FOCUS FAMILY PHYSICIAN

Winter 2016

A publication of Arizona Academy of Family Physicians

ARIZONA ACADEMY OF FAMILY PHYSICIANS
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Register for ACE '16 on Page 14

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Family Physician
FOCUS
VOLUME 16 ~ ISSUE 3
Family Physician Focus is the official magazine of the Arizona Academy of Family Physicians and Arizona Society of the American College of Osteopathic Family Physicians and is published quarterly.

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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.

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Created by **Publishing Concepts, Inc.**
David Brown, President • dbrown@pcipublishing.com
For Advertising info contact
Michelle Forinash • 1-800-561-4686
mforinash@pcipublishing.com

Edition 23

Chris Shearer, MD

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.

TMI

Andrew Carroll, MD

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 has 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.

We are so busy satisfying the needs of actuarials that we are no longer satisfying the needs of one another.

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.

FOLLOW THE @AZAFP ON TWITTER: https://twitter.com/AzAFP

NOT on twitter? YOU might be missing out on exciting news and insights from your colleagues! Did you know that MOST young physicians are on Twitter and post daily? Even if you don't want to post, it's worthwhile to "follow" several colleagues, friends and businesses to stay up to date.

Check it out and "follow" the @azafp! Also follow our President, Chris Shearer, MD @cpshearer!

Need help setting up your account? Contact Laura at ldearing@azafp.org and she'll help you!

Valley Fever is a Burden in Arizona

Arizona Department of Health Services

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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Organizational App

The power of the AAFP, now available on the go.

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.

The CME reporting applet within the AAFP app allows you to:

- Search the AAFP's database of accredited CME, plus search non-AAFP activities to report.
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- Check your re-election status.
- Complete quizzes you have saved and start new quizzes that are available

The AAFP mobile app also features resources for students and residents.

Students can:

- Search through residency, fellowship, and clerkship directories.
- Mark programs as favorites so they can go back and explore them later.
- Browse general residency information in the Strolling Through the Match publication.

Residents can:

- Assess their medical knowledge through more than 1,000 free Board Review prep questions as a members-only benefit.
- Get the latest news and blog posts on issues related to family medicine.
- Post their resume and connect to potential employers through AAFP CareerLink.
- Make evidence-based decisions about the treatment and prevention of disease with AAFP clinical recommendations, sortable by topic or title.

"The AAFP mobile app has something for everyone. Download it today."

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

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.

Dignity Health

Please respond to:

Robert Galbreath, M.P.R., M.P.P.,C.M.S.R.
Director-Physician Recruitment AZ Service Area
Dignity Health - Arizona Service Area
1875 W. Frye Road
Chandler, AZ 85224
DD: 480-728-3854 Fax: 602-294-5815

KRMC KINGMAN REGIONAL MEDICAL CENTER
Serving our Community with Compassion and Commitment

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, 280 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 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

Contact: Ms. Ryan Hampton,
Kingman Regional Medical Center Physician Recruiter
Office: 928.681.8595
Cell: 928.377.2380
Fax: 928.757.0604
rhampton@azkrmc.com

