

Officers and Directors Installed for Coming Year

The ARKANSAS FAMILY PHYSICIAN

Volume 18 • Number 4



**Doctor Daniel
Knight , our 67th
AR AFP President**
(See article on Page 4)



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Dear Academy Member,

With the 67th Annual Scientific Assembly behind us we thank all of you that attended, participated and exhibited with us! The meeting had a net income of over \$45,000. which is outstanding considering the number of programs available to Family Doctors not only live programs but online.

We had excellent evaluations of the assembly this year with our top speakers being our own Family Physicians, Doctor Angela Driskill, Doctor Elton Cleveland and Doctor Mark Jansen. Other speakers receiving high marks were Doctor Carol Havens, A family doctor from California and Doctor Barbara Yawn, a Family Doctor from Minnesota and Doctor Charles Bower, a pediatrician at Arkansas Children's Hospital and Doctor Scott Dinehart a dermatologist in Little Rock.

We now focus on the AAFP Congress of Delegates coming up in October in Washington D.C., and planning for our Assembly again at the Doubletree Hotel in Little Rock beginning June 10-14, 2015. More information will be provided in upcoming articles and emails. If you have speaker or topic suggestions, please forward them to us as soon as possible.

This issue of our Journal highlights our newly installed President, Doctor Daniel Knight and the officers and directors installed during our meeting by AAFP President Elect Doctor Robert Wergin of Nebraska.

The AR AFP Board of Directors will meet soon with a three hour session by our Planning Committee on Strategic Planning for the coming five years. We hope to address all of your concerns at this planning session and do our best in serving you in the future.

If you are due for re-election at the end of this year, we hope you will take advantage of the Core Content Review advertised in this issue of the Journal or the many resources offered online through the AAFP website. Please remember that you can go back 12 months and report any AFP Journal quiz's that are worth as many as 3 AAFP Prescribed Credit Hours each issue. And if you were dropped for non payment or CME, please remember, we are here to help you. If you were dropped for non payment of dues, you simply pay the back dues to the AAFP by calling 1-800-274-2237. You may pay with a credit card or send a check to the headquarters office in Leawood.

We look forward to hearing from you and please visit our website at arkansasafp.org!

Sincerely,

Carla Coleman

Executive Vice President

Photographs by Darrick Wilson
Photography
Little Rock, Arkansas

On the cover:

Daniel Knight, 68th AR AFP President Installed

See page 4

Doctor Daniel Knight Installed 68th President of the Arkansas AFP

Doctor Daniel A. Knight, Garnett Chair and Associate Professor of the Department of Family and Preventive Medicine at the University of Arkansas for Medical Sciences was installed as President of the Arkansas Academy of Family Physicians Friday June 20 during the Installation of Officers Luncheon at the Doubletree Hotel in Little Rock by AAFP President Elect Robert Wergin of Nebraska.

Doctor Knight graduated from the University of Arkansas with a B.S. in Biology, received his M.D. degree from the University of Arkansas for Medical Sciences in 1985 and completed a Family Medicine Residency at the UAMS Department of Family and Community Medicine and served as Chief Resident in 1987-88. He completed the Program for Chiefs of Clinical Services, Harvard School of Public Health in 2012.

After residency he practiced Family Medicine in Sherwood and also served as an Emergency Physician for five years before joining the Department of Family and Preventive Medicine as Director of Education. He served for over ten years as Residency Program Director and became Vice Chair of the Department in 2007; Acting Chair in 2007-2009 and was named Chair in July 2009.

He has served on the Arkansas Chapter's Board of Directors since 2006 as a Director and an officer and is a Diplomate of the American Board of



AAFP President elect Robert Wergin installs President Daniel Knight.

Family Medicine. He also holds numerous professional memberships: the American Association of Medical Colleges, Council of Faculty and Academic Societies Board Member; UAMS Center for Primary Care Advisory Committee member; Arkansas State Medicaid Patient Centered Medical Home Advisory Committee; UAMS Residency Position Allocation Committee; Governors Health Care Workforce Strategic Planning Taskforce Stakeholders; as well as dozens of other professional memberships and activities. He received the UAMS Residency Educator Award – UAMS College of Medicine in 2007; the Association of Family Medicine Residency Directors Program

Director Silver Recognition Award for Directors demonstrating accomplishments in tenure, training, performance and advocacy and the Dean's Resident Teaching Award from graduating Family Medicine Residents in 2007 as well as the Red Sash Award presented by UAMS Senior Medical Student classes in five different years presented to faculty who have had the most significant input into their education.

He is the author and co author of several publications and has presented over 15 presentations in Arkansas and in several other states.

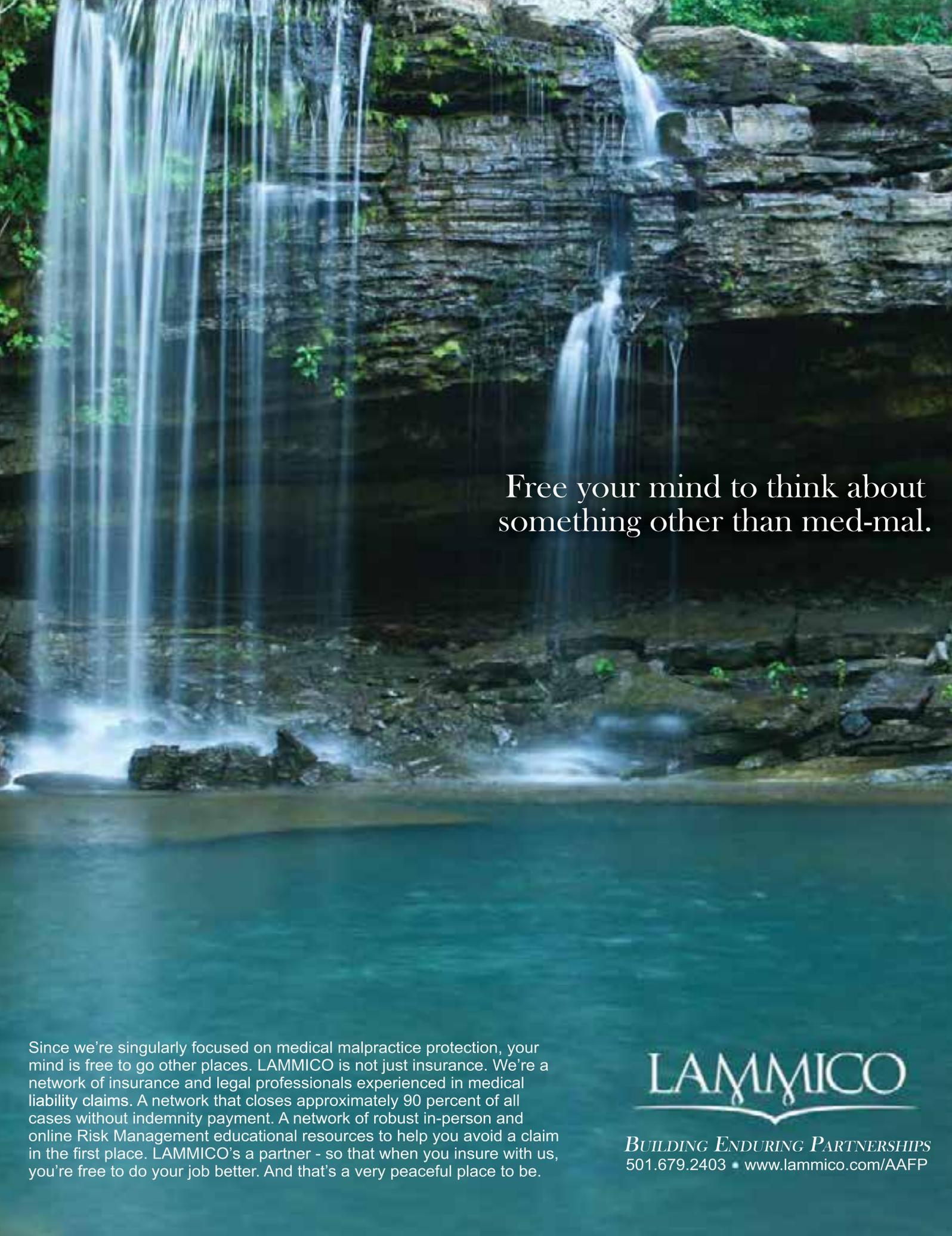
His personal hobbies are weight lifting, bicycling travel and home improvement.



