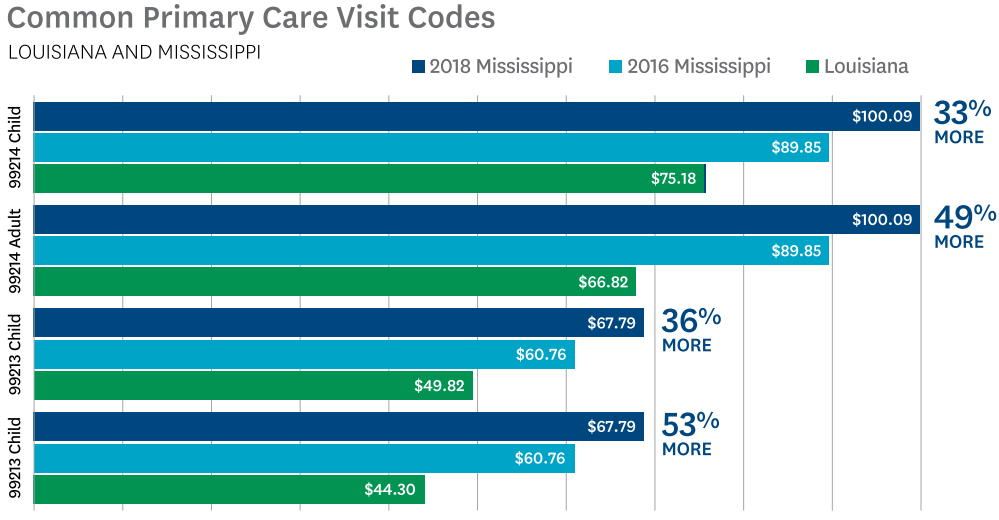
To achieve these successes, the Louisiana Department of Health simplified Medicaid eligibility and enrollment processes, earning recognition as a national leader for streamlining renewal processes for children receiving Medicaid and CHIP benefits.

This approach resulted in increases of adult residents who have received mental health and substance abuse treatment. In addition, the numbers of new Medicaid enrollees who have received cancer screenings, women's health services, and comprehensive diabetes care have grown exponentially.

Working For a Healthier Louisiana
LaHealth.cc/working

BUILDING A HEALTHY LOUISIANA

As a result of its innovations in Medicaid coverage, Louisiana is moving the needle on the healthcare issues that have plagued it for generations. Increasing the professional services fee schedule to a rate at least more comparable to Medicare will strengthen the state's investment in Medicaid recipients while supporting the combined efforts of LDH, the Managed Care Organizations and physicians to truly build a healthier Louisiana.



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Highest Achievement in DIABETES CARE:
East Jefferson Internal Medicine

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.

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