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Subscriptions are available to non-members for $12 per year. Opinions expressed here are not necessarily those of the AzAFP. Letters to the editor are welcomed and published as room allows. Send letters to the AzAFP office at PO Box 1170, Queen Creek, AZ 85142.
Readmissions: Whose Job (fault) is it anyway?

**A CASE**

Mary Leyba (not her real name and not a real patient) has been admitted to Best Community Hospital (BCH) in Metroplex, AZ. After a thorough workup her physician team has determined that she has newly diagnosed (to them) heart failure and a pulmonary infiltrate, possibly pneumonia. She also has poorly controlled diabetes type 2 and hypertension. She’s discharged to home (she lives alone but has a son who checks on her periodically) on doses of furosemide and lisinopril along with meds for BP and DM. She’s advised to see her regular cardiologist in the next week and her PCP in two weeks. Over the next several days she gets more short of breath and calls her PCP. The office was not aware of her recent hospital stay and advised her to return to BCH’s Emergency Department. She calls an ambulance and instead is brought to the closest hospital, Next Best Medical Center (NBMC).

**READMISSIONS: WHAT’S THE BIG DEAL?**

A hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from an earlier (initial) hospitalization. For Medicare, this time period is defined as 30 days, and includes hospital readmissions to any hospital. From 2008 to 2013 the 30 day readmission rate for all ages, all payors, all causes was about 8.6%. Over the same time period the rate for Medicare patients was about 18%. For Medicare beneficiaries the Heart Failure readmission rate it was about 25%. In their never ending quest to drive costs out of the Health system, payors believe readmissions are a source of unnecessary and expensive healthcare rework. The readmission of Medicare patients alone costs $26 billion annually. The feds believe that ⅔ of that was due to inadequate hospital care the first time around. As a consequence Medicare, through the Hospital Readmission Reduction Program (HRRP) penalizes hospitals with “relatively higher rates” of Medicare readmissions. Other providers in the healthcare continuum are now also scrutinized and penalized.

**WELL WHOSE FAULT IS THAT?**

Acute care hospitals have received the most scrutiny regarding readmissions. Research indicates however many factors, historically out of the realm of “hospital care”, contribute to hospital readmissions. So who else plays a role?

- **The Hospitalist:** The vast majority of hospital inpatients are cared by hospitalists. The great majority of hospitalist are residency-trained internists. Many went into their hospitalist career right of residency. Given the limited exposure Internal Medicine residencies have for continuity primary care, it should no surprise that hospitalists may not effectively handoff discharged patients to their primary care physician.

- **The Hospital Specialist:** Inpatients needing specialty care will not necessarily receive that care from the same physician who provided it on an outpatient basis. For example, a heart failure patient regularly seen by cardiologist X in cardiology group X may go to hospital Y’s ED where cardiology group does not go. In the likely absence of past test and treatment results the cardiologists at hospital Y may repeat an echo and start medication that historically did not work for that patient. That patient may accept the new ARB valsartan as long as it’s not the Diovan that didn’t work for her in the past.

- **The Health plan:** While the health plan may exhort the PCP to reduce his/her readmission rate, that same plan may not any additional resources (i.e. dollars) to timely office follow up, hospital care team communication and/or collaboration etc. The health plan may not even provide more basic resources such as notification of patient admission.

- **The Pharmacists and the drugs:** Research indicates that many patient are confused about their discharge medications and how their prescriptions should be reconciled with the meds they were already taken. Programs that have successfully reduced hospital readmissions have found that early post-discharge medication review and education can prevent serious medication errors which often lead to a return to the hospital.

- **The Primary Care Physician:** Lack of early, effective office follow up contributes to the readmission phenomenon. Primary Care physicians often lack the necessary time and information to effectively evaluate a recently discharged, medically complex senior. Medicare has recently attempted to support that care through the Transitional Care Management codes. Unfortunately many PCP office have neither the needed discharge information nor the office resources to complete the early post discharge contact (i.e. within two business days) to meet the coding requirements.
I am starting to get very frustrated by the lack of cogent information I am receiving from the hospitals, consultants, and other Guest Houses of the Medical Home that I’m trying to keep aligned.

As a primary care physician, I am asked to maintain the overall longitudinal care of a patient by coordinating the principle care of their chronic health issues, as well as engage the services of ancillary facilities, specialist consultants, lab facilities, urgent cares, and hospitals, and to make sure that not only is the best team being put on the field, but also that each member of the team is performing their duties. I have to make sure that the receivers are going down their intended path, and are ready to receive the ball, and not to embellish, dance on the field, or run in the wrong direction.

Well, I’m getting overwhelmed by the information that is coming back. In the drive to provide categorized and standardized information in a “note,” the current healthcare system has produced the most jumbled collection of data in existence. And for me to find the information that is needed, I need to get out my mental machete to hack through the ridiculous amount of completely unnecessary data to find the physician’s assessment and plan, along with the discharge medications and studies that need follow up.

It’s stupid. We are so busy satisfying the needs of actuarials that we are no longer satisfying the needs of one another. And we are, without argument, doing a great disservice to our patients.

For what patients, and the healthcare system, truly needs is continuity. We all need the ability to know what one another hears, sees, thinks, and does about the patient. Right now, I would challenge that the information we need is not readily available. If we are expected to see a discharged hospital patients within 1-2 days of discharge, then I need a well written, organized, detailed, and focal discharge summary. Don’t send me the patient instructions. Don’t send me the times and dates and the lot number of each and every point of care glucose check that the patient endured (and will have to pay for) in the hospital. I don’t need to know that the patient only drank half the Ensure, and that the dietitian visited the patient, but because the patient was not in the room, the dietitian had decided to come back two hours later, but then the respiratory therapist was there, so the dietitian had a conference with the utilization and discharge coordinator, and the nursing home visited but they can’t accept the insurance, so they wrote a note on the chart to that effect.

I don’t need to know! What I need to know is the clinical care of my patient. I need the labwork that was obtained along with trends. I need imaging studies. I need consult notes.

So I guess what I’m asking for, for my patients is those things that are clinically relevant to me in the longitudinal care of my patient. And nothing more than that. So stop sending me every single minute detail. If my patient is seen in the ER, I want the ER physician’s notes, the vitals, the testing done, the imaging results, and the discharge plan, including medications that were prescribed. I don’t need anything else.

If what needs to be produced are two separate charts, then let’s do it. Let’s make a chart for docs and a chart for everyone else. If I need to check the other chart, I’ll do so. That’s the way it used to be done. We need to return to a system that provides clinically relevant data, and a separate system for nurses and other ancillary providers, and then finally a chart for population and quality care data. Because otherwise, it’s just too much information.
Every year in the United States, approximately 150,000 people are believed to be infected with coccidioidomycosis (valley fever). Arizona accounts for 65 percent of all reported cases in the US, and it is one of the most commonly reported infectious diseases in the state (over 7,600 cases were reported in 2015, a significant increase from the prior year). There are probably many more cases than this – most patients with coccidioidomycosis have mild respiratory symptoms and/or do not undergo diagnostic testing.