Dr. Knight's DFPM "Family" – Dr. David Nelsen, Diane Jarrett, Dr. Knight, Mary Prince, Dr. Mark Jansen.



Dr. Barry Pierce, Past President, awarded Plaque of Appreciation by Dr. Knight.



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Along with Dr. Daniel Knight installed as President for the coming year, the following officers were installed:

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Doctor Tommy Wagner of Manila – Vice President
Doctor E. Andy Gresham of Crossett – Secretary/Treasurer
Doctor Lonnie Robinson of Mountain Home – Alternate Delegate
Doctor Julea Garner of Hardy – Delegate
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Doctor Hunter Carrington of Hot Springs – Director
Doctor James Chambliss of Magnolia – Director
Doctor Eddy Hord of Stuttgart – Director
Doctor Jason Lofton of DeQueen - Director
Doctor Philip Pounders of Little Rock – Director
Doctor Tasha Starks of Jonesboro – Resident Director
Brian Bowlin , Medical Student, UAMS, Student Director
Doctor Scott Dickson, UAMS AHEC NE, Residency Program Representative Director



Doctors Wergin, Gresham, Dawson, Wagner, Robinson, Garner, Bowlin, Lofton, Chambliss, Carrington, McGrath, Starks (not pictured was Doctors Eddy Hord, Philip Pounders and Scott Dickson).

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LITTLE ROCK - Family physicians will receive up to 16 hours of continuing education at the 18th Annual Family Medicine Update, October 3 and 4, at the Jackson T. Stephens Spine and Neurosciences Institute on the UAMS campus in Little Rock.

The two-day conference features a wide range of family practice topics such as pain management, anemia, medical dermatology, ADHD in children, antipsychotics and benzodiazepines, diabetes, vaccines and testosterone replacement. Harvey Makadon, clinical professor of medicine at Harvard Medical School, will speak on "Providing Optimal Care to LGBT Patients: What Clinicians Need to Know."

The early-bird rate for the conference is \$259 ending September 10. Standard registration will begin September 11 at \$309. To register and see the complete agenda, go to cme.uams.edu or call 501-526-5439.

The conference is sponsored by the UAMS Department of Family and Preventive Medicine, CME division.

UAMS is the state's only comprehensive academic health center, with colleges of Medicine, Nursing, Pharmacy, Health Professions and Public Health; a graduate school; a hospital; a statewide network of regional centers; and seven institutes: the Winthrop P. Rockefeller Cancer Institute, the Jackson T. Stephens

Spine & Neurosciences Institute, the Myeloma Institute for Research and Therapy, the Harvey & Bernice Jones Eye Institute, the Psychiatric Research Institute, the Donald W. Reynolds Institute on Aging and the Translational Research Institute. It is the only adult Level 1 trauma center in the state. UAMS has more than 2,800 students and 790 medical residents. It is the state's largest public employer with more than 10,000 employees, including about 1,000 physicians and other professionals who provide care to patients at UAMS, Arkansas Children's Hospital, the VA Medical Center and UAMS regional centers throughout the state.

W. Scott Bowen, M.D. • William F. Hefley, M.D. • David M. Rhodes, M.D. • Jason G. Stewart, M.D. • Jesse B. Burks, D.P.M. • Joe W. Crow, M.D. • Larry L. Nguyen, M.D. • Alina Voinea, M.D. • Sam Moore, D.O.

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Dr. Voinea is a Fellowship-trained and Board Certified Rheumatologist. During her career, Dr. Voinea has completed residencies at Danbury Hospital/Yale School of Medicine and the University of Arkansas for Medical Sciences (UAMS), as well as fellowships at Universite de Medicine Paris Bobigny in Paris, France, and UAMS. She also served as Assistant Clinical Professor in the Department of Medicine at UAMS. Call OrthoSurgeons today to schedule an appointment with Dr. Voinea.

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The Importance of Continuing Arkansas' Legislative Mandate for the UAMS College of Medicine Admissions from all Four Congressional Districts

Mark B. Mengel, MD, MPH
Robin A. Howell, BA
June 27, 2014

University of Arkansas for Medical Sciences
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Email: mmengel@uams.edu
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History and Background

From its early beginnings in 1879, the University of Arkansas for Medical Sciences' (UAMS) College of Medicine was established with a core mission to ensure that all Arkansans have access to excellent health care. Since that time, UAMS has evolved from a small medical school with a charity hospital into a world-renowned comprehensive health sciences center and research institution, including six colleges, seven institutes, eight regional centers, and the UAMS Medical Center. UAMS is the state's largest public employer with more than 10,000 employees in 73 of Arkansas' 75 counties. UAMS and its clinical affiliates, Arkansas Children's Hospital and the VA Medical Center are economic engines for the state with an annual economic impact of \$3.92 billion (UAMS History, 2013).

Regional Programs, formerly the Area Health Education Centers (AHEC) program, was founded in 1973, through combined efforts of UAMS, the Governor, and the State Legislature, as a means to encourage more UAMS medical school graduates to remain in Arkansas, and to help address the state's shortage and maldistribution of primary care physicians. Regional Programs has proven extremely successful in its mission, with its six residency programs having trained nearly half of Arkansas' family physicians. Historically, 70% of Regional Programs' graduates remain in Arkansas to practice, with 40% electing to practice in rural areas and small towns

across the state. As of fall 2013, 719 graduates were practicing in 126 Arkansas communities, including 68 of the state's 75 counties (Howell, Montague, 2013).