American Academy of Family Physicians:
MEMBERSHIP DASHBOARD

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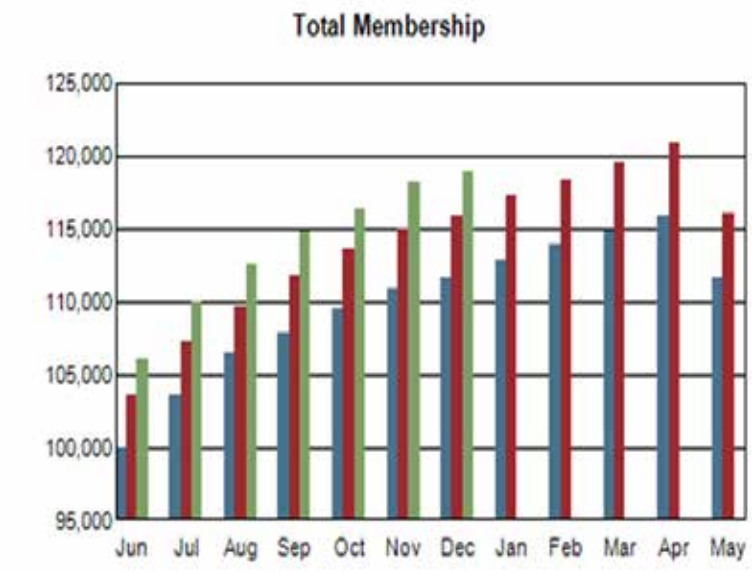
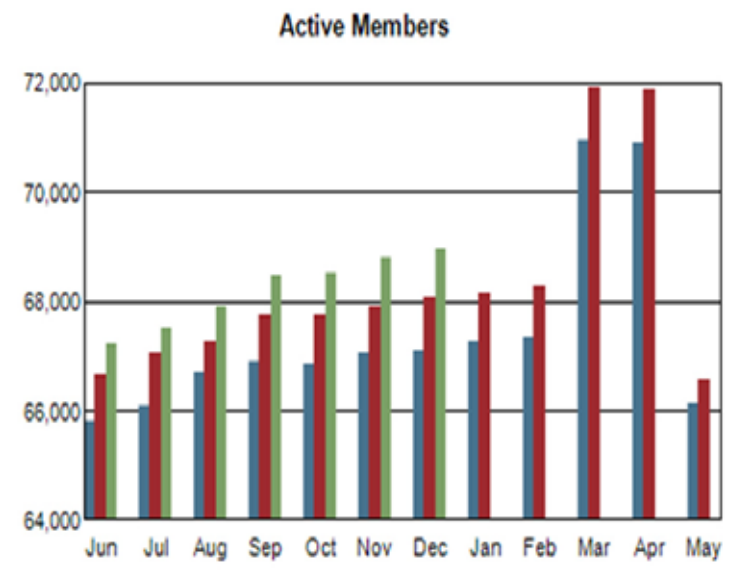
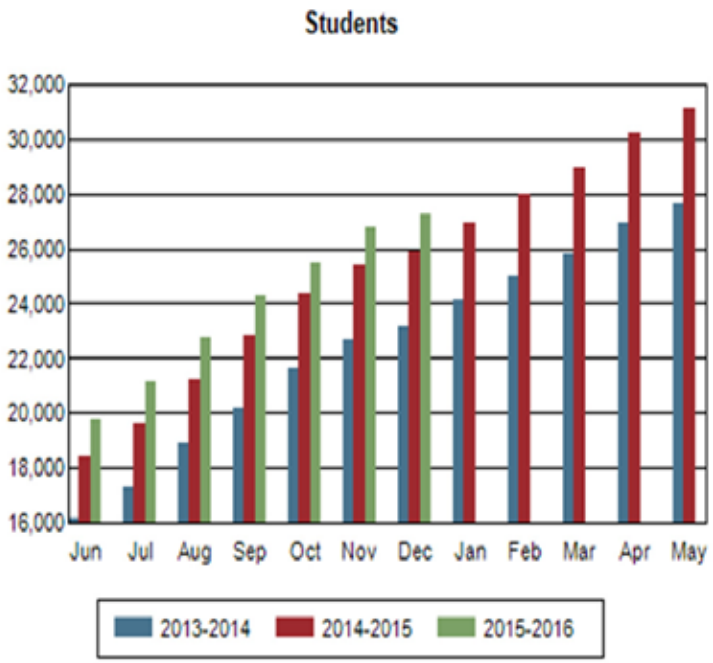
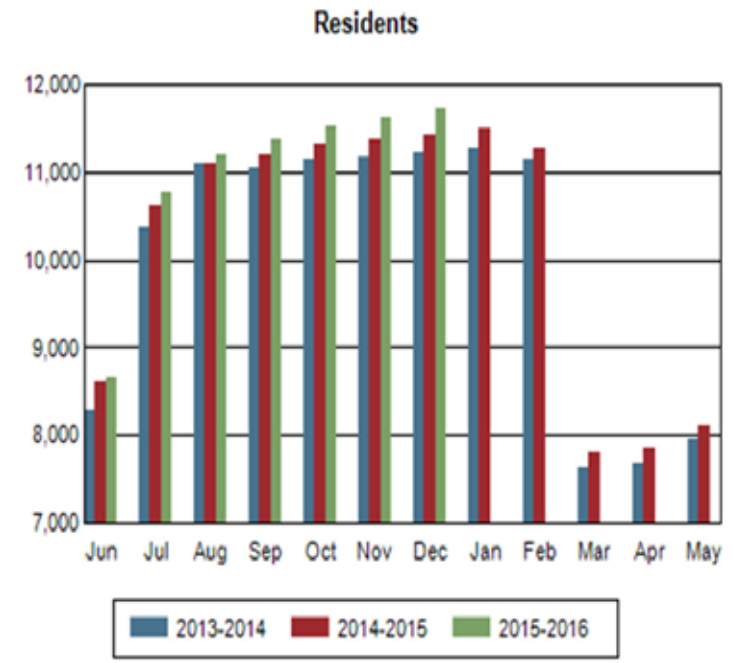
Dec-15

