Emergency Medicine Fellowship Offered at UA College of Community Health Sciences

Are Tax Cuts Coming for the Small-Business Owner?
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NOTE: This rule has a projected effective date of March 9, 2017.

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
RULES & REGULATIONS
540-X-4-.09 Risk and Abuse Mitigation Strategies by Prescribing Physicians

(1) The Board recognizes that the best available research demonstrates that the risk of adverse events occurring in patients who use controlled substances to treat pain increases as dosage increases. The Board adopts the “Morphine Milligram Equivalency” (MME) daily standard as set out by the Centers for Disease Control and Prevention (CDC) for calculating the morphine equivalence of opioid dosages.

(2) It is the opinion of the Board that the best practice when prescribing controlled substances for the treatment of pain shall include medically appropriate risk and abuse mitigation strategies, which will vary from patient to patient. Examples of risk and abuse mitigation strategies include, but are not limited to:

- Pill counts
- Urine drug screening
- PDMP checks
- Consideration of abuse-deterrent medications
- Monitoring the patient for aberrant behavior
- Providing a patient with opiate risk education prior to prescribing controlled substances
- Using validated risk-assessment tools, examples of which shall be maintained by the Board.

(3) For the purpose of preventing controlled substance diversion, abuse, misuse, addiction, and doctor-shopping, the Board sets forth the following requirements for the use of Alabama’s Prescription Drug Monitoring Program (PDMP):

- For controlled substance prescriptions totaling 30 MME or less per day, physicians are expected to use the PDMP in a manner consistent with good clinical practice.
- When prescribing a patient controlled substances of more than 30 MME per day, physicians shall review that patient’s prescribing history through the PDMP at least two times per year, and each physician is responsible for documenting the use of risk and abuse mitigation strategies in the patient’s medical record.
- Physicians shall query the PDMP to review a patient’s prescribing history every time a prescription for more than 90 MME per day is written, on the same day the prescription is written.

(4) Exemptions: The Board’s PDMP requirements do not apply to physicians writing controlled substance prescriptions for:

- Nursing home patients
- Hospice patients, where the prescription indicates hospice on the physical prescription
- When treating a patient for active, malignant pain
- Intra-operative patient care

(5) Due to the heightened risk of adverse events associated with the concurrent use of opioids and benzodiazepines, physicians should reconsider a patient’s existing benzodiazepine prescriptions or decline to add one when prescribing an opioid and consider alternative forms of treatment.

(6) Effective January 1, 2018, each holder of an Alabama Controlled Substances Certificate (ACSC) shall acquire two credits of AMA PRA Category 1™ continuing medical education (CME) in controlled substance prescribing every two years as part of the licensee’s yearly CME requirement. The controlled substance prescribing education shall include instruction on controlled substance prescribing practices, recognizing signs of the abuse or misuse of controlled substances, or controlled substance prescribing for chronic pain management.

(7) The Board recognizes that all controlled substances, including but not limited to, opiates, benzodiazepines, stimulants, anticonvulsants, and sedative hypnotics, have a risk of addiction, misuse, and diversion. Physicians are expected to use risk and abuse mitigation strategies when prescribing any controlled substance. Additional care should be used by the physician when prescribing a patient medication from multiple controlled substance drug classes.

(8) A violation of this rule is grounds for the suspension, restriction, or revocation of a physician’s Alabama Controlled Substances Certificate or license to practice medicine.
Notifiable Disease Rules
FOR VACCINE-PREVENTABLE DISEASES (VPDs)

HIGHLIGHTS

- Physicians cannot delegate laboratories to report for them, but must report separately

- Laboratories are required to report electronically to EPI

- Expanded minimum data elements required

- Report “presumptive” within 4-hour (Polio) and 24-hour diseases (Diphtheria, Hib, Hepatitis A, Measles, Meningococcal Disease, Pertussis, Polio-nonparalytic, and Rubella)

- Report Standard Notification diseases (Hepatitis B, Mumps, Strep pneu invasive disease, Tetanus, Varicella) within 5 days

- Report ALTs with all acute hepatitis A & B reports

To learn more about VPDs, go to adph.org/immunization or call 1-800-469-4599.