In spite of these successes, Arkansas still has a shortage of nearly 500 primary care physicians, with 90% of those needed outside Central Arkansas (Bynum, 2011). Arkansas' most critical health workforce needs have never been as simple as an overall shortage of physicians, but rather the greatest needs have always been related to specific types of physicians, especially in rural areas of the state.

Arkansas' Rural Incentive Programs

Around 1985, when the Arkansas General Assembly increased the College of Medicine (COM) class size from 135 to 150 student admissions per year, they also began requiring that 70% of every class be accepted equally from each of the state's four congressional districts, meaning at least 27 students from each district (Saylor, 2013). Persistent shortages in rural areas over the years have prompted further increase in COM class size (174 students were accepted in 2013), as well as other incentives to encourage rural practice choices, such as the *Community Match* and *Rural Medical Practice Student Loan and Scholarship* programs (UAMS Rural Practice, 2014).

Although Dr. Richard Wheeler, COM Executive Associate Dean for Academic Affairs, has stated that for most applicants, the congressional district mandate does not affect the school's admission decisions (Saylor, 2013), some individuals still occasionally question the need for this law, asserting that the COM should be free to accept only the highest scoring students. Regional Programs agrees that our state's only medical school should maintain the highest academic standards, and shares the conviction that Arkansans deserve only the best physicians providing care for them and their families. However, in this article, we will submit the reasons why an applicants' county of origin is vitally important to ensure future healthcare access for all

Arkansas, and we will challenge the narrow view of how a "quality" applicant has been defined by traditional metrics.

Looking at the numbers

Over the last two decades, the UAMS COM has experienced a large fluctuation in the number of Arkansas applicants, dropping from a high of 450 in the mid-1990s to a low of 262 in 2005. In recent years, applications have settled in at just above 300, ranging from 307 to 324 (Dupuy, 2014). This means that as the COM class size has increased, the number of Arkansas applicants has actually decreased, leaving fewer than two in-state applicants now competing for each slot. The 2013 in-state applicant pool of 310 came from our four congressional districts as listed below; 2,056 out-of-state students also applied, but only 18 of them were admitted (Saylor, 2013).

- District 1 (North/East AR) – 65 applicants
- District 2 (Central AR) – 117 applicants
- District 3 (Northwest AR) – 70 applicants
- District 4 (South/West AR) – 58 applicants

How It Works

When students apply to the COM, a curriculum committee of 15 members interviews each Arkansas applicant. State law dictates that committee members include six from UAMS, two from each Congressional district, and one at-large member. Four must hold UAMS faculty appointments, which can include regional centers' faculty. Once interviews are completed, committee members review applicant files, and rank each student from one to seven. Individual committee member scores are totaled and divided by 15, to come up with an average score for each student. All students are then placed into a single list, according to their score. The committee then counts down to determine the point where they would cut off the list of applicants if they were to admit the previous year's class size of students. At that point, they examine the counties of origin among the top group of students to

[continued on page 12](#)



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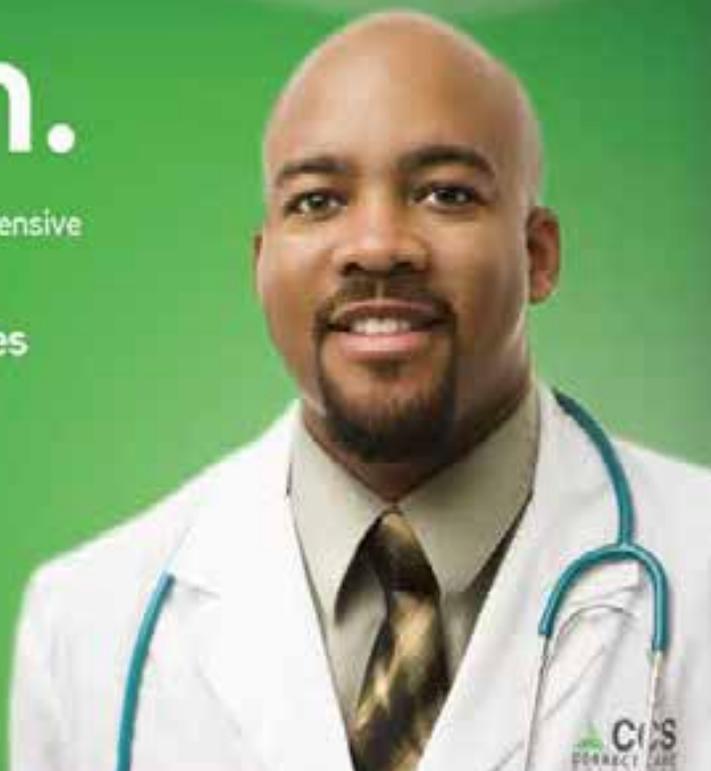
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make sure there are at least 27 students from each district. In the event that there are not, then one or more applicants at the bottom of this list may be displaced to make room for another at the top of the alternative list who hails from the targeted rural district (Saylor, 2013).

Periodically, someone will challenge the fairness and validity of the congressional district mandate and will lobby state

legislators for the removal of this constraint on the COM admissions process. Such claims often operate under a false assumption that the law forces the COM to accept inferior applicants; but this has never been demonstrated. Another charge has been that the law is a failure because only a small percentage of medical school graduates actually return to their home districts to practice (Blomeley, 2007). However, although anything less than 30% might be portrayed by some as failure,

the reality is that even 20% of physicians returning to their home counties or another rural area to practice is a significant showing in the broader context of data. We would further argue that, for small towns in Arkansas, a single returning graduate is indeed very significant and can mean life or death to the local healthcare community.

Social responsibility and mission of state medical schools

Rosenblatt claims that persistent national shortages of rural primary care physicians reflect a dominant medical school culture that is typically urban, technologically intensive, and specialty-dominant. His premise is that rural physician shortages are in large part due to a systematic bias against primary care that tends to be built into the culture, organization, and reward structures on which our national medical care system is built (Rosenblatt, 2010). Historically, there has been little talk of holding state-supported medical schools accountable for producing certain types of physicians, but Chen, et al remind us that the basic purpose of medical schools is to educate physicians to care for the national population (Chen, Fordyce, Andes, Hart, 2010). Thus, beyond their general educational mission, medical schools are also expected to have a social mission to train physicians to care for the population as a whole, taking into account such issues as primary care, an appropriate mix of medical specialties, adequate distribution to underserved areas, and workforce diversity (Mullan, Chen, Petterson, Kolsky, Spagnola, 2010).