Coccidioidomycosis is a difficult disease to identify clinically, since the primary symptoms include cough, fever, and fatigue (also chest pain, dyspnea, night sweats, weight loss, arthralgia, and rash). These nonspecific symptoms often lead to patients receiving escalating treatment regimens and workups, leading to patient anxiety and overutilization of health care resources. Due to its high prevalence in central and southern Arizona, coccidioidomycosis can be included early in a physician’s differential. When sending diagnostic tests, one can consider timing (initial tests may be negative, so repeated tests may be required) and need for treatment (certain patient populations are at greater risk of dissemination). Guidelines for managing patients with coccidioidomycosis can be found at the Infectious Diseases Society of America (www.idsociety.org) and the Valley Fever Center for Excellence (www.vfce.arizona.edu).

For further learning opportunities, the Valley Fever Center for Excellence offers a free online continuing medical education course for primary care physicians and a primary care tutorial. For patient educational materials, please visit the Arizona Department of Health Services website (www.valleyfeverarizona.org) or call (602) 364-3676.
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* Based on 2014 data.

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Organizational App

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The AAFP mobile app for iOS (itunes.apple.com) and Android (play.google.com) is available for download. Featuring enhanced access to AAFP services, the mobile app puts valuable tools and resources at the fingertips of members.

The app features access to account information, American Family Physician and Family Practice Management journal content, upcoming event listings, AAFP News Now updates, member discounts, member-only Board review practice questions, a new CME reporting feature, and more.

A full-page (1 page PDF) and half-page ad (1 page PDF) are available for chapters to promote the app and its features to members.

Sample promotional copy is also provided for chapter use:

“AAFP Mobile App Now Offers CME Reporting”

Family medicine is in your hands. Now the AAFP is, too. Download the AAFP’s mobile app and get enhanced access to AAFP services and benefits at your fingertips. You can now report your CME on your mobile device through the AAFP app as a members-only benefit. More than 1,000 Board Review prep questions are available to members so you can assess your medical knowledge and get CME credit at no charge. Plus, make evidence-based decisions about the treatment and prevention of disease using AAFP clinical recommendations, sortable by topic or title.

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- Browse general residency information in the Strolling Through the Match publication.

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Chapters may contact Stephanie Taylor-Rymer at staylor@aafp.org or ext. 5623 with questions.

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Contact your Arizona Physician Recruiter, Blake Farrill for more information: Blake.Farrill@corizonhealth.com, 800.222.8215 EXT 9351.
Urgent Care Opportunity for Full-time, Part-time and PRN family physicians

Dignity Health owns and operated four (4) Urgent Care facilities located in Ahwatukee, Gilbert, Queen Creek and Maricopa. The centers are open 7 days a week from 7:00 am to 10:00 pm daily including holidays with the exception of Maricopa that has daily hours of 12:00 pm through 9:00 pm. There is a need to add Full-time, Part-time and PRN physicians to our staff. Candidates must be board certified/eligible family physicians with ACLS, BLS and PALS certifications. Prior urgent care experience preferred but not mandatory. For candidates that are qualified, excellent hourly compensation with additional compensation for nights, weekend and holidays. Full-time physicians are eligible for the following benefits: health, dental, life, vision, PTO (paid time off) and a CME allowance. Malpractice coverage is provided by Dignity Health.

Pediatrician Opportunity in Kingman, AZ

Families in northwest Arizona need your expertise!
If you are a skilled team-oriented Family Practice physician (BC or BE), please consider our exclusive opportunity for providing primary healthcare services to families in scenic Kingman, Arizona. As an employed physician at Kingman Regional Medical Center, you will experience camaraderie among our team of skilled medical providers combined with some of modern medicine’s most advanced technologies—all while enjoying the excellent quality-of-life found in our tranquil community.

- Highly-competitive salary (as compared with MGMA benchmarks)
- Sign-on bonus
- Relocation compensation
- Productivity bonus possibilities
- Student loan repayment (National Health Service Corporation approved site)

About Kingman Regional Medical Center
Kingman Regional Medical Center (KRMC) is the largest healthcare provider and the only remaining non-profit hospital in Mohave County, Arizona. As a 235-bed multi-campus healthcare system, our medical center includes more than 1,800 employees, 260 physicians/allied health professionals, and 250 volunteers.

When you visit KRMC, you will find that we are unique among small-city medical centers. Our most valuable asset is our talented medical staff who work together in a spirit of collaboration and cooperation for the good of our patients. Our culture and vision empower us in offering a full-continuum of highly-technical and specialized healthcare services—from essential primary and preventative care—to sophisticated medical imaging and diagnostic capabilities—to intricate surgical technologies and techniques—to advanced treatments in cardiac care, wound care, and cancer care—to progressive rehabilitation and pain management therapies.

Mayo Clinic Network Member
KRMC was one of the first hospitals in the nation to become a member of the Mayo Clinic Care Network, which provides our community many options for receiving quality care close to home. With this membership, our healthcare providers have direct access to Mayo Clinic medical expertise, research, and clinical practices. Our ties with Mayo Clinic are also reinforced through other collaborative programs. For example, Mayo Clinic neurologists are immediately available via telemedicine technology to provide local evaluation of neurological conditions in both adults and children.

About our Community
Located in the picturesque high desert of northwest Arizona, Kingman has beautiful year-round weather with easy access to mountain sports and water recreation. Ideally located just 90 minutes south of Las Vegas, Nevada; we are also only a few hours’ drive to professional sporting events and shopping in Phoenix or to the beaches of southern California. Kingman serves as the county seat of Mohave County—one of Arizona’s fastest growing areas. Our service area population is over 70,000 with a draw area of 200,000.