To schedule a 1-hour Notifiable Disease CEU Training, go to adph.org/epi or call 1-800-338-8374.
The Scope of Family Medicine

According to the National Federation of Independent Business, small-business optimism is at its highest rate since 2004. Small-business owners are hopeful that President Donald Trump’s promises of regulatory reform and lower taxes will become a reality and that small businesses will reap the rewards. And with Republicans controlling the House and Senate that hope appears to be well-founded.

Trump and the Republican Congress have promised a repeal of the Patient Protection and Affordable Care Act (ACA) will lower insurance requirements for small businesses, the deconstruction of the banking regulations of the Dodd-Frank Act will give small businesses more access to credit and tax reform will provide small businesses with tax savings. Let’s take a look at some of the specific tax plans Trump has proposed that have small-business owners excited.

The new administration has proposed cutting the highest corporate tax rate from 35 percent to 15 percent. S corporations and other pass-through entities may also see a reduced tax rate, as Trump has proposed a maximum rate of 15 percent on business income that is reinvested into the company. This proposal provides some relief to the business owner on his “phantom income” tax bill. Comparatively, the House GOP tax plan reduces the corporate rate to 20 percent and the pass-through rate to 25 percent.

Of course, small-business owners are also individual taxpayers, and Trump’s tax plan contains several facets to benefit the individual taxpayer. Trump’s proposal is to reduce the number of personal income tax

Are Tax Cuts Coming for the Small-Business Owner?

by Leslie Pitman
brackets from seven to three. For joint filers, the proposed marginal rates on taxable income are 12 percent for up to $75,000, 25 percent for $75,000 to $225,000, and 33 percent for more than $225,000. (Dollar amounts for single filers are half of these amounts.) Here, the House GOP tax plan aligns with Trump’s proposal, save a slight variation in the dollar amounts.

Of particular interest to many high-income earners is the Net Investment Income Tax (NIIT). The NIIT was enacted within the ACA and imposes a tax of 3.8 percent on investment income, such as interest, dividends, short-term and long-term capital gains, rental income, royalty income and passive-activity income. It applies only to investment income that exceeds a threshold of $200,000 of adjusted gross income for single filers and $250,000 of adjusted gross income for joint filers. Trump, however, has proposed to repeal that tax. And because the NIIT is part of the ACA, which is first and foremost on the Republican Congress’ list of laws to repeal, this 3.8 percent tax may be the first tax to go. Trump’s tax plan also includes more than doubling the standard deduction, eliminating the estate tax, and providing revised child care deductions and rebates. Additionally, he has proposed providing for the establishment of dependent care savings accounts with a government matching program.

It is worth noting, though, that Trump has a stated goal of tax simplification. To that end, he has proposed to eliminate the reduced capital gains tax rate for carried interest, eliminate personal exemptions, eliminate the head-of-household status and impose a cap on itemized deductions. As such, not all of Trump’s proposed tax plan will provide a benefit to the taxpayer’s bottom line.

Even so, small-business owners should be energized by the lower rates and simplification. A reduction of tax compliance expenditures could be significant for the small business. Piggyback that on the expected repeal of the Affordable Care Act, and small-business owners can anticipate spending less time and effort on the compliance side and more on the business side.

The new administration has proposed cutting the highest corporate tax rate from 35 percent to 15 percent. S corporations and other pass-through entities may also see a reduced tax rate, as Trump has proposed a maximum rate of 15 percent on business income that is reinvested into the company.

Although portions of the House Republicans’ tax plan are not as aggressive as Trump’s, the plans set forth similar reductions to the individual and business tax rates. Consequently, small-business owners should rightly expect to see tax cuts in the near future.

$1,000 Stan Brasfield, MD, Scholarship for Alabama AFP Residents Is Available

All resident-members of the Alabama Academy of Family Physicians are eligible to apply for the annual Stan Brasfield Memorial Scholarship. The family of the late Dr. Brasfield created the scholarship fund to honor his memory; it is to be given annually to a first- or second-year resident who meets certain criteria.

Dr. Brasfield, a Montgomery native, earned his medical degree in Alabama. He died at the untimely age of 33 while practicing in Florida. The scholarship is in the amount of $1,000. The criteria are as follows:

• The award will go to a first- or second-year Alabama family medicine resident who has demonstrated financial needs, as expressed in a short (one page or less) essay submitted by the applicant.
• The recipient will preferably be married and have an Alabama connection of some kind. Please tell us of any such connection.
• The deadline for receipt of essays will be Sunday, December 31, 2017; send your essay to the attention of Chapter EVP Mr. Jeffrey Arrington at: alafamdoc@charter.net.
Emergency Medicine Fellowship Offered at UA College of Community Health Sciences

Program Put on with Rush Foundation Hospital in Meridian, Mississippi

by Brett Jaillet

Two family medicine physicians will begin to receive additional training in emergency medicine through a yearlong fellowship starting in July at The University of Alabama College of Community Health Sciences (CCHS). Plenty of preparation has taken place to bring the program to fruition.