Since the 1980s, UAMS has established itself as a comprehensive academic health center and research leader, with our researchers now receiving over \$100 million in research funding, ranking UAMS among the top 18% of all U.S. Colleges & Universities in federal research funding (Mullen et al, 2010). This growth has had far-reaching benefits for all Arkansans, not only through cutting-edge medical innovations and quality health care, but also as an economic engine for the entire state. This article in no way seeks to minimize or challenge the tremendous value of the UAMS research mission. However, as our state's only medical school, we simply



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believe it is important occasionally to revisit its social mission, which is to produce a substantial percentage of rural physicians for our predominantly rural state.

Logical correlation has been established between institutional emphasis on research and a corresponding emphasis on and promotion of technology and medical subspecialties. The amount of NIH funding received by a medical school has been inversely associated with social mission score and with output of primary care physicians and physicians practicing in underserved areas (Mullen et al, 2010). It is therefore not surprising that in the last 20 years, with UAMS' emphasis on research, an occasional undercurrent surfaces to move toward strict focus on student test scores as the preeminent basis for COM admission. This bias is also reflected in traditional assessments of medical schools, such as the US News & World Report ranking system, which are inclined to value research funding, school reputation and student selectivity factors over outputs related to the number of graduates entering primary care or practice in underserved areas, or who are underrepresented minorities (Chen et al, 2010).

Since the 1990s, UAMS has placed among the top quarter of US medical schools for percentage of graduates practicing in rural areas and, in Chen's study, UAMS was ranked 52nd out of 141 schools on the social mission score (Chen et al, 2010). So although UAMS is now known for receiving significant NIH funding for cutting edge research, it also still ranks better than nearly two-thirds of other institutions in social mission score. It is the premise of this article that Arkansas' congressional district admissions mandate, combined with quality rural primary care training opportunities offered through UAMS Regional Centers across the state, have been key factors in maintaining this uncommon institutional balance of research and social missions over the last 40 years.

Trends on the Statewide and National Levels

Arkansas' chronic health workforce shortages were discussed by the authors in a previous article published in the winter 2013 edition of the *Arkansas Family Physician* (Mengel, Bynum, Howell, 2013).

With the entire nation facing a shortage of primary care physicians, the specific mix and composition of the medical workforce is under increasing scrutiny. Medical schools that have historically reported high percentages of their graduating classes pursuing "primary care" are being challenged about inflated claims due to the common practice of including all internal medicine and pediatric residents in their "primary care" counts. Coined "the Dean's lie," these inclusions falsely inflate primary care production numbers because, in reality, the vast majority of internal medicine (80%) and pediatric residents (70%) go on to sub-specialize, leaving less than one-third of them to actually practice primary care (Pugno, McGaha, Schmittling, Fetter, Kahn, 2006).

Nationally, the last decade has seen a decline in US medical school graduates choosing to specialize in family medicine. Even though more than 50% of UAMS COM graduates are reported every year as pursuing a "primary care specialty," we must consider that these numbers include not only graduates who match with family medicine residencies, but also internal medicine, pediatrics, and OB/Gyn. Consequently, if the lower practice percentages attributed to Pediatrics and Internal Medicine residency matches cited above are applied, then the numbers of graduates we can expect to actually end up in practice as primary care "generalists" will be much smaller (see graph right).

Thus, it must be noted that simply increasing the number of medical or

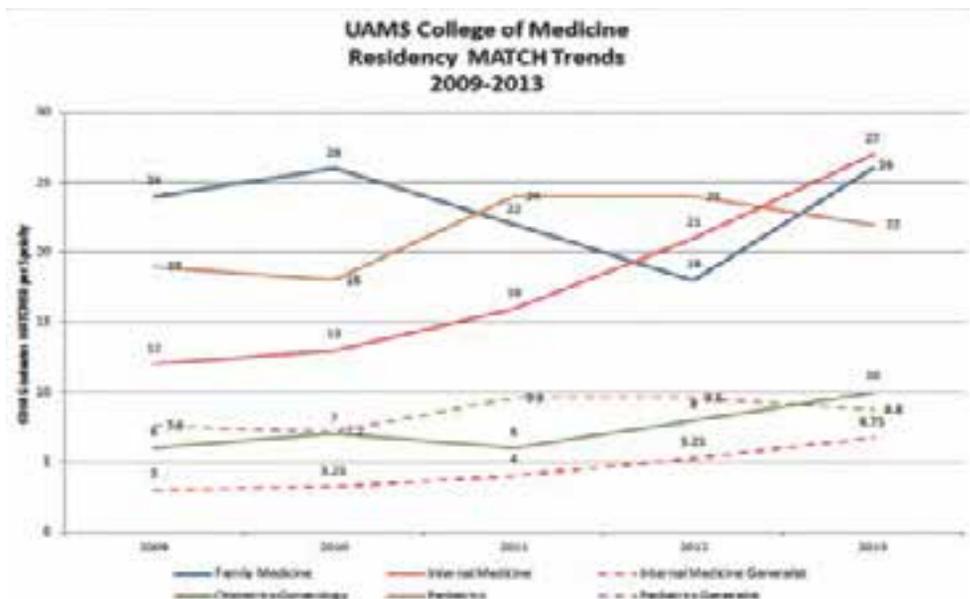
osteopathic school slots in Arkansas will not be an automatic answer to our state's primary care workforce needs. Expanding medical school class size without explicitly targeting and incentivizing primary care residency training and rural practice could ultimately worsen our state's shortage and maldistribution problems. If too few primary care residency slots are available in Arkansas to accommodate new graduates, then many of them will be lost to residencies in other specialties or in other states. Further, without emphasis on rural recruitment, training and placement, new graduates may simply add to the concentration of physicians practicing in urban areas, doing nothing to alleviate chronic shortages in outlying regions where nearly half of our population lives.

Factors that have been shown to impact rural/primary care practice choice

Over the years, many studies have noted various influences that affect choice of practice location, ranging from gender, social and work opportunities for spouse, schools, lifestyle preferences, and family ties, among others. However, a few commonly cited factors noted below have passed the tests of time and repeated scrutiny as consistent predictors of rural practice choices.

- Medical students from small, rural hometowns are more than TWICE as

continued on page 16



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likely (compared to those from non-rural communities) to practice in rural areas (AAFP, 2014) (Hyer JL, Bazemore AW, Bowman RC, et al, 2007) (NRHA, 2006).

- Trainees who experience residency training in rural clinical settings are over THREE times more likely to practice in rural areas (Daniels ZM, VanLeit BJ, Skipper BJ, et al, 2007)
- Family medicine graduates are TWICE as likely as pediatricians and internists to practice in rural areas (Rosenblatt RA, Whitcomb ME, Cullen TJ, et al, 1992).