For more information about KRMC and the community we serve, please visit our website at: www.azkrmc.com
# American Academy of Family Physicians:
## MEMBERSHIP DASHBOARD

*“AAFP info”, December, 2015, copyright AAFP.*

**Dec-15**

<table>
<thead>
<tr>
<th></th>
<th>YTD Actual</th>
<th>YTD Projection</th>
<th>% Variance Actual to Projection</th>
<th>Yearly Projection</th>
<th>Prior YTD Actual</th>
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</thead>
<tbody>
<tr>
<td>ACTIVE NEW MEMBERS</td>
<td>684</td>
<td>625</td>
<td>9.44%</td>
<td>1,070</td>
<td>628</td>
</tr>
<tr>
<td>ACTIVE PAYMENTS</td>
<td>43,963</td>
<td>42,030</td>
<td>4.60%</td>
<td>65,650</td>
<td>41,515</td>
</tr>
<tr>
<td>ACTIVE REINSTATEMENTS</td>
<td>1,680</td>
<td>1,395</td>
<td>20.43%</td>
<td>2,455</td>
<td>1,417</td>
</tr>
</tbody>
</table>

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![Bar charts showing membership trends from June to May for different categories (Total Membership, Active Members, Students, Residents)]
## Membership Dashboard

### TOTAL Membership

<table>
<thead>
<tr>
<th>MEMBERSHIP COUNT</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2015-2016</strong></td>
<td>106,013</td>
<td>110,011</td>
<td>112,535</td>
<td>114,753</td>
<td>116,272</td>
<td>118,134</td>
<td>118,988</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2013-2014</strong></td>
<td>99,966</td>
<td>103,602</td>
<td>106,432</td>
<td>107,896</td>
<td>109,533</td>
<td>110,880</td>
<td>111,587</td>
<td>112,861</td>
<td>113,875</td>
<td>114,884</td>
<td>115,910</td>
<td>111,611</td>
</tr>
</tbody>
</table>

### DELINQUENT MEMBERS

| **2015-2016**    | 4,276 | 14,130 | 10,107 | 7,825 | 4,144 | 3,010 | 2,221 |
| **2014-2015**    | 4,254 | 14,315 | 10,472 | 5,683 | 3,186 | 2,642 | 1,810 | 25,309 | 20,028 | 16,437 | 11,686 | 4,405 |
| **2013-2014**    | 4,290 | 13,703 | 9,787 | 5,721 | 3,161 | 1,740 | 1,176 | 23,815 | 18,582 | 15,235 | 10,934 | 4,404 |

### Active Members

#### ACTIVE MEMBERS

| **2015-2016**    | 67,205 | 67,511 | 67,910 | 68,496 | 68,521 | 68,791 | 68,946 |

#### NEW MEMBERS

| **2015-2016**    | 9 | 147 | 92 | 114 | 23 | 191 | 108 |
| **PROJECTED**    | 10 | 145 | 115 | 100 | 15 | 145 | 95 | 130 | 95 | 90 | 70 | 60 | 1,070 |
| **2014-2015**    | 12 | 147 | 117 | 97 | 17 | 144 | 94 | 134 | 112 | 90 | 71 | 45 | 1,080 |
| **2013-2014**    | 22 | 135 | 174 | 99 | 27 | 176 | 84 | 165 | 124 | 72 | 51 | 56 | 1,185 |

#### PAYMENTS

| **2015-2016**    | 597 | 736 | 4,284 | 5,635 | 7,013 | 10,449 | 15,049 |
| **PROJECTED**    | 550 | 630 | 4,225 | 4,750 | 5,000 | 11,575 | 15,300 | 9,400 | 4,800 | 3,520 | 4,400 | 1,500 | 65,650 |
| **2014-2015**    | 535 | 628 | 4,207 | 4,739 | 4,784 | 11,441 | 15,181 | 9,318 | 4,749 | 3,528 | 4,367 | 1,450 | 64,927 |
| **2013-2014**    | 539 | 612 | 4,212 | 4,587 | 7,077 | 9,842 | 14,037 | 10,314 | 4,601 | 3,210 | 4,032 | 1,242 | 64,305 |

#### REINSTATEMENTS

| **2015-2016**    | 518 | 328 | 265 | 209 | 159 | 104 | 97 |
| **PROJECTED**    | 435 | 250 | 190 | 215 | 125 | 80 | 100 | 60 | 40 | 30 | 20 | 910 | 2,455 |
| **2014-2015**    | 434 | 254 | 191 | 218 | 125 | 84 | 111 | 64 | 54 | 42 | 26 | 811 | 2,414 |
| **2013-2014**    | 444 | 262 | 204 | 193 | 129 | 75 | 70 | 74 | 45 | 31 | 32 | 933 | 2,492 |

#### CANCELLATIONS

| **2015-2016**    | 24 | 114 | 41 | 42 | 6 | 12 | 14 |
| **PROJECTED**    | 35 | 10 | 140 | 45 | 25 | 15 | 20 | 20 | 25 | 45 | 40 | 5,400 | 5,820 |
| **2014-2015**    | 33 | 5 | 140 | 43 | 28 | 15 | 18 | 18 | 15 | 26 | 22 | 5,360 | 5,721 |
| **2013-2014**    | 16 | 28 | 14 | 164 | 19 | 18 | 19 | 29 | 25 | 48 | 23 | 4,845 | 5,248 |

#### DELINQUENT MEMBERS

| **2015-2016**    | 4,182 | 3,909 | 69 | 9 | 9 | 0 | 1 |
| **2014-2015**    | 4,181 | 4,078 | 130 | 16 | 17 | 19 | 3 | 23,003 | 18,411 | 15,111 | 10,677 | 4,248 |
| **2013-2014**    | 4,151 | 4,017 | 290 | 3 | 3 | 1 | 1 | 21,701 | 17,201 | 14,083 | 10,046 | 4,265 |

#### RETENTION RATE

| **2014**    | 94.4% |
| **2013**    | 94.9% |
| **2012**    | 95.0% |
|------------------|----------|----------|----------|----------|----------|----------|----------|
| **TOTAL NEW ACTIVE** |          |          |          |          |          |          |          |
|                   | 100%     | 100%     | 100%     | 100%     | 100%     | 100%     | 100%     |

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</thead>
<tbody>
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<td>% 49 years old or Younger</td>
<td>100.00%</td>
<td>75.00%</td>
<td>25.00%</td>
<td>40.00%</td>
<td>0.00%</td>
<td>60.00%</td>
<td>66.67%</td>
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<tr>
<td>% 60 years or Older</td>
<td>0.00%</td>
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<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>20.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>% ABFM Certifieds</td>
<td>0.00%</td>
<td>0.00%</td>
<td>25.00%</td>
<td>40.00%</td>
<td>0.00%</td>
<td>40.00%</td>
<td>33.33%</td>
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<tr>
<td>% DO's</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
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<tr>
<td>% Fellows</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>% Female</td>
<td>100.00%</td>
<td>50.00%</td>
<td>25.00%</td>
<td>40.00%</td>
<td>0.00%</td>
<td>80.00%</td>
<td>66.67%</td>
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<tr>
<td>% IMGs</td>
<td>0.00%</td>
<td>0.00%</td>
<td>25.00%</td>
<td>50.00%</td>
<td>0.00%</td>
<td>40.00%</td>
<td>33.33%</td>
</tr>
<tr>
<td>% Male</td>
<td>0.00%</td>
<td>50.00%</td>
<td>75.00%</td>
<td>60.00%</td>
<td>0.00%</td>
<td>20.00%</td>
<td>33.33%</td>
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<tr>
<td>% New Physicians</td>
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<td>0.00%</td>
<td>25.00%</td>
<td>10.00%</td>
<td>0.00%</td>
<td>40.00%</td>
<td>33.33%</td>
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<td>% 49 years old or Younger</td>
<td>37.50%</td>
<td>53.15%</td>
<td>64.77%</td>
<td>61.54%</td>
<td>47.83%</td>
<td>54.30%</td>
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</tr>
<tr>
<td>% 60 years or Older</td>
<td>25.00%</td>
<td>11.89%</td>
<td>12.50%</td>
<td>2.88%</td>
<td>17.39%</td>
<td>11.29%</td>
<td>12.38%</td>
</tr>
<tr>
<td>% ABFM Certifieds</td>
<td>75.00%</td>
<td>81.82%</td>
<td>72.73%</td>
<td>75.00%</td>
<td>86.96%</td>
<td>89.25%</td>
<td>83.81%</td>
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<td>% DO's</td>
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<td>8.65%</td>
<td>13.04%</td>
<td>11.83%</td>
<td>11.43%</td>
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<td>% Fellows</td>
<td>12.50%</td>
<td>7.69%</td>
<td>4.55%</td>
<td>4.81%</td>
<td>13.04%</td>
<td>4.84%</td>
<td>5.71%</td>
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<tr>
<td>% Female</td>
<td>37.50%</td>
<td>45.45%</td>
<td>52.27%</td>
<td>58.65%</td>
<td>52.17%</td>
<td>46.24%</td>
<td>43.81%</td>
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<tr>
<td>% IMGs</td>
<td>25.00%</td>
<td>26.57%</td>
<td>28.41%</td>
<td>28.85%</td>
<td>34.78%</td>
<td>19.89%</td>
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### Resident Members