Curriculum development and recruitment have been some of the biggest areas of preparation for the college’s new Emergency Medicine Fellowship, said Dr. Tamer Elsayed, assistant director of The University of Alabama Family Medicine Residency, which is operated by CCHS. He and Dr. Richard Friend, director of the residency, are co-directors of the fellowship, which is provided in conjunction with Rush Foundation Hospital in Meridian, Mississippi, where Dr. Walt Willis, emergency room director for the hospital, is site director of the fellowship.

The program will include rotations through radiology, anesthesia, orthopedics and trauma, and advanced courses in obstetrics, airway management and advanced life support.

Developing the curriculum involved comparing what family medicine and emergency medicine physicians learn during residency, and filling in the gaps, Dr. Elsayed said.

“We looked at what emergency residents do and their ACGME [Accreditation Council for Graduate Medical Education] requirements and compared that to the family medicine residents, and we tried to see what the differences were,” he said. “We saw that family medicine physicians have more experience with pediatrics and OB/GYN than emergency medicine physicians. And we are going to provide more hours in the ER, more trauma and procedures education, and teach about practice management in the ER.”

Dr. Willis said the regions that Rush Foundation Hospital serves are particularly in need.

Drs. Elsayed, Friend and Willis developed four basic components of the curriculum: clinical training, research, didactics and procedural. Didactics will take place at CCHS, and some rotations will be held at other sites, but the bulk of the program will be at Rush Foundation Hospital.

Recruitment took place throughout the year, with the biggest emphasis at the American Academy of Family Physicians National Conference for family medicine residents and medical students, held each year in July in Kansas City, Missouri. Candidate interviews were held in November and December.

Funding for the program is provided by Rush Foundation Hospital, and more funding is being sought to grow the program over time, said Dr. Friend, who has a special interest in emergency medicine. Establishing the Emergency Medicine Fellowship has been one of his goals since he arrived at the college in 2013.

“Fifty percent of all family physicians do some sort of urgent care or emergency medicine, and I think this will provide another venue for advanced education in areas where family medicine physicians might need some additional training,” Dr. Friend said.

Dr. Elsayed also has a special interest in emergency medicine. In addition to his role at CCHS as assistant director of the residency and assistant professor of family medicine, he works shifts in the emergency rooms at Fayette Medical Center and Choctaw Gen-
eral Hospital. "There is a lot of need in rural areas," Dr. Elsayed said. "Most emergency rooms in rural areas are covered by family physicians."

Dr. Willis said the regions that Rush Foundation Hospital serves are particularly in need. The emergency room treats 30,000 annually.

“We have five critical access hospitals in the Rush Health System and face a chronic shortage of seasoned physicians who can work in our emergency departments and also manage patients in the inpatient services at these hospitals,” Dr. Willis said. “We believe that providing emergency medicine training to these family medicine physicians will give them the confidence to be successful in this small-community environment.”

Dr. Elsayed said that, throughout 2017, the curriculum will continue to develop, and rotations may be added.

“Once the program starts, we’ll learn where to make changes and adjustments,” Dr. El-

sayed said. He said a plan for recruitment will also be developed.

Fellows will complete orientation in June and then attend a conference for the Alabama chapter of the American College of Emergency Physicians.

The college provides training in subspecialties of family medicine to suit the needs of communities in Alabama and the region, including obstetrics, sports medicine, hospital medicine, behavioral health, rural public psychiatry and geriatric medicine. Learn more about the college’s fellowships at fmr.ua.edu/fellowships.
Hospitals and health care facilities were once considered safe havens from violent incidents. Unfortunately, the health care industry is more likely to experience workplace violence than most realize.

Data from the U.S. Bureau of Labor Statistics indicates in 2010, health care and social assistance workers were the victims of 11,370 assaults, more than a 13 percent increase since the year before. In 2011, Modern Healthcare reported the bureau’s statistics showed the chance of registered nurses being assaulted at work are more than triple that of the average American worker. Nurses had a 6.1 in 10,000 chance, while the general population had a one in 10,000 chance. The article further pointed out registered nurses are at greater risk of workplace violence than taxi-cab drivers or bartenders.