Connection between Regional Programs' Training and the Congressional District Mandate

Historically, 70% of Regional Programs residency graduates have remained in Arkansas to practice, with 40% of them choosing practice in small towns of less than 15,000 population. This is a much higher percentage than is common among urban-based residency programs. In April 2013, a preliminary study was conducted by UAMS Regional Programs to assess the counties of origin of UAMS COM graduates who had matched to Regional Programs Family Medicine residency programs and ultimately elected to practice in rural communities in Arkansas. Our findings noted that of all medical students from Arkansas (N=3,413), 20% came from a hometown in the Northeast (1st district); 20% came from the South (4th district); 21% came from the Northwest (3rd district), and 37% came from Central Arkansas (2nd district). Of the 279 COM graduates with Arkansas origins who matched with a Regional Programs residency program, 92% remained in Arkansas, and 46% elected to practice in a "rural" Arkansas county. Of those rural practitioners, 70% of them came from hometowns in the more *rural* 1st or 4th Congressional Districts. Students from the 1st and 4th Districts selected Regional Programs residencies at twice the rate of students from the more *urban* 2nd and 3rd Districts. Even though students from the 2nd District comprised 37% of all COM graduates, only 5% of them selected an AHEC residency (Howell, Montague, 2014).

These data were analyzed to test the

relationship between rural status of a person's hometown and the location they chose for practice. Descriptive statistics revealed a statistically significant .26 correlation, thus warranting an additional chi-squared analysis. A Chi Squared test of independence showed that the strong relationship between the rural status of the hometown and the rural status of the town where professionals chose to practice after completing the training program is statistically significant: $\chi^2(1, N = 280) = 20.03, p < .001$ (Martel, 2014).

These preliminary local data confirm national evidence that there is a greater probability for an individual to practice in a location similar to his/her hometown. This further suggests that removing the mandate for COM enrollment from rural districts, combined with a likely subsequent loss of COM graduates training in UAMS Regional Centers, could result in an even greater physician workforce deficiency in rural areas of Arkansas.

Changing Paradigm for Medical School Admissions Criteria

At national and state levels, the traditional premise that a student's GPA or MCAT score is the only legitimate means of identifying a "quality" applicant or future doctor is being increasingly challenged. In light of dramatic paradigm shifts in our nation's historic healthcare practice and reimbursement models, health workforce educators and experts are now recognizing that expanded skill sets are needed to define the type of professionals needed to lead our nation through the next era of health system evolution. Issued in 2009, "Scientific Foundations for Future Physicians" noted that a strong background in the basic and natural sciences will always be critical to success in medical school and it defines the scientific competencies that future graduates should possess (AAMC, 2009). However, the companion report, "Behavioral and Social Science Foundations for Future Physicians," found that concepts from behavioral and social sciences are equally important, serving to prepare graduates for comprehensive, patient-centered practice and provide the conceptual framework needed to address complex societal problems that have direct bearing on health and health care disparities (AAMC, 2011).

Recent healthcare reforms have triggered a system-wide shift toward team-based practice. Physicians who have historically practiced with considerable autonomy are now being required to become members of team-based patient centered care models. Yet, little scholarly attention has been paid to date on how the medical school admission process might adapt to identify individuals best suited for the collaborative, team-based practices of the future. An article in the December 2013 issue of *Academic Medicine*, titled *Selecting Tomorrow's Physicians: The Key to the Future Health Care Workforce* offered some novel recommendations to medical schools that we believe are vital for consideration (Mahon, Henderson, Kirch, 2013). The authors challenge the traditional paradigm for selection of healthcare practitioners within the historical context of medical school admissions, which have placed a premium on grades and standardized test scores. They then explore how admission practices need to undergo fundamental changes in order to select physicians with both the academic, interpersonal, and intrapersonal competencies necessary to operate in the health care system of the future.

The MCAT exam is an important tool for medical student's selection, and revisions are planned to that exam beginning in 2015, with two of the most prominent changes being the addition of a section to test knowledge of concepts from the behavioral and social sciences, and a new section on critical analysis and reasoning skills. In today's environment of big data, the higher educational mindset is finally shifting to recognize that a student's ability to seek and reason through massive amounts of information is more important than their capacity for rote memorization. In 2013, the AAMC identified some of the most desirable interpersonal and intrapersonal competencies for entering medical students as service orientation, cultural competence, reliability, and dependability (AAMC, 2013). The AAMC Admissions Initiative (AI) is aimed at transforming the way in which medical school applicants are assessed and selected in order to identify those who will become the kinds of physicians best suited for our dynamic health care environment (Mahon et al, 2013).

Conclusion

Mullan has challenged all schools to examine their educational commitment regarding the service needs of their states and the nation. He claimed that a diverse, equitably distributed physician workforce with a strong primary care base is essential to achieving quality health care that is accessible and affordable, regardless of the nature of any future health care reform (Mullan et al, 2010).

When a medical school's admissions process is designed to accept students based exclusively on the highest standardized test scores, those policies will always favor students from larger population centers where educational opportunities provide an advantage. However, research has shown that physicians are inclined to practice in areas close or similar to where they grew up and/or where they completed residency training. If the UAMS COM were allowed to accept only the highest scoring Arkansas applicants regardless of origin, the law of averages would expect most applicants to come from our population centers of Central and Northwest Arkansas. Ultimately, the vast majority of those applicants could also be expected to return to Central and Northwest Arkansas to practice, leaving the rural areas of our state to suffer even greater workforce shortages than they currently face. Consequently, we believe the best way to ensure a health workforce pipeline for all areas of Arkansas, especially the most underserved areas, is to maintain COM admissions provisions that require enrollment of a representative number of qualified students *from* those areas who specifically express intent to return *to* those areas to practice.

If not enough highly "qualified" applicants are coming from the 1st and 4th districts, then the answer is not to bemoan the congressional district mandate, but rather do a better job of increasing the qualified applicant pool in those districts. There are many students in rural districts who are capable of becoming outstanding doctors and who are more likely to return to practice in an underserved area of Arkansas than their urban counterparts. Our job as educators is to make sure those promising students are identified and provided with the academic options, tools, and support networks to help them succeed.

Like the founders of UAMS, the COM continues to fulfill its unique role as the state's main foundation for education, research, clinical care, and outreach efforts. We can never forget that the fundamental commitment and very heart of the institution was to ensure that all Arkansans have access to excellent health care. As a public institution that has historically been charged with producing physicians to serve all the people of Arkansas, we must never compromise or fail to protect the interests of *all* our citizens ... *not* just the ones living in our population centers.

Recommendations

1. **Maintain Congressional District Mandate.** Maintenance of the Congressional District mandate for the COM admissions process is essential to ensure the most basic level of student representation from all regions of our state. Removing that mandate and allowing admissions to be based purely on academic scores will always give advantage to a larger pool of applicants from population centers in

central and northwest Arkansas, whose students enjoy the greatest educational opportunities.