	YTD Actual	YTD Projection	% Variance Actual to Projection	Yearly Projection	Prior YTD Actual
ACTIVE NEW MEMBERS	684	625	9.44%	1,070	628
ACTIVE PAYMENTS	43,963	42,030	4.60%	65,650	41,515
ACTIVE REINSTATEMENTS	1,680	1,395	20.43%	2,455	1,417









TOTAL Membership

MEMBERSHIP COUNT	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**106,013**	**110,011**	**112,535**	**114,753**	**116,272**	**118,134**	**118,988**					
2014-2015	103,626	107,255	109,655	111,820	113,579	115,021	115,850	117,250	118,307	119,608	120,923	116,097
2013-2014	99,966	103,602	106,432	107,898	109,533	110,893	111,587	112,861	113,875	114,884	115,910	111,611

DELINQUENT MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**4,276**	**14,130**	**10,107**	**7,825**	**4,144**	**3,010**	**2,221**					
2014-2015	4,254	14,315	10,472	5,838	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	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**67,205**	**67,511**	**67,910**	**68,496**	**68,521**	**68,791**	**68,946**					
2014-2015	66,666	67,045	67,250	67,740	67,736	67,928	68,059	68,147	68,269	71,901	71,876	66,584
2013-2014	65,783	66,076	66,704	66,877	66,868	67,078	67,118	67,246	67,355	70,951	70,926	66,136

NEW MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**9**	**147**	**92**	**114**	**23**	**191**	**108**						**684**
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	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**597**	**736**	**4,284**	**5,835**	**7,013**	**10,449**	**15,049**						**43,963**
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	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**518**	**328**	**265**	**209**	**159**	**104**	**97**						**1,680**
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	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**24**	**114**	**41**	**42**	**6**	**12**	**14**						**253**
PROJECTED	***35***	***10***	***140***	***45***	***25***	***15***	***20***	***20***	***25***	***45***	***40***	***5,400***	***5,820***
2014-2015	33	5	140	43	26	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	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
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	Dec
2014	**94.4%**
2013	94.9%
2012	95.0%

Membership Dashboard

TOTAL NEW ACTIVE	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015
	9	147	92	114	23	191	108
TOTAL NEW ACTIVE	100%	100%	100%	100%	100%	100%	100%

# Never Been a Member	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015
	1	4	4	10	0	5	3
% 49 years old or Younger	100.00%	75.00%	25.00%	40.00%	0.00%	60.00%	66.67%
% 60 years or Older	0.00%	0.00%	0.00%	40.00%	0.00%	20.00%	0.00%
% ABFM Certifieds	0.00%	0.00%	25.00%	40.00%	0.00%	40.00%	33.33%
% DO's	0.00%	0.00%	0.00%	20.00%	0.00%	40.00%	66.67%
% Fellows	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% Female	100.00%	50.00%	25.00%	40.00%	0.00%	80.00%	66.67%
% IMGs	0.00%	0.00%	25.00%	50.00%	0.00%	40.00%	33.33%
% Male	0.00%	50.00%	75.00%	60.00%	0.00%	20.00%	33.33%
% New Physicians	0.00%	0.00%	25.00%	10.00%	0.00%	40.00%	33.33%