The increase in workplace health care violence may be attributed to:

• Deinstitutionalization of psychiatric patients
• Increased substance abuse (both street drugs and controlled substances)
• Gang violence
• Economic stress
• Frustration due to long waits in emergency departments
• Increased use of emergency departments by police to hold unruly/ intoxicated patients

Defining “Workplace Violence” and Taking Action
The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts, including physical assaults and threats of assaults, directed toward persons at work or on duty.”

Once violence is defined, the next step is to develop a workplace violence prevention program. The American Society for Industrial Security (ASIS) Healthcare Security Council’s 2011 white paper “Managing Disruptive Behavior and Workplace Violence in Healthcare” recommends workplace violence prevention teams adopt a multidisciplinary approach. This approach includes security, first responders, clinical staff, risk management, legal, human resources, administration and other key stakeholders. Security experts recommend IT and security staff coordinate their efforts due to increased use of technology in hospital security.

The white paper also cites the International Association for Healthcare Safety & Security’s five components of an effective workplace violence prevention program, which include (1) management commitment and employee involvement, (2) worksite analysis (including evaluating the physical environment), (3) hazard reduction and response, (4) training and (5) recordkeeping and program evaluation (measured by empirical data). The white paper includes a sample threat assessment checklist, a workplace violence prevention policy, a list of common warning signs and an assessment outline.

The Joint Commission requires that accredited hospitals assess their risk of violence, develop written plans and implement security measures. Risks may vary by facility and by department, underscoring the importance of individualized analysis.

Worksite Analysis
Multiple sources suggest researching crime statistics in your facility’s immediate area. A physical environment assessment may include the monitoring of facility entrances, parking ramps and grounds. A walkthrough also may determine whether in-house emergency call numbers are posted and panic buttons are available at registration desks and nursing stations.
Additionally, determine if staff lounges are locked and layouts of patient rooms help prevent entrapment. Some facilities ensure bulletproof vests are readily available.

You can identify additional risks by conducting surveys with all shifts and in multiple situations. This allows you to determine whether employees are familiar with the facility’s violence prevention program and their reporting responsibilities.

A number of federal and state agencies provide easy access to information and tools to assist in conducting assessments. The Occupational Safety and Health Administration’s (OSHA) “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers” lists specific steps to access, monitor and analyze violent events and to evaluate the effectiveness of your workplace violence program. The guidelines also list engineering and administrative controls to help minimize violence. The guidelines, sample checklists and violence incident report forms are available on OSHA’s website, www.osha.gov.

**Hazard Reduction and Response**

The next step is developing strategies and policies for preventing and managing the potential for violence. Consider implementing and/or revising:

- Education for administration and staff on recognizing the risk of violence
- Definitions for “violence” and certain crimes
- An easily accessible reporting and documentation system
- Written policies and procedures and personnel responsibilities, including reporting of incidents (describe specific codes to call, who to notify in specific situations and interactions with law enforcement)
- The facility’s assistance to employees following a violent incident
- Debriefings (within 24 to 72 hours of an incident)
- Ongoing training programs with required staff attendance

Additional security measures might include metal detectors, bag searches, cameras, appropriate lighting, video monitoring, security personnel, stationing security in high-risk locations and nighttime escorts to parking lots.

**Training**

Staff training may be one of your most effective tools in reducing violent incidents. New employees should receive violence prevention training as part of their orientation. Training should be ongoing and include supervisors and security staff. Topics may include:

- Recognizing potentially violent situations and using de-escalation techniques
- Understanding behaviors that help diffuse anger – a calm and caring attitude, avoiding giving orders, and acknowledging the individual’s feelings – and avoiding behavior that might be interpreted as aggressive (rapid movement, speaking loudly or getting too close)
- Taking patients to safe and quiet areas to calm emotions
- Moving disruptive patients away from the rest of the hospital population

**Record Keeping and Program Evaluation**

Lastly, it is key to document your violence prevention efforts — whether to defend an employee’s or the hospital’s actions, or in response to an OSHA investigation. Thorough documentation also will assist in evaluating the effectiveness of your violence prevention program.