2. **Maintain primary care representation on COM admissions committee.** Maintaining the balance of perspectives among faculty representing all aspects of healthcare including primary care, rural practice, and urban sub-specialists is required to ensure a fair and balanced admissions process.
3. **Pay attention to the institutional environment.** All UAMS faculty have a responsibility to maintain an institutional atmosphere that values, esteems, and promotes primary care equally with other subspecialties. With the implementation of team-based care and emerging initiatives in Interprofessional Education (IPE), the importance of creating and maintaining an atmosphere of mutual respect and value for every member of the team cannot be overemphasized.

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4. **Ensure that future COM applicants are evaluated according to a more holistic grid.** Holistic admissions refers to a “flexible, highly individualized process by which balanced consideration is given to the multiple ways in which applicants may prepare for and succeed as medical students and doctors.” Holistic review has three goals: 1) to assess applicants’ academic readiness for medical school, 2) to identify and assess applicants’ interpersonal and intrapersonal competencies, and 3) to encourage diversity in medical education.
5. **High quality clinical, practicum, and peer support mechanisms throughout the medical school years.** Peer and professional interest groups and events such as the Family Medicine Interest Group and Rural Medical Student Leadership Association provide important support and encouragement for students interested in primary care and rural practice. Clinical and mentoring opportunities in every year of medical school help to ensure consistent reinforcement of the primary care and rural mission.
6. **Additional Study is needed in the following areas:**
 - a. The primary limitation of our preliminary COM graduate analysis above is that it only included data from Regional Programs residency programs. In order to generalize and make informed policy decisions, additional study is needed to examine residency and practice choices of UAMS COM graduates who matched to both AHEC and Non-AHEC residencies, with the ability to compare between groups the numbers that ultimately selected rural practice locations.
 - b. It would be helpful to know the number of COM applicants and enrollees per Congressional District each year over the last 5-10 years, comparing GPA, MCAT scores, as well as GPA and USMLE scores throughout medical school. The differences in test scores and performance could then be

compared among rural vs. urban, as well as congressional districts. This data would help identify groups with specific challenges, and would inform stakeholders regarding how academic and support networks might strategically begin to address regional and/or cultural barriers.

- c. Regional Programs is currently planning with UAMS partners to conduct a retrospective assessment of various academic enrichment programs that have been offered over the years to scrutinize student outcomes of these program. The goal is to identify specific interventions and best practices that have been successful in improving students’ chances of acceptance into medical school (e.g., MCAT prep), as well as those focused on improving specific skills needed to equip them to navigate through all the rigors of medical school to successful graduation.
- d. It would be helpful to know the counties of origin and the success/failure/default rates of those who have received state-funded rural loan and scholarship or community match awards over the years and which of them entered and remained in rural communities to practice.
- e. In a future article, Regional Programs plans to propose some recommendations for strengthening strategic and targeted recruitment and pipeline programs to more directly address the long-term healthcare workforce needs of our state.

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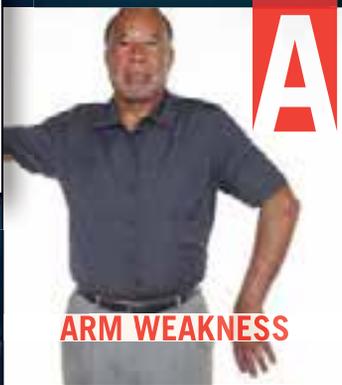
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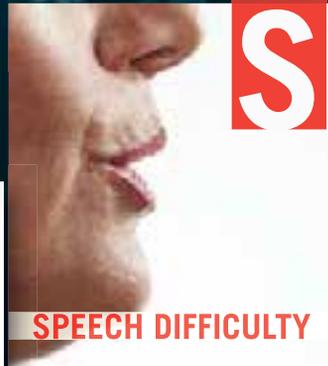
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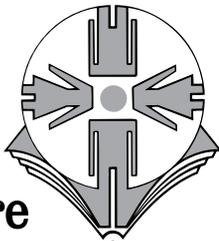
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Is an ACO In Your Future?

Regaining control and shared savings

Ray Hanley, President and CEO,
Arkansas Foundation for Medical Care

Does it feel like you've lost control of your patients' health care? Many primary care physicians experience frustration with the disconnect between wanting to provide a continuum of quality health care but only serving a portion of their patients' needs.

Accountable care organizations (ACOs) can be the answer to both regaining control of patients' health care and sharing in the savings you will generate when costs get under control.

The current fee-for-service (FFS) health care model is not sustainable. FFS creates powerful incentives to deliver more care and more tests, but not necessarily better care or the most cost-effective care. American health care is the most expensive in the world without correspondingly superior outcomes. This contributes to physicians' frustrations with the current practice environment.

What's an ACO?

An accountable care organization is a network of health care providers – that may include primary care physicians, specialists and hospitals – that work together collaboratively and accept collective accountability for the overall care, cost and quality that is delivered to a defined patient population. When providers generate savings, there is a promise of sharing those savings.

ACOs are accountable for cost and quality within and outside of the primary care relationship, including specialists and hospitals. Comprehensive care is necessary to control costs and improve health outcomes across the entire care continuum.

Medicare was an early adopter of the ACO model because, with the transition of 70 million-plus baby boomers to Medicare, the program was not financially sustainable. The ACO model is being watched closely by Medicare for results.

Currently 5.3 million Medicare

beneficiaries are enrolled in ACOs under the Medicare Shared Savings Program (MSSP). Additionally, more than 30 million Americans now receive health care through an ACO.

The Arkansas Foundation for Medical Care (AFMC) has worked hard to implement the patient centered medical home (PCMH) model with Arkansas physicians. PCMH's emphasis on primary care is the future of health care. PCMHs operate effectively with ACOs because ACOs can manage multiple PCMHs. The economies of scale with larger patient populations facilitate overall cost management, less variation within the population, and the ability to track and trend for quality.

ACOs can improve your practice

Health care payments are shifting from a volume-based system to one based on value and quality. With this shift, primary care physicians (PCPs) will increasingly feel the pressure to make changes in how they practice medicine.

AFMC believes it is critical to strengthen independent PCPs in a rural state like Arkansas. Physician-led ACOs are appealing to PCPs because they give the PCP control over patients' health care through the power of information and analytical data, and through the totality of care coordination. Better control means improved quality of care and lower costs.

A PCP practicing in an ACO will continue to receive payment for his or her services. But by practicing in a more efficient manner through care coordination, chronic disease management and focusing on disease prevention, PCPs can capture and share in the value and savings they create for the health care system.

Joining an ACO is voluntary. Hesitancy about joining an ACO can stem from concerns about making fundamental changes in your business model. ACOs

require a culture of self-reflection and assessment, continuous improvement, flexibility, and information sharing and analysis. ACOs support and reward continuous quality improvement.

