

## Briefly Stated - April 18, 2017

### Earn up to 35 CME Credits at the GAFP Summer Family Medicine Weekend!

The Georgia Academy of Family Physicians (GAFP) would like to invite you to the Summer Family Medicine CME Weekend, scheduled for June 8-11, 2017 at the Wild Dunes Resort located on the Isle of Palms, SC. Come earn up to **35 CME credits** while basking in the sun and sand!

Over the course of the three-day meeting, there is a robust selection of clinical topics including: Vitamin Deficiencies, Treating IBS, Burn Care Management, Dementia and much more! We also balance the CME sessions with family and beach activities. Join us on Friday, June 9<sup>th</sup> from 4:30pm-6:30pm to Go Fly a Kite with us!

**Click here to register!** Additionally, you can always call the GAFP office at 1-800-392-3841 to register by phone. The agenda is updated weekly at [www.gafp.org/cme-event/2017-summer-meeting/](http://www.gafp.org/cme-event/2017-summer-meeting/).

### Upcoming Webinars for you and your staff!

The Georgia Academy of Family Physicians is bringing you webinars with key information that is vital to Georgia's family physicians and your patient population. These educational CME webinars offer a streamlined, comprehensive approach to services that are needed and accessible to clinicians. Please register and plan on participating today!

1. **The Hypertensive Burden in African Americans: Reaching a Community in Crisis** – April 26th, 12:30 pm- 1:00 pm (0.5 AMA PRA Category 1 CME credit)

Please click the link to register for the April 26th webinar. <https://attendee.gotowebinar.com/rt/6353936240793489921>

2. **GA HIV/Syphilis Pregnancy Screening Act of 2015** – April 26th, 1:15 pm- 2:15 pm (1 AMA PRA Category 1 CME credit)

Please click the link to register for the April 26th webinar. <https://attendee.gotowebinar.com/register/4886357598629140482>

3. **Adult Disability Medical Home (ADMH) - Transitioning from pediatric to adult healthcare** – May 24, 1:15 pm- 2:15 pm (1 AMA PRA Category 1 CME credit)

Please click the link to register for the May 24th webinar. <https://attendee.gotowebinar.com/register/968565672425276418>

4. **Spring Cleaning– How Family Physicians Can Ease the Child Dental Crisis in Georgia** – May 31, 12:00 pm - 1:00 pm (1 AMA PRA Category 1 CME credit)

Please click the link to register for the May 31st webinar. <https://attendee.gotowebinar.com/register/1873115196169259267>

### What you need to know from the AAFP: White Paper on Direct Primary Care

## **RECOMMENDATION**

The American Academy of Family Physicians (AAFP) policy supports physician and patient choice to provide and receive healthcare in any ethical healthcare delivery system model. This includes the Direct Primary Care (DPC) model. DPC is consistent with the AAFP's advocacy for the patient-centered medical home and a blended payment model for paying family physician payment.

### **An Alternative to Fee-for-Service**

DPC provides family physicians and patients with an alternative to fee-for-service insurance. DPC typically works by charging patients a fixed periodic fee that covers primary care services. DPC is designed to remove the financial barriers patients encounter in accessing routine primary care; including preventive, wellness, and chronic care services. DPC practices often suggest that patients acquire a high-deductible, wraparound insurance policy to cover subspecialty care, emergency room visits, and hospitalizations.

### **Federal Legislation Supporting DPC**

In January 2017, U.S. Representatives Erik Paulsen and Earl Blumenauer introduced the *Primary Care Enhancement Act of 2017* (HR 365). The bill proposes to allow HSA enrollees to contract for services from a DPC practice and pay for it with their Health Savings Accounts. The AAFP submitted a letter in support of HR 365 and released a statement applauding the bill.