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### International Members

#### MEMBERSHIP COUNT

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#### DELINQUENT MEMBERS

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#### NEW MEMBERS

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#### REINSTATEMENTS

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#### CANCELLATIONS

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### Inactive Members

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#### DELINQUENT MEMBERS

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#### CANCELLATIONS

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The Core Content Review of Family Medicine
Educating Family Physicians Since 1968
2016 Fellowship in the History of Family Medicine

Deadline March 31

January 13, 2016

The Center for the History of Family Medicine is accepting applications for the sixth annual Fellowship in the History of Family Medicine (www.aafpfoundation.org). Chapters are encouraged to promote this opportunity to members.

The award provides up to $2,000 to support travel, lodging, and incidental expenses related to research on a project of the applicant’s choice dealing with the history of general practice, family practice, or family medicine in the United States. Interested family physicians, other health professionals, historians, scholars, educators, scientists, and others are invited to apply.

The deadline to apply is 5 p.m. CT on Thursday, March 31. All applications will be reviewed in April, and the Fellowship awards will be announced by May 31. Complete fellowship rules, application forms, and instructions are available online (www.aafpfoundation.org).

Contact Don Ivey by email or at ext. 4420 with questions.
FP ad to come
The Member Interest Group (MIG)  
Member Information Guide is provided for quick reference by MIG members and AAFP members interested in MIGs. If you do not find the information you seek or if you would like additional information about MIGs, please contact:

Callie Castro, Member Interest Group Strategist, (800) 274-2237, ext. 6824.

The AAFP acknowledges and embraces the diversity of its membership. In an effort to strengthen all member voices from within the large membership as a whole, a Board-appointed task force was charged with examining how best to hear and address specific member issues. Effective April 2014, the AAFP Board of Directors approved the establishment of AAFP MIGs as a way to define, recognize, and engage various member groups.

MIGs serve as forums for AAFP members with shared professional interests and provide members with the opportunity to:

- Network with fellow AAFP members
- Participate in interest-specific continuing professional development activities
- Deliver a unified message to AAFP leadership
- Influence and suggest AAFP policy
- Provide input on AAFP policies and positions (upon request)
- Pursue professional leadership development within the AAFP
- Connect to existing AAFP resources
- Meet face-to-face at AAFP Assembly
- Promote AAFP membership

Applications to create an MIG must include the names of a minimum of 50 Active members for consideration. Once membership is established, however, the MIG is open to any AAFP member. MIG applications must be submitted to the AAFP’s Commission on Membership and Member Services (CMMS) and can be found online. The CMMS may then recommend establishment of the member interest group to the Board of Directors for approval.

MIG Officers
The MIG officers consist of the Chair, Vice Chair, and Secretary. Officers will be elected for one-year terms with timing to coincide with AAFP Assembly. If the group does not meet at Assembly, the elections will be conducted electronically during the same time. Officers for the first year of MIG existence will be those named on the application submitted with elections to occur prior to the second annual MIG meeting at Assembly.

Social Community
The AAFP will provide all MIGs a social platform to include listserv capability and document sharing as a means of communication, collaboration, and networking. MIGs are expected to utilize the provided platform for all business conducted and will be monitored by Staff Liaisons as a way to ensure AAFP membership requirements are maintained. Other non-AAFP social platforms, e.g., Google Groups/Docs, should not be used to conduct MIG business.

MIG Meetings
MIGs will be provided space during AAFP Assembly each year at the request of the MIG Chair. Should the MIG desire to formally meet face-to-face at other venues, such as the AAFP Leadership Conference for Current and Aspiring Leaders, the MIG membership must agree to the meeting in advance and request Staff Liaison participation. As outlined in the funding section of this document, MIG officers are not eligible for reimbursement of any travel expenses or per diem associated with MIG meetings.

Funding
MIGs will not have an AAFP-approved budget for any meetings or MIG expenses. Staff Liaison time devoted to supporting an MIG is provided through the assigned mission area and is estimated at approximately 25 hours per year.

MIGs may solicit funds from non-AAFP entities, if desired. AAFP staff will not participate in the solicitation of outside funding. Any fundraising efforts are strictly the responsibility of the MIG officers, but must be pre-approved by the MIG Staff Liaison and the Division of Strategic Partnerships.

MIG Staff Liaisons will be responsible for contacting Strategic Partnerships for such approval prior to solicitation. MIG Staff Liaisons will also be responsible for ensuring compliance with Sunshine Act reporting requirements that may come as a result of funding. Upon legal
review, AAFP staff will sign any contract for outside funding.

**Commission Oversight**

The AAFP commission that most closely aligns with the needs/interests of the group will sponsor the MIG and provide a Commission Member Liaison for each MIG assigned to it. MIGs may develop policy statements or position papers for consideration by their oversight commission. MIG officers should work with the Staff Liaison to ensure deadlines are met and appropriate format is followed for materials to be presented to the commission. MIGs may be asked to provide input into AAFP policy, meetings, and resources as needed. Requests for additional services beyond those outlines as opportunities for an MIG must be directed to AAFP Membership Staff.