If your practice is participating in Medicare's Comprehensive Primary Care initiative (CPCi), it may not participate in a Medicare ACO (MSSP).

While an independent PCP practice can probably survive on its own, an ACO offers the opportunity to thrive and improve quality. An ACO can provide valuable tools such as IT expertise and "boots on the ground" to help transform the practice, and training to facilitate quality improvements. An ACO can also help you navigate the considerable business applications, and the legal ramifications that permit collaboration and integration.

The savings are real

Claims data demonstrate that ACOs' shared savings are real. The Congressional Budget Office projects that ACOs will save \$5.3 billion nationwide from 2010-2019.

ACOs reduce costs by improving care coordination, avoiding unnecessary hospitalizations and emergency department visits, improving chronic disease management, avoiding unnecessary tests and procedures, and increasing focus on disease prevention. Potential savings will depend on how effective ACOs are in improving quality, containing costs and handling the different expectations of multiple payers.

Many proponents say the real savings will come from quality improvements.

Attracting patients

Improving patient engagement in

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health and health care is another benefit of ACOs. While Medicare automatically enrolls patients in ACOs, non-Medicare patients can be encouraged to participate in an ACO when they understand the numerous benefits of receiving “the right care at the right time and in the right setting.”

The patient becomes the focus of care. Patients will spend less time filling out medical history forms because the information is available electronically (EHR). You can securely share information, including lab results, via a patient portal. Communication between all members of the patient's care team will facilitate better-informed consumer decisions, thus lowering costs and improving care. This increased efficiency creates a leaner workflow in your practice. Patients will see fewer medical tests and co-pays, less stress, and fewer doctor visits.

Patients can choose their own providers and are not required to stay in the ACO network for any or all of their health care. This is not an option with HMOs or HMNs.

ACOs improve quality

ACOs can help you provide better care because ACOs must meet extensive quality standards.

HMOs are typically criticized for giving control of a patient's health care to the insurance company, not his or her physician. ACOs put the control back in your hands.

Farzad Mostashari, MD, says that longitudinal patient care means knowing everything health-care-related that's happening to your patients: Are they being hospitalized, taking their meds or bouncing from specialist to specialist?

“Unless you have this data on each patient, you cannot control their health care and thus make it more effective, higher quality and save costs in the process.” Mostashari told the Health Care Blog in March. Mostashari is the founder of Aledade, Arkansas' newest ACO.

“I was trained in an era where we were not supposed to think about, or even be aware of, the cost implications of our care recommendations. I now believe that we need physician engagement in addressing

the truly unsustainable rise in healthcare costs that threaten to bankrupt our nation,” Mostashari says.

Who creates ACOs?

There are two basic categories of ACOs: physician-led and hospital-led. ACOs can be formed around multi-specialty medical groups, physician-hospital organizations (PHO) or independent practice associations. They must be able to manage both cost and quality for a defined patient population.

Many of the more than 600 currently operating ACOs are run by private insurance companies that have the ability to track patient data and evaluate care costs. Analytical ability is crucial to a successful ACO. However, unless insurance companies develop networks of providers that will use actuarial data to provide efficient and effective care, they may be bypassed by ACOs.

While some HMOs can meet the requirements of an ACO, most HMOs still rely on payment contracts with a network of mostly disaggregated physicians and hospitals, or they have developed into fully integrated delivery systems but only serve the HMO's insured patients. Kaiser Permanente is a highly successful example of the latter.

AFMC has been a respected, long-time leader in the key areas of ACO success. That's why we have just partnered with Aledade, a new ACO in Arkansas. AFMC brings an in-depth knowledge of Arkansas' health care environment to the ACO initiative. We have both earned the trust of and have a good working relationship with the state's physicians and other key healthcare stakeholders. AFMC also has an experienced and trusted analytical capacity. Our deeply veteran work force understands the unique needs of both providers and Arkansas consumers.

Improving health care quality and reducing its costs — attributes of ACOs and of Aledade — have long been a part of the Arkansas Foundation for Medical Care's (AFMC) core values and goals.

If you have questions about ACOs contact Nathan Ray, MBA Director, HIT Arkansas, at nray@afmc.org or 501-212-8616.

Screening Newborns for Critical Congenital Heart Disease (CCHD)

Bryan L. Burke, Jr., MD
Director, Term Nursery
Professor, General Pediatrics
University of Arkansas for Medical Sciences

Congenital heart disease is the most common congenital malformation, affecting about 8 out of every 1000 newborns. Some of these infants have Critical Congenital Heart Disease (CCHD). Many infants with CCHD look well while in the nursery but deteriorate rapidly at home, usually during the first week of life. A CCHD screening program can detect many, but not all, CCHDs while the baby is still in the nursery. Early diagnosis is critical.

The American Academy of Pediatrics has endorsed the use of pulse oximetry as a reliable screening tool for CCHD. The CCHDs which can be remembered by the mnemonic PTH – pulmonary atresia, the five classic cyanotic heart diseases, and hypoplastic left heart syndrome – will likely be detected by CCHD pulse oximetry screening. Other CCHDs – such as aortic stenosis, coarctation of the aorta, double-outlet right ventricle, Ebstein anomaly, and pulmonary stenosis – may be detected by CCHD pulse oximetry screening, but not as reliably so.

As you may know, to improve early detection of CCHD, Arkansas passed a law (Act 768) in April 2013 requiring that all birthing facilities perform pulse oximetry to screen newborns for CCHD before discharge from the facility. A number of resources are available to assist hospitals:

- The American Academy of Pediatrics (AAP) has established a protocol for conducting CCHD screening with pulse oximetry.
- Arkansas Children's Hospital

(ACH) is leading a work group with help from representatives of the University of Arkansas for Medical Sciences (UAMS) ANGELS telemedicine program and the Arkansas Department of Health, to provide education and resources to assist birthing facilities plan and implement their screening programs. Find sample hospital policies, an instructional video, related publications from the AAP and more at www.archildrens.org/cchd.

The University of Arkansas for Medical Sciences (UAMS) voluntarily adopted CCHD screening more than two years ago, in January 2012. Since that time, no false positives have been found. Thus, you can be reassured that birthing hospitals will not spend a lot of time making unnecessary interventions and referrals, nor will they be unnecessarily frightening a large number of parents. UAMS' positive CCHD screens have enabled us to improve the morbidity and mortality of the babies found as a result of CCHD screening.

Family practice physicians or nursery pediatricians who encounter an infant with a positive screen should evaluate the infant for other potential causes of low oxygen saturation. If the infant is asymptomatic and otherwise well, a cardiologist should be consulted and an echocardiogram should be performed. This can be done at the birthing facility, through telemedicine for remote evaluation, or after transport to another institution equipped for the procedure.