**When Violence Occurs**

Additional training may be necessary for employees in high-risk areas, which typically include emergency departments, intensive care units (ICUs), behavioral health and operating rooms. Training may include proper use of restraints, physical techniques to subdue violent individuals and administering medical care once the individual is subdued.

The Emergency Nurses Association’s November 2011 Emergency Department Violence Surveillance Study indicated the overall frequency of physical violence and verbal abuse for an emergency department nurse working 36.9 hours in a seven-day period was 54 percent of the 7,169 nurses participating in the study. Nurses were most often involved in triaging a patient, performing an invasive procedure or restraining/subduing a patient when the violence occurred. Patients were the main perpetrators in all incidents. Over 83 percent of the incidents occurred in patients’ rooms.

Further, the study indicates that physical violence rates increase as population density increases (9.1 percent in rural areas versus 14.1 percent in large urban areas). The odds of physical violence occurring were higher for younger nurses. Male nurses were more likely to experience physical violence than females. Also, the use of panic buttons/silent alarms correlated with less physical violence. And decreased odds for physical violence and verbal abuse were associated with enclosed nursing stations, locked or coded emergency department entries, security signs and well-lit areas.

Risk management experts recommend the following should a health care workplace violence incident occur:

- Avoid confrontation and retreat to a safe place, if possible
- Do not approach or attempt to disarm an individual with a weapon
- Summon security or a behavioral response team, or call 911
- Remain calm – refrain from agitating or threatening a violent person
- Isolate the individual – protect patients, lock doors, direct traffic away from the area, and evacuate, if possible

**Communicating with Media and Law Enforcement**

ProAssurance Risk Resource consultants suggest hospitals develop policies and procedures for communicating with the media and law enforcement. We also suggest designating a hospital spokesperson and making sure that staff receives ongoing training for these situations.
Ensure the staff knows how to respond to requests for interviews, subpoenas and/or search warrants. Be sure to provide contact information and backup numbers so the staff knows whom to contact in such situations. Staff also should be trained on how to preserve and maintain a chain of evidence, which may include illegal firearms or drugs and statements of witnesses and victims. Lastly, ensure staff understands Health Insurance Portability and Accountability Act (HIPAA) privacy issues in these situations.

**Of Course, Document**

Once the situation diffuses, staff should document what was seen, heard and/or done. Documentation will be critical should the facility or an employee be named in a professional liability lawsuit.

Unfortunately, violence occurs all too often in health care, but it still catches health care staff off guard because it’s so unpredictable. Implementing and adhering to a workplace violence program will assist you and your facility in preparing for these situations and help prevent injury to you, your staff, your patients and patients’ families.

**Resources**

2. www.g4s.us/~/media/Files/USA/PDF-Articles/Hospitals%20and%20Healthcare/Council_Healthcare_WorkplaceViolence ashx

Submitted by ProAssurance Indemnity Company, Inc.

ProAssurance insured physicians and their practice managers may contact Risk Resource for prompt answers to liability questions by calling 844-223-9648 or via e-mail at riskadvisor@proassurance.com.

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The Alabama Academy of Family Physicians is proud to announce its new Career Center — the premier resource to connect career opportunities with highly qualified health care talent. The Career Center is designed to provide you with a better overall experience through a modern design and an intuitive interface. You will be able to access the Career Center through any device of your choice — smartphone, tablet or desktop. To access the Career Center, visit: www.alabamafamilyphysicians.org.

The redesigned Career Center will allow you to:

**Manage Your Career**

- Search and apply to the best health care jobs at organizations that value your credentials
- Upload your anonymous résumé so employers can contact you, but you maintain control of your information and choose to whom you release your information
- Receive an alert every time a job becomes available matching your personal profile, skills, interests and preferred location(s)
- Access career resources and job searching tips and tools

**Recruit for Open Positions**

- Post your jobs or your organization’s jobs where the most qualified health care industry professionals will find and apply to them
- Promote your jobs directly to the Career Center job seekers via our exclusive Job Flash email
- Search the résumé database and contact qualified candidates proactively
- Expose your job postings to a larger audience through our new diversity, veterans and social networks

**Take a look and log on today at** www.alabamafamilyphysicians.org.

We hope this newly designed Career Center will make a significant difference for our members as they navigate their career paths. Thank you for your ongoing support.