### **State Legislation Expanding Access and Alternatives for DPC**

Laws in many states lack clear definitions of DPC terms, creating a varying patchwork of state level regulation. This patchwork creates confusion for physicians and regulators on whether and how to conform DPC practices so they can comply. DPC legislation commonly seeks to clarify that a DPC arrangement is not an insurance product and not subject to state insurance regulations. DPC creates an agreement for a defined set of services that patients can use throughout the month and thus, some state insurance regulators have interpreted DPC as a capitated risk arrangement. In traditional health insurance arrangements, one party assumes certain risks from another for compensation (the premium) and is obligated to pay the other party for covered health care services. A DPC agreement is not an insurance agreement as the principal benefit of DPC is primary care. Even though DPC agreements cover the risk of assorted primary care complications, they usually contain an express provision for additional charges (based on the actual expense incurred) and refunds—both of which are absent in insurance agreements. The passage of DPC legislation should allow regulators to differentiate a single primary care practice charging a periodic fee for primary care from an insurance entity. As of December 2016, 16 states have enacted legislation supporting DPC and/or defining it as a medical service outside the scope of insurance regulation.<sup>1, 2</sup> In the 2016 legislative session Nebraska, Tennessee, and Wyoming all enacted DPC legislation. There were eight additional states that considered DPC legislation in their 2015/16 legislative sessions.

### **2016 States with DPC Legislation**

Many DPC proponents believe the Wyoming statute serves as a model to codify DPC due to its simplicity. Wyoming's law defines a DPC arrangement with minimal requirements and exempts DPC practices from insurance regulations. Proponents also point to the Oregon statute and the West Virginia statute as state legislation to avoid. In Oregon and West Virginia, DPC practices must register with the state insurance department, which has expanded authority to regulate DPC practices. The Oregon statute does not exempt DPC practices from insurance regulations. The West Virginia statute imposes advertising restrictions, additional taxation, limits on DPC services, and an approval process for setting the periodic fee.

### **New Jersey State Pilot: DPC Model of Health Care Finance and Delivery**

In 2015, New Jersey began a voluntary pilot program "Direct Primary Care Medical Homes" for public employees, early retirees, and their families in non-HMO plans. The benefits available in the program provides participants with 24/7 access to a primary care physician while eliminating deductibles, copays, and coinsurance for primary care services. The pilot was developed by the joint labor-management design committees of the New Jersey School Employees Health Benefits Plan and the State Health Benefits Plan, with support from public employee unions and bipartisan elected state leaders. The pilot started on April 1, 2016, and after three years, the pilot will be evaluated by an independent group with an option to expand if it is successful.<sup>3</sup> The New Jersey pilot will gather data on quality, cost, utilization, and outcomes to illustrate the impact of the DPC model on health care finance and delivery.

1. Direct Primary Care Coalition. Direct Primary Care: An Alternative Payment Model. <http://www.dpcsummit.org>. Published January 28, 2016. Accessed October 14, 2016.
2. States with DPC Laws. DPC Frontier website. <http://www.dpcfrontier.com/states>. Accessed October 14, 2016.
3. The Direct Primary Care Journal. New Jersey Pilot Project – Direct Primary Care Medical Homes. <http://www.directprimarycarejournal.com/2015/10/11/new-jersey-pilot-project-direct-primary-care-medical-homes-voluntary>. Published October 11, 2015. Accessed October 12, 2016.

## **GHFA Community Health Grant Award Spotlight on: My Team Triumph, Georgia and Mercer School of Medicine at Columbus**

*Team Triumph Captains at the start of a recent event. GHFA Grant funds will be used to purchase two ADA-approved Axiom Racing Wheelchairs for events in communities throughout Georgia. The wheelchairs will feature both GHFA and GAFP logos.*

MyTeam Triumph – Georgia Chapter" is a 501(c)3 non-profit organization based in Columbus, Georgia and staffed by 3<sup>rd</sup> and 4<sup>th</sup> year Mercer medical students. The organization provides physically-limited children, adults, and veterans, or "Captains," opportunities to participate in endurance races throughout several communities in Georgia with the assistance of specialized wheelchairs and teams of able-bodied runners, or "Angels." Their mission is "to enhance the health and well-being of individuals with physical-limitations by fostering lasting, authentic relationships through the teamwork environment of endurance athletes," said fourth year Mercer medical student and My Team Triumph-Georgia Chapter Executive Director Kristen Kettelhut.