# Former Members	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015
	8	143	88	104	23	186	105
% 49 years old or Younger	37.50%	53.15%	64.77%	61.54%	47.83%	54.30%	51.43%
% 60 years or Older	25.00%	11.89%	12.50%	2.88%	17.39%	11.29%	12.38%
% ABFM Certifieds	75.00%	81.82%	72.73%	75.00%	86.96%	89.25%	83.81%
% DO's	0.00%	11.89%	12.50%	8.65%	13.04%	11.83%	11.43%
% Fellows	12.50%	7.69%	4.55%	4.81%	13.04%	4.84%	5.71%
% Female	37.50%	45.45%	52.27%	58.65%	52.17%	46.24%	43.81%
% IMGs	25.00%	26.57%	28.41%	28.85%	34.78%	19.89%	33.33%
% Male	62.50%	54.55%	47.73%	40.38%	47.83%	53.76%	56.19%
% New Physicians	0.00%	1.40%	2.27%	0.00%	0.00%	1.08%	1.90%

# Upgraded Residents	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015
	156	0	87	10	11	2	3
% 49 years old or Younger	95.51%	0.00%	94.25%	100.00%	100.00%	100.00%	100.00%
% 60 years or Older	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% ABFM Certifieds	17.95%	0.00%	21.84%	80.00%	63.64%	100.00%	100.00%
% DO's	23.72%	0.00%	28.74%	20.00%	18.18%	0.00%	66.67%
% Fellows	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% Female	65.38%	0.00%	57.47%	50.00%	81.82%	100.00%	100.00%
% IMGs	33.33%	0.00%	21.84%	20.00%	18.18%	50.00%	33.33%
% Male	33.97%	0.00%	41.38%	50.00%	18.18%	0.00%	0.00%
% New Physicians	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

# Reinstatements	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015
	518	328	265	209	159	104	97
% 49 years old or Younger	64.67%	64.63%	67.92%	64.11%	66.67%	64.42%	64.95%
% 60 years or Older	10.42%	12.20%	10.19%	7.18%	7.55%	12.50%	7.22%
% ABFM Certifieds	88.03%	85.06%	86.04%	86.12%	86.79%	87.50%	88.66%
% DO's	14.09%	13.41%	11.70%	11.96%	16.35%	9.62%	9.28%
% Fellows	9.27%	10.67%	9.43%	8.13%	8.81%	7.69%	10.31%
% Female	49.03%	47.56%	48.68%	46.89%	50.94%	50.00%	44.33%
% IMGs	27.22%	24.70%	26.04%	33.49%	21.38%	28.85%	28.87%
% Male	50.39%	51.83%	50.94%	53.11%	49.06%	50.00%	55.67%
% New Physicians	32.63%	35.06%	40.00%	36.36%	32.70%	31.73%	6.19%

Resident Members

MEMBERSHIP COUNT	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**8,645**	**10,776**	**11,195**	**11,381**	**11,513**	**11,617**	**11,719**					
2014-2015	8,614	10,622	11,091	11,207	11,310	11,365	11,416	11,488	11,278	7,809	7,857	8,110
2013-2014	8,265	10,368	11,087	11,043	11,149	11,169	11,208	11,268	11,146	7,626	7,673	7,946

* DELINQUENT MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**52**	**10,193**	**10,034**	**7,814**	**4,133**	**3,009**	**2,219**					
2014-2015	38	10,210	10,338	5,821	3,166	2,621	1,805	925	377	220	134	114
2013-2014	93	9,650	9,491	5,716	3,157	1,739	1,175	844	300	183	128	87

NEW MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**703**	**2,049**	**460**	**260**	**122**	**100**	**91**						**3,785**
2014-2015	823	1,925	480	230	119	80	57	54	38	47	18	252	4,123
2013-2014	604	2,030	672	188	81	29	30	47	49	33	12	273	4,048

PAYMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**86**	**413**	**679**	**2,440**	**3,861**	**1,248**	**903**						**9,630**
2014-2015	56	265	456	4,652	2,778	629	876	974	343	164	166	95	11,454
2013-2014	93	691	932	3,873	2,682	1,453	609	401	428	101	120	72	11,455

REINSTATEMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**10**	**15**	**8**	**13**	**7**	**4**	**7**						**64**
2014-2015	0	13	7	11	7	4	6	7	29	15	13	6	118
2013-2014	8	5	18	12	9	8	2	6	7	16	8	5	104

CANCELLATIONS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**50**	**4**	**4**	**103**	**12**	**12**	**14**						**199**
2014-2015	40	4	5	130	34	21	10	4	260	5	9	2	524
2013-2014	28	43	18	164	5	23	11	7	184	3	6	4	496

MARKET SHARE RATE	Feb
2014-2015	**97.48%**
2013-2014	98.47%
2012-2013	98.50%

* Note: Graduated residents are upgraded to Active Membership in March to facilitate the early billing of discounted Active member dues.

Student Members

MEMBERSHIP COUNT	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**19,802**	**21,123**	**22,724**	**24,301**	**25,480**	**26,761**	**27,256**					
2014-2015	18,422	19,596	21,201	22,845	24,340	25,368	25,876	26,938	27,950	28,934	30,195	31,082
2013-2014	16,125	17,260	18,915	20,198	21,578	22,635	23,150	24,081	24,991	25,826	26,899	27,668

DELINQUENT MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**					
2014-2015	0	0	0	0	0	0	0	0	0	0	0	0
2013-2014	0	0	0	1	0	0	0	0	0	0	0	0

NEW MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**910**	**1,308**	**1,589**	**1,572**	**1,177**	**1,284**	**679**						**8,519**
2014-2015	886	1,165	1,602	1,643	1,493	1,032	670	1,067	1,012	993	1,274	993	13,830
2013-2014	646	1,140	1,659	1,282	1,380	1,051	630	934	914	836	1,075	871	12,418

PAYMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**						**0**
2014-2015	0	0	0	0	0	0	0	0	0	0	0	0	0
2013-2014	0	0	0	0	0	0	0	0	0	0	0	0	0

REINSTATEMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**20**	**26**	**4**	**13**	**3**	**2**	**1**						**69**
2014-2015	8	18	7	4	2	2	3	0	2	1	1	2	50
2013-2014	0	7	5	4	3	6	2	4	1	3	2	1	38

CANCELLATIONS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**11,872**	**6**	**11**	**5**	**5**	**6**	**188**						**12,093**
2014-2015	9,790	2	6	5	0	8	163	4	3	11	12	14	10,018
2013-2014	8,237	7	9	4	4	2	118	7	6	4	5	4	8,407

MARKET SHARE RATE (Allopathic Schools)	Apr
2014-2015	**30.90%**
2013-2014	28.70%
2012-2013	25.00%

MARKET SHARE RATE (Osteopathic Schools)	Apr
2014-2015	**15.00%**
2013-2014	12.90%
2012-2013	11.20%

Membership Dashboard

International Members

MEMBERSHIP COUNT	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**2,121**	**2,330**	**2,403**	**2,537**	**2,570**	**2,689**	**2,750**					
2014-2015	1,875	1,953	2,056	2,164	2,217	2,287	2,333	2,409	2,495	2,593	2,673	2,091
2013-2014	1,596	1,676	1,744	1,827	1,858	1,917	1,967	2,049	2,111	2,197	2,283	1,829

DELINQUENT MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**12**	**3**	**3**	**1**	**1**	**0**	**0**					
2014-2015	7	3	3	0	0	0	0	1,037	961	877	698	13
2013-2014	6	3	2	0	0	0	0	892	783	719	574	18

NEW MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**30**	**222**	**86**	**130**	**34**	**112**	**59**						**673**
2014-2015	38	93	107	111	50	70	46	73	85	95	73	76	917
2013-2014	41	89	77	78	31	58	43	81	63	80	83	66	790

PAYMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**49**	**246**	**106**	**638**	**172**	**257**	**348**						**1,816**
2014-2015	53	103	121	534	147	261	299	291	164	183	256	107	2,519
2013-2014	62	103	83	372	167	210	231	309	172	149	230	106	2,194

REINSTATEMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**16**	**16**	**2**	**11**	**1**	**0**	**3**						**49**
2014-2015	10	6	7	6	2	0	1	3	3	2	0	14	54
2013-2014	14	10	5	8	2	2	1	2	1	3	0	21	69

CANCELLATIONS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**2**	**3**	**0**	**9**	**1**	**3**	**6**						**24**
2014-2015	1	2	0	5	2	3	6	4	2	1	2	648	676
2013-2014	0	2	3	5	2	1	5	9	5	2	3	513	550

Inactive Members

MEMBERSHIP COUNT	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**752**	**758**	**776**	**431**	**515**	**561**	**605**					
2014-2015	819	827	834	530	591	631	670	708	734	753	787	749
2013-2014	821	836	557	532	602	630	670	742	769	804	837	804

DELINQUENT MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2015-2016	**1**	**0**	**0**	**0**	**0**	**0**	**0**					
2014-2015	0	0	0	0	0	0	0	173	134	99	70	2
2013-2014	0	0	0	0	0	0	0	174	131	106	73	1

NEW MEMBERS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**0**	**3**	**16**	**0**	**1**	**0**	**1**						**21**
2014-2015	0	1	0	8	1	0	5	0	0	0	0	4	19
2013-2014	1	1	12	2	3	0	0	7	1	1	0	1	29

PAYMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**6**	**7**	**12**	**72**	**137**	**108**	**134**						**476**
2014-2015	16	7	5	80	89	120	154	105	66	57	69	31	799
2013-2014	18	12	12	66	142	104	135	136	73	63	67	41	869

REINSTATEMENTS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**3**	**1**	**5**	**1**	**2**	**2**	**1**						**15**
2014-2015	7	5	3	0	1	1	0	0	0	0	2	4	23
2013-2014	10	2	4	2	1	1	0	1	0	0	2	13	36

CANCELLATIONS	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
2015-2016	**2**	**1**	**2**	**2**	**0**	**0**	**0**						**7**
2014-2015	0	0	0	2	1	1	0	4	0	3	2	59	72
2013-2014	1	0	1	1	2	0	0	1	2	3	3	60	74

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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

Member Interest Group (MIG)

MEMBER INFORMATION GUIDE

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.

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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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- 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

WHEN
APRIL 7-9

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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.

2016 ACE CONFERENCE – APRIL 7-9

CONFERENCE SCHEDULE

Thur, April 7th	Topic/Event
8:00	**Breakfast**
9:00	Health Analytics- Jim Dearing, DO
10:00	DVT/PE/Anticoagulation-Kelly Luba, DO
11:00	Break
11:15	Introduction to Musculoskeletal Ultrasound Imaging-Inder Makin, MD, PhD
12:15	Lunch
1:30	Opioid Prescribing: Safe Practice, Changing Lives
3:30	BREAK
3:45	Opioid Prescribing: Safe Practice, Changing Lives
4:45	Aaron Boor, DO
5:45	Adjournment for the day

Fri, April 8th	Topic/Event
7:00 am	**Breakfast and Registration**
8:00 am	Pediatric Potpourri-Steve Brown, MD
8:30 am	Musculoskeletal-Mark Ebell, MD
9:00 am	Hot Topics
9:30 am	Heart and peripheral vascular disease-Gary Ferenchick, MD
10:00 am	Break & visit exhibits
10:30 am	Infectious disease update-John Hickner, MD
11:00 am	Editor's Choice – 1 hour-All Speakers
12:00 pm	Lunch & Legislative update with Susan Cannata, JD(
1:00 pm	Novel anticoagulants and atrial fibrillation-Gary Ferenchick, MD
1:30 pm	What's new in men's health-Steve Brown, MD
2:00 pm	Screening: USPSTF update-Mark Ebell, MD
2:30 pm	COPD & asthma-John Hickner, MD
3:00 pm	Break & Visit Exhibits
3:30	Acute respiratory infections-Mark Ebell, MD
4:00	Hyperlipidemia-Steve Brown, MD
4:30	Adjournment for Day of CME
4:30	Awards Reception, appetizers, drinks and Foundation Raffle at Conference Center (1 guest per attendee please).