**Maintenance of an MIG**

Each MIG must work toward fulfillment of the MIG goals (both short-term and long-term) and adhere to the mission of the AAFP at all times. In addition, MIG membership must not fall below 50 Active members. At such time, the CMMS will notified and make determination of next steps for the MIG in question. If, at any time, the actions of an MIG are deemed to be in conflict with the AAFP bylaws, the MIG may be suspended by the Board Chair. In addition, if the actions of an MIG are determined not to be in accordance with the goals, objectives, or in the best interest of the AAFP, the MIG may be suspended by the Board Chair.

**Authority of MIGs**

MIG members are bound by and warrant full compliance with the AAFP bylaws and any social platform terms of use. MIGs are not empowered to commit AAFP resources, support positions of other organizations, or establish policy. MIG members should seek AAFP staff review of any publications that make mention of the AAFP or AAFP MIG involvement. In addition, a disclaimer should accompany every publication on behalf of the MIG that states the published content does not necessarily represent the official position or view of the AAFP.

**Member Constituencies**

MIGs may petition the Board of Directors to become a member constituency after one year. Member constituencies include AAFP members from groups that are perceived to be underrepresented in leadership at the national and chapter levels and unable to enter leadership through typical pathways. They may also be groups whose issues of concern are not being adequately heard in the Congress of Delegates. Petitions should be directed to Membership Staff.

---

Exciting opportunity to become the Director of Medical Education of our expanding Family Medicine residency program in Arizona!!

A unique opportunity awaits you, as you seek to utilize your experience and expertise to lead our ACGME accredited Family Medicine Residency program in the Southwest corner of Arizona.

Yuma Regional Medical Center (YRMC), a 406 bed top-in-technology hospital, boasts a medical staff of 450+ across most specialties, who support this residency program and this is your opportunity to become an integral part of our exciting future.

- Responsible for the leadership, oversight and administration of the program
- Responsible for the ongoing improvement of the GME program & Family Medicine residents
- Affiliation and academic support from University of Arizona College of Medicine
- Diverse population and research potential in bilingual medical education and border medicine patient care

Working with supportive community physicians, as well as newly recruited faculty, this position will provide you the opportunity to emphasize the development of leadership skills and teamwork, to enable our resident physicians the ability to practice the highest quality of medicine, while enhancing the health of the community we serve.

A generous compensation package including full benefits and relocation is offered commensurate with experience.

Located just under a 3-hour drive-either direction-from both San Diego, CA and Phoenix, AZ - our thriving, diverse community offers a wealth of outdoor recreational opportunities year around.

We encourage applications from family physicians who have an interest in working with diverse patient populations and are up for the challenge of border medicine issues. Our location provides unequalled opportunities to develop innovative curricula and scholarly programs to include the healthcare of border communities and the local underserved population.

For complete information or questions about this EXCITING opportunity please contact:

Pam Orendorff - Director of Physician Recruitment & Physician Relations
(928) 336-3032 porendorff@yumaregional.org
Seeking a dynamic Family Medicine physician to join as core faculty of our growing Family Medicine residency program in Southwestern Arizona!

- Thriving residency program started July, 2013
- 17 Family Medicine residents currently within program
- Affiliation and academic support from The University of Arizona College of Medicine
- Yuma Regional Medical Center (YRMC) is fully engaged as a clinical partner in the Mayo Clinic Care Network
- 406 bed community hospital offering a full spectrum of care, with expansion underway for future growth
- Fully implemented EHR system (EPIC)

Join three experienced senior faculty members in a core faculty position that will include approximately 40% direct patient care in the family medicine clinic, with the other 60% involved in precepting and administrative time.

- No obstetrics practice required
- Experience in a family medicine residency program or in teaching students and residents is preferred

*A generous compensation package is offered commensurate with experience.*

Our location provides an exciting and unequalled opportunity to develop innovative curricula and scholarly programs to help address the unique healthcare issues facing rural and border communities.

Located just under 3 hours drive- either direction- from both San Diego, CA and Phoenix, AZ our thriving, diverse community offers a wealth of outdoor recreational opportunities year around, including boating on the Colorado River, hiking, camping and fishing or off-road motorsports within the Imperial San Dunes area.

Additionally, golf can be enjoyed year around on any of our 13 golf courses within the community.

We encourage applications from Family Medicine physicians who enjoy teaching, have an interest in working with diverse patient populations, and who have an interest in developing unique community health and border medicine teaching experiences.

Contact me to learn more details about this incredible opportunity!!

Pam Orendorff
Director, Physician Relations
928-336-3032
porendorff@yumaregional.org
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Your Trusted Partner In Our Dynamic Healthcare Environment

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**2016 ACE (ANNUAL CLINICAL EDUCATION) CONFERENCE**

**Evidence in Practice**

**QUALITY EDUCATION**

**NETWORKING**

**HONOR THE BEST OF FAMILY MEDICINE**

**SUPPORT THE AZAFP FOUNDATION**

**SPECIAL EVENTS**

- **LEGISLATIVE UPDATE - SUSAN CANNATA, JD**
- **AZAFP ALL MEMBER RECEPTION - ALL INVITED, NO EXTRA CHARGE - FRIDAY APRIL 7th**
- **AZAFP AWARDS RECEPTION AND FOUNDATION RAFFLE**
- **AAFP VIP UPDATE WITH BOB WERGIN, MD**
- **CMS UPDATE WITH Q & A**

**REGISTER TODAY!**

Register by mail or email (acereg@azafp.org)! Mail to AzAFP, PO Box 74235, Phoenix, AZ 85087

---

**WHEN**

April 7-9

**WHERE**

**DESSERT WILLOW CONFERENCE CENTER**

4340 E. Camelback Road, Phoenix, AZ 85018

**LODGING**

Phoenix Marriott Tempe at The Buttes, 2600 W. Winding Way, Tempe, AZ 85282 for $169 USD per night 1-888-867-1792 mention AzAFP

**MEALS**

Meals included with meeting registration include breakfast and lunch on Thursday, Friday and Saturday plus awards reception! Please indicate any food restrictions on your registration form.