My Team Triumph-Georgia recently received a \$5,000 Community Health Grant Award to purchase two ADA-approved Axiom Racing Wheelchairs to expand the reach of My Team Triumph to communities throughout Georgia. The wheelchairs will feature both Georgia Healthy Family Alliance and Georgia Academy of Family Physicians logos.

Currently, the primary impacted populations are children and adults with physical limitations, their families, and the Angels serving as their legs. Since December 2015, My Team Triumph has influenced 26 Captains, over 50 family members, and over 75 Angels. Additionally, each race they participate in draws more publicity and community support as thousands of individuals see the teams progress from starting line to finish line. With the expansion to 10 races on the schedule this year, they plan to serve over 50 Captains, at least 150 Angels, family members, and thousands of race day participants and bystanders.

*A Team Triumph Captain greets members of the military attending the recent Soldier Marathon.*

The Georgia Healthy Family Alliance (GHFA) is currently accepting applications for the second cycle of the 2017 Community Health Grant Awards. More than \$28,000 was awarded during the first grant cycle of 2017. Grant awards of up to \$5,000 are made to GAFF member affiliated charitable organizations that support GHFA program priorities including underserved populations and outreach programs that promote healthy practices consistent with the principles of family medicine. Current GAFF members including medical students, residents and active/ life members are eligible to apply. **The application deadline for second cycle 2017 awards is May 14th.** Second cycle grant awards will be announced in June 2017. Visit <http://www.georgiahealthyfamilyalliance.org/grants/> to download the 2017 application or view a list of previously funded grant projects.

## **Opioid Dose Calculations: Risk Assessment and Conversion Charts – Tips to Follow to Manage Your Risk**

*MICHAEL CROOKS, PharmD Care Coordination Task Lead, Pharmacy Interventions Technical Lead  
Michael.Crooks@AlliantQuality.org*

Use of opioid therapy for chronic pain presents unique challenges to manage patient expectations, adequate pain control, and opioid tolerance, risk of dependence and risk of adverse drug events. Additional complications may be present when necessary to switch from one opioid product to another to achieve pain relief, mitigate side-effects, or due to formulary restrictions in transitions of care or due to insurance coverage. Opioid conversion tables may be helpful in determining appropriate doses of a new opioid to replace an existing one, however, prescribers are cautioned that any conversion factor is an estimation, at best, and requires cautious consideration of individual patient, therapeutic and drug/dose form characteristics.

The CDC Guideline for Prescribing Opioids for Chronic Pain suggests calculating total daily opioid dose to assess risk. Total daily opioid dose thresholds of 50 and 90 morphine milligram equivalents (MME) are identified as points above which additional, cautious consideration should be given to benefit versus risk. Calculation of total daily opioid dose is standardized using morphine and the MME as a reference standard for opioid potency. A chart of conversion factors for common opioids is included at [https://www.cdc.gov/drugoverdose/pdf/calculating\\_total\\_daily\\_dose-a.pdf](https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf)

*Example. L.S. is a 68-year-old female with severe rheumatoid arthritis who takes oxycodone extended release 40mg twice daily and Oxycodone/APAP 5mg/500mg up to four times daily as needed for breakthrough pain.*

*Total daily opioid dose (MME) = (2 x 40mg oxycodone + 4 x 5mg oxycodone) x (oxycodone conversion factor - 1.5 MME) = (100mg oxycodone) x 1.5 = 150 milligram morphine equivalents.*

Equivalence can vary at higher doses, with chronic versus acute use, or when opioids are combined with non-opioid analgesics. Additionally, conversion factors cannot account for inter- and intraindividual differences in opioid response, tolerance and side-effects. Due to incomplete cross-tolerance and the reasons above, clinicians are advised to reduce the calculated equivalent dose for the new agent by 25 to 50%.

While the CDC Guideline does not address conversion between dosage forms or between opioid drugs, such changes may be necessary due to transfer of care setting, status change, insurance coverage, mucositis, or intolerance to side-effects. Drug rotation may be considered as an alternative to further dose escalations of the same opioid.