Sat, April 9th	Topic/Event
7:30 am	Breakfast and Registration
8:00 am	Liver & GI Update- Gary Ferenchick, MD
8:30 am	Women's Health- John Hickner, MD
9:00 am	Chest Pain Evaluation-Mark Ebell, MD
9:30 am	New Drugs in Primary Care-Steve Brown, MD
10:00 am	Break & visit exhibits
10:30 am	Primary Care Coordination-John Hickner, MD
11:00 am	Pregnant Patient-Steve Brown, MD
11:30 am	Cancer surveillance-Mark Ebell, MD
Noon	Editor's choice-All Speakers
12:30 pm	Lunch
	CMS Update w/ Q & A- Ashby Wolfe, MD
	AAFP VIP Robert Wergin, MD
2:30 pm	Travel Medicine-Gary Ferenchick, MD
3:00 pm	Adolescent Medicine-Steve Brown, MD
3:30 pm	Vitamin D-John Hickner, MD
4:00 pm	Exercise & Rehab-Gary Ferenchick, MD

Accreditation - Application for CME credit has been filed with the American Academy of Family Physicians

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Registration fees (circle applicable type):

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

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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

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"I wish my state did their annual meeting in this format- so I'm suggesting this to them"! - Annonymous

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A Great Opportunity to Reach Family Physicians!

Annual Clinical Education (ACE) Conference

ARIZONA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR ARIZONA

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 on 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.

Exhibit Contract

Arizona Academy of Family Physicians
CONTRACT FOR EXHIBIT SPACE

Exhibiting Company (Enter name exactly as you wish to be identified.)
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Fees
❑ Annual Clinical Education (ACE) Conference – Phoenix, April 7 & 8, 2016 (6-ft table) $800_____

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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.

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PO Box 74235, Phoenix, AZ 85087
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FAMILY MEDICINE for AMERICA'S HEALTH

Happy New Year!

Health is Primary
BROUGHT TO YOU BY AMERICA'S FAMILY PHYSICIANS

***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 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 Team is developing a survey tool to help them understand where physicians and practices are in their readiness for change. Much work has been done to help physicians understand patients' readiness to change behavior – this effort seeks to help physicians better understand their own readiness as a starting point for exploring opportunities for improving their practice.

The Team is also working to develop brief statements of the importance and value of practice transformation – called "elevator pitches." These elevator pitches are written to influence multiple different stakeholders. For example, the pitch geared toward physicians emphasizes arguments for practice transformation that speak to physicians' issues:

- Improve the care of, and our relationships with, our patients
- Decrease the hassle of practice
- Enhance income through payment reform and reduction of the costs of providing primary care

The next phase of 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 lookout for more updates about this exciting work soon.

Second, it has created a listsev 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 listsev, 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.

Family Medicine for America's Health

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, to the Future of Family Medicine 2.0 project, to now Family Medicine for America's Health(FMAHealth.org), these organizations are committed to continually transforming family medicine to meet the needs of patients.

The initiatives build on one another. In 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.

From the Future of Family Medicine project, to the Future of Family Medicine 2.0 project, to now Family Medicine for America's Health(FMAHealth.org), these organizations are committed to continually transforming family medicine to meet the needs of patients.

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.

Please join us! For updates and information on this exciting initiative, visit Family Medicine for America's Health(FMAHealth.org). Latest information about the public-facing communications campaign can be found at Health is Primary(www.healthisprimary.org).

The 2016 Legislative Session Begins

PETERS, CANNATA & MOODY PLC

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.

Transitioning Healthcare Providers

CONTACT: **Dr Patrick Lynch**

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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.

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