---

**CONFERENCE SCHEDULE**

<table>
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<th>Topic/Event</th>
<th>Fri., April 8th</th>
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<tbody>
<tr>
<td>8:00 am</td>
<td>Breakfast and Registration</td>
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<tr>
<td>9:00 am</td>
<td>Pediatric Psychosocial-Steve Brown, MD</td>
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<tr>
<td>9:15 am</td>
<td>Musculoskeletal-Mark Ebell, MD</td>
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<tr>
<td>10:00 am</td>
<td>Break &amp; visit exhibits</td>
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<tr>
<td>11:00 am</td>
<td>Heart and peripheral vascular disease-Gary Ferenchick, MD</td>
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<tr>
<td>12:00 pm</td>
<td>Lunch &amp; Legislative update with Susan Cannata, JD</td>
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<td>1:30 pm</td>
<td>What’s new in men’s health-Gary Ferenchick, MD</td>
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<td>3:00 pm</td>
<td>Break &amp; visit exhibits</td>
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<th>Topic/Event</th>
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<td>8:00 am</td>
<td>Liver &amp; GI Update-Gary Ferenchick, MD</td>
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<tr>
<td>9:00 am</td>
<td>Women’s Health-John Hickner, MD</td>
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<td>10:00 am</td>
<td>New Drugs in Primary Care-Steve Brown, MD</td>
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<tr>
<td>11:00 am</td>
<td>Breast &amp; visit exhibits</td>
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<td>12:00 pm</td>
<td>Primary Care Coordination-John Hickner, MD</td>
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<td>2:00 pm</td>
<td>Cancer surveillance-Mark Ebell, MD</td>
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<tr>
<td>3:00 pm</td>
<td>Editor’s choice-All Speakers</td>
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**SUPPORT THE AZAFP FOUNDATION**

**MEDICINE**

**HONOR THE BEST OF FAMILY**

**NETWORKING**

**QUALITY EDUCATION**

**EVIDENCE IN PRACTICE**

**CONFERENCE (ANNUAL CLINICAL EDUCATION)**

---

**MEMBER TESTIMONIALS FROM PREVIOUS ACE CONFERENCES:**

“I could actually stay engaged the entire time!” - Member physician from Anaheim, CA

“I really liked the 30 minute sessions more than sitting through hours of lectures at a time!” - Physician’s assistant from Phoenix, AZ

“This was the best CME conference I’ve ever attended!” - Member physician from Tucson, AZ

“I like that I am taking away several practice pearls that I’ll be implementing right away in my practice!” - Member physician from Bisbee, AZ

“I wish my state did their annual meeting in this format- so I’m suggesting this to them!” - Anonymous

---

**MAIL TO AZAFP, PO BOX 74235, PHOENIX, AZ 85087**

**REGISTRATION FORM**

How you want your name to read on badge (think about using your twitter name): ______________________________

Name: ______________________ Designation (MD, DO, etc.): ______________

Address: __________________________ City: __________ State: ______ Zip: ______

Email: __________________________

Phone: __________________________

List Any Special Needs: (circle one) Vegetarian / Vegan / Other: __________________________

Registration fees (circle applicable type):

- AAFP/ACOFP Member $475 / Non-Member $575 / Life Member $150 / Resident $75 / Student $75 / Allied Health Provider $260

Total Amount Due: ___________________ Payment Information: Check # ________

or Credit Card # __________________ Exp. ______ CSC # ______

Card Type (circle one): Visa / MasterCard / Discover / AmEx Name on Card: __________________________

---

**ACCREDITATION** - Application for CME credit has been filed with the American Academy of Family Physicians.
Pioneers still live here.

Phoenix Children's is home to the new Phoenix Children’s Research Institute, envisioned to be the nation’s hub for pioneering discoveries in pediatric genomics and personalized medicine. And our system of care provides the most comprehensive pediatric services in the Southwest today.

We are leading the way with our deep expertise in more than 75 pediatric specialties, including Barrow Neurological Institute at Phoenix Children's, Phoenix Children's Heart Center and other elite programs in cancer, orthopedics and trauma for children with conditions from common to complex, all here on the frontier of pediatrics.
A Great Opportunity to Reach Family Physicians!
Annual Clinical Education (ACE) Conference

We are hosting our annual general membership and CME conference this year on April 7-9, 2016 at the Desert Willow Conference Center in Phoenix, AZ. Exhibits will be held on 4/07 & 4/8. We provide dedicated exhibit times and contact card prizes.

The AzAFP Annual Clinical Education (ACE) Conference should top 200 attendees this year. Interact in an intimate setting with decisionmakers for small and large practices, new physicians, allied health professionals.

Join the Healthcare Team with a Heart!

**MHC Healthcare** has outstanding career opportunities for Board Certified and Board Eligible physicians and psychiatrists in:

- Family Medicine
- Internal Medicine
- Child/Adult Behavioral Health

We are an NCQA-recognized Patient-Centered Medical Home (PCMH). Through our 14 Community Health Centers, we provide comprehensive primary care for individuals of all ages, and all stages of life. **Bilingual Providers a Plus!**

**Our On-Site Services Include**
- Radiology
- Laboratory
- Dental
- Integrated Behavioral Health

**Our Key Benefits Include**
- National Health Service Corps and Arizona Loan Repayment Opportunities
- Malpractice Coverage Paid Through FTCA
- UpToDate Subscription

For more information contact Steve Klepinger at 520-616-1440 or sklepinger@mhchealthcare.org

www.mhchealthcare.org/jobs
Exhibit Contract

Arizona Academy of Family Physicians
CONTRACT FOR EXHIBIT SPACE

Exhibiting Company (Enter name exactly as you wish to be identified.)

________________________________________________________________________________________

Contact Person (All confirmation information will be sent here.)
Name__________________________________________
Authorized signature____________________________________
Street Address__________________________________________
City________________________________ State ___________ Zip __________
Phone________________________________ Fax ______________________
E-mail______________________________________________

Booth Personnel (Names of individuals who will be staffing your booth)
_________________________________________  ___________________________________________
_________________________________________  ___________________________________________
_________________________________________  ___________________________________________
_________________________________________  ___________________________________________

List companies you prefer not to be near. (Booths are assigned after payment is received, on a first-come, first-served basis.)
__________________________________________________________________________

What products/services will you be promoting?__________________________________________________
Will you need a power source? □ Yes □ No

Fees
☐ Annual Clinical Education (ACE) Conference – Phoenix, April 7 & 8, 2016 (6-ft table) $800_______

Payment by ☐ Check (Payable to Arizona Academy of Family Physicians) (AzAFP Tax ID #86-6052331)
☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Card Number ________________________________________ Exp Date _______/_______

Signature____________________________________________ CSC _______ ZIP CODE ________

Name on card ________________________________________

Cancellations: Cancellations received in writing prior to 15 days before the meeting, will receive a full refund less a $50 Administration fee. NO refunds will be given after 15 days before the meeting.

Arizona Academy of Family Physicians,
PO Box 74235, Phoenix, AZ 85087
Phone 602-663-0255 or email to
christy@azafp.org

For Office Use Only
Date Rec’d contract________________________ Payment type: ☐ Check ☐ Credit card
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Happy New Year!

Health is Primary kicks off year two of the campaign. Health is Primary has a full slate of campaign events planned for 2016. The campaign will continue its work identifying stories of innovation, transformation and primary care delivery. While we are interested in case studies from all over the country, our focus this year will be on California, Georgia, Kansas, Missouri, Kentucky and New Jersey. Check out our Making Health Primary eBook to learn more about the case studies we featured in 2015.

Health is Primary will focus on a series of consumer health issues in 2016:

- February – End of Life Care
- May – Mental Health
- September – Health Aging
- November – Family Caregivers

Visit here to see patient education materials from 2015 and sign up at healthisprimary.org to receive new materials when they are released.