*Example. L.S.'s insurance company will no longer cover oxycodone extended release, but it will cover morphine sulfate extended release. In order to cover breakthrough pain, she will continue her as*

*needed medicine. An appropriate starting dose of morphine equal to 50% of the replaced oxycodone dose is*

*50% x (MME of oxycodone 80 mg) = 0.5x (1.5 MME x 80) = 60 mg Morphine Sulfate = one 30mg morphine sulfate extended release twice daily.*

Prescribers are encouraged to follow these points of advice when making changes to opioid therapy for chronic pain:

- Conversion factors are population estimates often based on limited studies
- Conversion factors may vary widely depending on the conversion factor table selected
- Typically, starting doses of new opioids are reduced 25% to 50% from the MME of the replaced opioid,
- Use extra caution when transitioning between high doses of opioids, or when methadone is involved as conversion factors may be less accurate or variable
- Check medication history, including patient interview and Prescription Drug Monitoring Program data, to assess current and past opioid use
- Consider referral to a pain specialist for patients requiring frequent dose adjustments, high dose usage, methadone use, or drugs utilization with potential interactions (anxiety, sleep, CNS-depressant or muscle-relaxer medications)

#### References

Chou, Roger et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. The Journal of Pain , Volume 10 , Issue 2 , 113 - 130.e22

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016; 65 (No. RR-1):1–49.  
DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>.

PL Detail-Document, Opioid Conversion Algorithm. Pharmacist's Letter/Prescriber's Letter. August 2012.

## **Don't miss out on the Georgia Medicaid Fair**

Join us on Tuesday, May 2 at the Cobb Energy Centre located at 2800 Cobb Galleria Parkway from 7 a.m.- 1:00 p.m. and get the latest news from the Georgia Department of Community Health (DCH) including an overview of current initiatives and program and policy updates. The day will feature break-out sessions focused on relevant topics for the Medicaid provider community along with time for questions and answers. Some of the areas that will be covered are:

- Georgia Medicaid Appeals and Administrative Process
- Alliant GMCF/Medical Claim Appeals
- Overview of Common Denials
- Clinical Viewer
- Meaningful Use of Electronic Health Records (EHR) /Audit Preparedness
- Panel discussions featuring all four Care Management Organizations (CMO's)
- Children Intervention and Autism Services
- Amerigroup, GA Families 360 (foster care)
- Nursing Facility Services
- Division of Family & Children's Services (DFCS)
- Behavioral Health Services
- Hospital Services
- Physicians and Physician Extenders Programs

- Provider Enrollment, Revalidation, and the Centralized Credentialing Verification Organization (CVO)
- Medicaid Home and Community Based Waiver Programs

To register online and for details, including the facility layout, map to the facility, parking locations, and an agenda, visit <http://www.cvent.com/d/wvqwd5>. Attendees must register to reserve a seat for each individual session selected. Bring your lunch.

In addition to break-out sessions, you will be able to interact with Georgia Medicaid exhibitors and DCH Medicaid staff who will have displays set up in the Pre-function space of the Ballroom. You will also have the opportunity for your claims questions to be researched and addressed by both Hewlett Packard Enterprise (HPE) and Care Management Organization (CMO) personnel, who will be available throughout the day in the Pre-function space of the Ballroom.

Questions? Contact Hewlett Packard Enterprise at [georgiamedicaidfair@hpe.com](mailto:georgiamedicaidfair@hpe.com).

## **Mercer University-Macon hosts Suture Clinic**

Mercer University School of Medicine's Family Medicine Interest Group (FMIG) in Macon, under Faculty Advisor Dr. Harry Strothers, hosted a Suture Clinic for forty first and second year medical students with the support of upper level students, Family Medicine Department staff, and Navicent Family Medicine Residents and Faculty. First and second year students learned the basics of using a scalpel and correct technique for stitching basic wounds. Given the event's popularity, Mercer Family Medicine Department used a points system to select participants. Students applied for a spot using a Google form.

The event was made possible through AAFP and GAFP funding and support.

Third Year Medical Students:

- Katie Rhoades
- Sebastian Hyman
- Deanna Joe

Fourth Year Medical Students:

- T.J. Bergman

Residents:

- Sarah Choo-Yick, MD
- Shayan Zafrani, MD

Faculty:

- Hugh McLaurin, MD
  - Harry Strothers, MD
  - Patrick Roche, MD
  - David Burtner, MD
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