**Please visit our new website at:** www.alabamafamilyphysicians.org.
On January 20, only a few hours after taking his oath of office to become president of the United States, Donald Trump signed an executive order titled “Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.” This executive order is less than two pages long and is extremely vague about how it seeks to minimize the “economic burden” of the Patient Protection and Affordable Care Act (ACA), but some of this vagueness translates into broadness of power. It must be noted that only Congress can vote to repeal the ACA.

All instructions given to the Department of Health and Human Services (HHS) secretary and all relevant department and agency heads are “to the maximum extent permitted by law.” Section 2 of the executive order calls for the secretary and relevant heads to “waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose” costs, fees or penalties incurred by states or individuals. This language clearly targets the individual mandate, the provision of the ACA requiring all Americans who are not covered by an employer-sponsored plan, Medicare, Medicaid or other public insurance programs to purchase insurance through the HealthCare.gov marketplace or pay a penalty. The text of the ACA itself calls for the individual mandate penalty to be paid “upon notice and demand by the Secretary,” but Trump has directed the HHS secretary not to enforce the penalty. Hence, the future of the individual mandate is very uncertain regardless of whether or not the ACA is repealed or replaced. For example, if for some reason the Trump administration is ultimately unsuccessful in repealing any part of the ACA but chooses not to enforce the individual mandate penalty, the next president may technically be able to immediately start re-enforcing the penalty without any new legislation or regulations, even after several years of nonenforcement.

Other sections of the executive order may not accomplish much at all. Section 3 of the executive order calls on the secretary and relevant department and agency heads to “exercise all authority and discretion available to them to provide greater flexibility to States and cooperate with them in implementing healthcare programs.” This section provides no indication of what exactly Trump hopes to accomplish with regard to providing states with greater flexibility and cooperating with them for implementation. Section 4 calls on the secretary and relevant heads to “encourage the development of a free and open market in interstate commerce for the offering of healthcare services and health insurance,” but this doesn’t specify what Trump would like for the secretary and relevant department and agency heads to do.

All regulations promulgated by the HHS secretary or the heads of relevant departments and agencies will be subject to the full rulemaking process and the notice-and-comment period required by the Administrative Procedures Act, but all proposed regulations are always subject to this. However, only time will tell what actions the Trump administration will take and what will become of the structures put in place by the ACA.

Rich Sanders is an attorney in Birmingham representing physicians in corporate and regulatory matters throughout Alabama. He can be reached at rsanders@southernhealthlawyers.com or 205-930-4289.
REGISTRATION FORM

ANNUAL MEETING AND SCIENTIFIC SYMPOSIUM
June 22-25, 2017 • Sandestin Golf and Beach Resort, Destin, Florida

Physician’s name (as you prefer it on your name badge): _________________________________________________________________

Email: ____________________________________________________________________________________________________________

Spouse/Guest name (as you prefer it on your name badge): ________________________________________________________________

Full Four-Day Conference Registration Fees

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Two-Day Conference Registration Fees

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Activities Registrations and Fees

Conference Registration (see prices above) $ ________

Thursday
Business Breakfast for Members only: I will attend ________ I will not be able to attend ________ $ FREE
Get Acquainted Party: Number of people in family attending ________ $ FREE

You may pay by check or credit card. Please select your payment method.

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Pediatric Surgery at Children’s of Alabama now offers a new, minimally invasive procedure to repair inguinal hernias in select patients. The laparoscopic technique:
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This technique allows the surgeon to perform minimal dissection of the vas deferens and spermatic blood vessels, which may reduce the chance of vascular injury to the testicle which may lead to testicular atrophy in the future.

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Pickens County Partnership

Pickens County, Alabama, is a medically underserved area and a Primary Care, Mental Health and Dental Health Professional Shortage Area. The county ranks 45th in health outcomes among the state’s 67 counties.

The University of Alabama®-Pickens County Partnership is a newly established community outreach program that seeks to provide sustainable health resources for the rural county and real-world training for UA students. Students gain experience and practice in Pickens County, and the county gains much-needed additional health resources.

The partnership is currently facilitating eight different health-related projects led by UA faculty and Pickens County organizations, and the fellowship program is in its first year, providing year-long fellowships to four recent UA graduates. Applications for 2017-2018 fellowships will soon be available online.

The UA-Pickens County Partnership is another example of how the College of Community Health Sciences is working to improve health in your community.

For more information, visit cchs.ua.edu/pickenscounty.