Read the AAFP News piece for a full recap of Health is Primary’s 2015 activities.

Tweet us if you see us. Health is Primary ads and public service announcements are running in malls, movie theaters, supermarkets and billboards. (Look for our public service announcement in the January issue of Fortune Magazine!)

News about the Monthly Updates of the FMAHealth Tactic Teams. The FMAHealth Tactic Teams have been amazed at the tremendous amount of interest in getting involved with FMAHealth. We have been working to “onboard” volunteers on specific projects and advisory groups.

To provide more information to you, we will be using these monthly updates to spotlight in more detail the work of the FMAHealth Tactic Teams, which we hope you will use to take back to your colleagues and use for your own presentations and discussion groups. Each team will be featured on a quarterly basis, with additional timely updates provided as needed.

Some of you have volunteered to be “Connectors,” a role that involves staying informed about the activities of FMAHealth, letting people in your network know about these activities, and connecting people who are looking to get more engaged and offer their support. We ask that those of you who have volunteered as “Connectors” use these updates as your source of information and as a channel to engage your colleagues in the work of FMAHealth. If you need additional information or have questions about the information in these updates, please feel free to reach out to us at questions@fmahealth.org and we will get back to you quickly.

The Practice Team’s focus is on developing the capability to meet physicians where they are in their practice transformation efforts and help them get to where they would like to go. The team’s mission is to help physicians rediscover the joy of practice and simultaneously meet the Triple Aim of better health, better care and better cost effectiveness. We’d like to showcase two projects on this update that are important to the Team’s overall effort.

The Practice team’s work will be to link pre-existing practice transformation resources to physicians based on where they are as they meet the many challenges of everyday practice.

The Technology Team is currently working on two major projects. First, the team is developing a vision for how technology can promote health in the value-based world of 2020 and beyond. It is developing this vision in collaboration with some of the brightest minds in the healthcare technology sector. Once a draft is complete, it will seek input from a broad array of other organizations and individuals. Keep on...
The AAFP, along with seven other national leadership organizations within the family medicine specialty (the American Academy of Family Physicians Foundation, American Board of Family Medicine, American College of Osteopathic Family Physicians, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, North American Primary Care Research Group, and the Society of Teachers of Family Medicine) have examined the challenges and opportunities facing family medicine, and defined a path forward in the rapidly changing health care landscape.

From the Future of Family Medicine project, extensive national research helped identify and define a new model of practice, now known as the Patient-Centered Medical Home. In the Future of Family Medicine 2.0 Project, two key plans were developed – a communications platform based on research and creative testing, that aligns with stakeholders’ expectations, perceptions, and emotional attachments, along with a plan to communicate the value and benefits of family medicine, and an action-oriented strategic plan with a five-year timeline, addressing the issues most critical to family medicine and providing a role for the eight family medicine organizations.

Today, Family Medicine for America’s Health is uniting the family medicine specialty to further the evolution of the PCMH, advance the use of technology, ensure a strong primary care workforce, and shift to comprehensive primary care payment.

Family Medicine for America’s Health

Second, it has created a listserve whereby health technology innovators can connect to forward thinking family physicians in order to get valuable feedback on their emerging solutions. The result will be twofold. First, solutions aimed at the primary care space that receive this feedback will be better able to assist family physicians as they work to achieve the Triple Aim. Second, it gives the Technology Team valuable insight into the cutting edge of health technology, further informing and strengthening the visioning work described above. If you would like to join the listserve, write to questions@FMAHealth.org and let us know you are interested. We will send you an onboarding questionnaire to get started.

FMAHealth Board Forms a Cross-Tactic Team on Reducing Health Disparities in the United States. The FMAHealth Board has formed a cross-tactic team focused on the challenge of reducing health disparities in the United States. The team plans to collaborate with, and build on the work that the 8 family medicine organizations are already doing to help reduce health disparities in the United States. Reducing health disparities is one of seven strategic objectives agreed upon by those organizations as part of the FMAHealth Strategic Plan. (For more on the FMAHealth Strategic Plan see http://fmahealth.org/about.)

The team, composed of one member of each of the 6 Tactic Teams, is chaired by Viviana Martinez-Bianchi, M.D FAAFP, Assistant Professor and Residency Program Director at Duke Department of Community and Family Medicine. The cross-tactic team will help FMAHealth make reducing health disparities a concrete part of all of its work.

The team is also collaborating with the University of California San Francisco Department of Family and Community Medicine. The department, chaired by Kevin Grumbach, MD, has built a strong research capability dedicated to reducing health disparities. The team looks forward to learning from them as well as from others, including minority groups and underserved people throughout the country.

We will be back in touch in future monthly updates as the team clarifies its charge with the FMAHealth Board and builds out its workplan for 2016.
The 2016 Legislative Session Begins

The 2016 regular legislative session is now open, and the Governor’s goals for the year have been outlined. In his second State of the State speech, Governor Ducey praised the legislative leadership and those who worked with him throughout the first year in office to achieve shared goals, including job growth, an agreement that ended the education lawsuit against the state, and progress for local businesses like Four Peaks Brewery. “The state of our state isn’t just strong,” he began. “It is on the rise.”

The Governor also provided highlights of his priorities for the coming year, which will be further defined in his budget proposal later this week. Most notably, he called for mandatory participation in the state’s Controlled Substances Prescription Monitoring Program. “Imagine how many more people we could help…if doctors were required to use the database,” he stated.

Among the Governor’s other priorities were:

• Tax cuts – The Governor pledged to pursue tax cuts for the next three years.

• Reduced regulation – The Governor called not only for a careful analysis of the need for new laws, but for a streamlined process to repeal existing statutes and rules that limit citizens and businesses – including a reduction in the number of licenses required to be employed in the state. Through an executive order, he created the Council on the Sharing Economy to identify opportunities and recommend changes.

• Enhanced education resources – The Governor pledged additional funding for Arizona’s public education each year for the next three years, without a tax increase. He also reiterated his commitment to the Arizona Public Schools Achievement District, an entity that was discussed but not defined last year. There are still no specifics on the Governor’s vision, but his speech outlined the District as a mechanism to expand successful public schools, provide low-cost financing for schools to improve their facilities, and reduce the wait lists for the state’s best schools.

• Revamp the state’s economic development entity – The Governor called for a shifted focus of the Arizona Commerce Authority, which was created by his predecessor Governor Brewer. He will pursue a “2.0” version of the entity, focusing on marketing the state’s qualities.

• Child safety – The Governor pledged state support to “stand up” for kids in the foster system. Few specifics were outlined, but the Governor called for legislation to remove statutes that penalize family members who want to care for foster kids in their family, and to provide better education options for families that serve as foster parents.

• Criminal justice – The Governor called for several changes, including the expansion of a Pima County community justice program that reduces recidivism in its criminal justice system and a stronger commitment to investigation and prosecution of rapists. He also outlined a plan that will use social media to broadcast information on fathers who do not pay child support, and pledged additional funding for border county sheriffs that will help fight the war against drugs on the border.

• Water – The Governor called for additional resources to identify the state’s long-term water needs and possibilities.

Above all, the Governor praised Arizonans themselves as the state’s greatest resource and answer to overcoming challenges. “Our people are our greatest resource,” he summarized, and were the key to moving Arizona forward.

New Faces, New Priorities

The full legislature convened to hear the Governor’s speech, and though this is the second regular session in the legislative term there were some new faces. The retirement of Senators Ed Ableser (D-Tempe) and Kelli Ward (R-Lake Havasu City) created an opportunity for two new senators: Andrew Sherwood, who has been serving in the House, replaced Ableser, and Sue Donahue, who recently retired from employment with Mohave County, replaced Ward. Celeste Plumlee, who has worked with the Arizona Coalition to End Sexual and Domestic Violence, was appointed to serve in the House seat vacated by Sherwood.

Each new leader comes to office with goals for their time in office, despite the challenge of joining just before the session starts. Donahue has pledged to protect local governments from additional budget cuts or cost shifts, and hopes to increase teacher salaries. Plumlee wants to use
her difficult experiences as a single mother and domestic violence survivor to help dedicate more resources to helping Arizonans who need assistance to move forward with their lives. She, too, has pledged to fight for more funding for schools.

**State Budget Challenges**

Other returning state legislators have mirrored the new officials’ call for additional education resources. The special legislative session earlier this year brought bipartisan support for a proposal that, if approved by voters in a May election, would dedicate resources to solve the years-long debate over appropriate levels of prior years’ funding, but the focus on resources going forward remains and was highlighted by Governor Ducey in today’s speech.

All new funding requests continue to face a difficult budget situation, however. State revenues have improved and so far this year are ahead of projections, but the state’s lengthy recession has caused many requests for increased resources. Transportation and infrastructure priorities must be considered as Arizona moves into the future, and the backlog of children in the Department of Child Safety’s system looms as an immediate priority.

**Policy Priorities**

Apart from the budget debate, several key policy areas are expected to also be considered. Reform of public pension systems is expected to be a major focus this year, after a months-long negotiation led by Senator Debbie Lesko (R-Peoria) may have created common ground between state leaders and police and firefighting unions that opposed earlier attempts to change pension systems.

Governor Ducey’s tax cut pledge will no doubt be debated this year, as will his effort to pursue prison reform – a concept that has inspired passionate debate in other states but that has not received much support in Arizona in the past. Regulatory reform is a key theme both from the Governor and key legislators, and is certain to be seen in numerous legislative proposals.

**Up Next**

The coming weeks will be a flurry of activity as hundreds of bills are introduced and committee hearings begin. This first week of the legislative session will be a slow start, but will quickly escalate as legislative leaders pursue their goal of a short session.

- The House Health Committee will receive presentations on Postural Orthostatic Tachycardia Syndrome and the Save the Cord Foundation on Tuesday at 2:00 p.m. Click here to watch.

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**Indian Health Service**

The Federal Health Program for American Indians and Alaska Natives

Southwest Region Indian Health Service is seeking a Family Practice Physician with an innovative spirit to improve the health status of our Native American population. We support this effort by providing:

- **Newly adjusted competitive salary**
- **Loan Repayment** Program or NHSC Loan Repayment Program – Up to $20,000 – 25,000 annually.
- No Malpractice insurance needed while working at Federal Facilities
- Innovative and cutting edge practices
- A proven health care team
- Exceptional Federal Benefits, including Health and life insurance benefits
- Outstanding Federal Retirement Plan, and much more

Our physician career opportunities are based on needs identified by our medical staff and patient population located at various rural sites throughout the states of Arizona, Nevada and Utah. The Southwest Region also has the largest Medical Center in the Indian Health Service located in downtown Phoenix.

If you, or someone you know has an interest, please contact CDR Stephen Navarro at 602-364-5222, or email Stephen at Stephen.navarro@ihs.gov. I hope we’ll talk soon.

*P.S. Your Southwest adventure awaits you.*
Transitioning Healthcare Providers

CONTACT: Dr Patrick Lynch
Patrick.Lynch2@ihs.gov
(928) 205-2301

- Relocate to the beautiful mountain resort community of Pinetop, Arizona, located within the largest contiguous ponderosa pine forest in the world with over 180 miles of developed hiking, mountain biking, and cross-country skiing trails throughout the community

- Opportunity to practice full-spectrum medicine if desired, to include ER, urgent care, low-risk OB, inpatient and outpatient medicine

- Alpine skiing and snowboarding only 36 miles away; three 18-hole courses in Pinetop and an additional four courses within 20 miles in nearby Show Low, AZ

- Wonderful four season climate with sunshine more that 70% of the time year-round

- Openings include both federal civil servant positions as well as positions for uniformed officers of the Public Health Service Corps

- Military physicians, FNP’s and PA’s have the opportunity to transfer services and retain active duty benefits, to include 20 year retirement, TSP, loan repayment, Tricare, access to military base lodging, recreational facilities and space-A flights; for compensation questions: http://www.usphs.gov/profession/physician/compensation.aspx
2016 Conference Theme: “Collaborative Care in Chronic Disease”

Presented by the National Kidney Foundation of Arizona and Cardio Renal Society of America.

Featured in 2016: Primary Care Track – offering sessions focused on cross-specialty collaboration and chronic disease management for the primary care physician and allied health.

For information on registration and exhibitor sponsorships:
www.SWNC.org or call 1(877) 587-1357
Integrity, Caring, Accountability, Stewardship, Excellence and Respect

Honor Quality Not Quantity

Healthcare is changing, and new models of care are necessary for healthcare providers to thrive in the future. These thoughts are what drove Scottsdale Healthcare and John C. Lincoln Health Network to affiliate and become HonorHealth. The historic trustworthiness and integrity of the brand builds on the strength of these two legacies. At the core of HonorHealth is the vision; “To be the partner of choice as we transform healthcare for our communities.”

HonorHealth is proud to be the only physician-led primary care network serving the greater Phoenix metro area. As the largest primary care network in the state, HonorHealth is ideally setup to provide outstanding practice opportunities as we lead the region in quality patient care. In addition HonorHealth leads the state as a locally owned and locally governed population health manager.

As an integrated system on Epic Electronic Health Records, HonorHealth is financially sound and fully prepared for potential changes in reimbursement, how physicians practice and how they are compensated. HonorHealth values the needs of our employees. Together, we are honored to put the patient at the center of everything accomplished at the five acute care hospitals and seventy four ambulatory sites.

To learn how to join HonorHealth Medical Group
Please contact Laura Hays: 480-391-9777
LHays@TrekPhysician.com
Exclusive Contract Physician Recruitment Department