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BRENTWOOD, TN – State Volunteer Mutual Insurance Company (SVMIC) has again received an “A” (Excellent) financial strength rating from A.M. Best Company. SVMIC has maintained an “A” or better rating for more than 30 years.

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For additional information, call SVMIC at (800) 342-2239, email svmic@svmic.com, or visit our website at svmic.com.

CLINICIAN'S REFERENCE: FECAL OCCULT BLOOD TESTING (FOBT) FOR COLORECTAL CANCER SCREENING

Guidelines from the American Cancer Society, the US Preventive Services Taskforce, and others recommend high-sensitivity fecal occult blood tests (FOBT) as one option for colorectal cancer screening. This document provides state-of-the-science information about guaiac-based FOBT and fecal immunochemical tests (FIT).

- ★ Colorectal cancer screening with FOBT has been shown to decrease both incidence and mortality in randomized controlled trials.
- ★ High-sensitivity FOBT detects colorectal cancer at relatively high rates.
- ★ Modeling studies suggest that the years of life saved through a high-quality FOBT screening program are essentially the same as with a high-quality colonoscopy-based screening program.
- ★ Access to colonoscopy and other invasive tests may be limited or non-existent for many patients. In addition, some adults prefer less invasive tests.

All of these elements make FOBT a reasonable choice for patients.

Recent advances in stool blood screening include the emergence of new tests and improved understanding of the impact of quality factors on testing outcomes.

Two main types of FOBT are available – guaiac-based FOBT and FIT

Guaiac-based FOBTs have been the most common form of stool tests used in the US. Modern high-sensitivity forms of the guaiac test (such as Hemoccult Sensa) have much higher cancer and adenoma detection rates* than older tests (Hemoccult II and others).

Guaiac-based FOBT version	Sensitivity for cancer	Sensitivity for adenomas
Hemoccult Sensa (high-sensitivity)	50% – 79%	21% – 35%
Hemoccult II	13% – 50%	8% – 20%

These differences are so significant that screening guidelines now specify that only high-sensitivity forms of guaiac-based tests (like Hemoccult Sensa) should be used for colorectal cancer screening. Hemoccult II and similar older guaiac tests should no longer be used for colorectal cancer screening.

FITs also look for hidden blood in the stool, but these tests are specific for human blood and guaiac tests are not. There are many brands of FIT sold in the US, and there is no consensus that one brand is superior to another. There is evidence that patient adherence with FIT may be higher than with guaiac FOBT; this may be a result of preparation needed by patients (no dietary and medication restrictions, only 1 or 2 specimens required with some brands).

FIT and guaiac-based FOBT	Sensitivity for cancer	Sensitivity for adenomas
Immunochemical tests (FIT)	55% – 100%	15% – 44%
High-sensitivity guaiac-based FOBT (Hemoccult Sensa)	50% – 79%	21% – 35%

When done correctly FIT and high-sensitivity guaiac-based FOBT have similar performance*; both are significantly better than Hemoccult II and similar older tests.

*Sensitivities cited are based on review of studies that used colonoscopy as the reference standard to determine FOBT performance characteristics.



Health Care Payment Improvement Initiative and the Patient Centered Medical Home

Three years ago, a collaboration called the Arkansas Health Care Payment Improvement Initiative was formed with Arkansas Medicaid, the Department of Human Services and private insurance companies that represented a large enough portion of the market that initiative leaders felt there would be a big enough incentive for providers to shift to a higher quality and more cost efficient system of care. This initiative also allows Medicaid to avoid making drastic cuts to the rates it uses to reimburse doctors or to programs on which many Arkansans depend upon.

Working closely with hundreds of physicians, hospital executives, patients, families and advocates, the payers worked for nearly a year to design and build the new payment system. The result is a bold initiative tailored to the needs of Arkansas patients and providers. Arkansas is the first to use this approach statewide with both public and private payers and is part of a larger effort to improve the state's overall health care system by improving access to care, increasing the number of people who are insured and improving the quality of care patients receive. Please visit the Arkansas Health Care Payment Improvement Initiative: <http://www.paymentinitiative.org>.

The Patient Centered Medical Home's goal is to: Improve the health

of the population: enhance the patient experience and reduce or control the cost of care. Today, visits to primary care doctors often focus on acute illnesses with less attention to managing chronic conditions. PCMH will actively promote prevention services such as vaccines and will empower patients with the education they need to stay healthy. PCMH is a team based care delivery model, led by a Primary Care Provider who comprehensively manages a patient's health needs with an emphasis on health care value and supports practices in establishing meaningful change and incentivizes practices by sharing cost savings. Medicaid will partner with providers to invest in improvement through care coordination and practice transformation support. Providers will be rewarded for performance on quality and cost of care through shared savings. Practices will receive monthly care coordination payments and Medicaid contracted vendor support for practice transformation.

Practice support is designed to provide additional resources to primary care physicians to help improve the delivery of healthcare to their patients. The PCMH program provides support for care coordination and practice transformation. Care coordination support is provided in the form of per beneficiary per month payments which may be used to work with a DHS

contracted vendor. Practice transformation support is provided in the form of support from a different DHS contracted vendor.

For enrolled practices: Care Coordination: the care coordination PBPM payment from DHS to your practice is for care coordination services and can be used with the pre qualified vendor or a vendor of your choice. Enrolled practices are now eligible to receive practice transformation support from DHS through Qualis Health. For more information on the services Qualis provides, see <http://www.qhmedicalhome.org/Arkansas>

Medicaid provides support to ensure that all patients especially high risk patients receive holistic, wrap around, coordinated care across providers and settings. Medicaid provides support to enable practices to integrate approaches, tools and infrastructure needed to improve performance and realize goals of the PCMH.

Requirements to sustain practice support:

- Have at least 300 attributed beneficiaries
- Achieve practice support activities and metrics

The Arkansas AFP is supportive of the Health Care Payment Improvement Initiative and the Patient Centered Medical Home.

Provider Enrollment number to Arkansas Medicaid is: 800-457-4454 or local 501-376-2211. If you have questions about the Arkansas Payment Improvement Initiative please contact toll free 866-322-4696 or local 501-301-8311 or email: ARKPII@hp.com

Summary of Open Payment Provisions within the 2015 Proposed Medicare Physician Fee Schedule

The American Academy of Family Physicians issued a media statement recently expressing disappointment that current law requires CMS to slash Medicare physician payments by 20.9 percent unless Congress intervenes before March 31, 2015. The AAFP continues to call on Congress to repeal the flawed sustainable growth (SGR) formula and pass payment reform legislation that builds on the value of the services provided rather than the volume of those services.

Medicare predominately pays physicians and other practitioners for care management services as part of face to face visits; however, citing a commitment to support primary care, CMS will begin payment in 2015 for managing the care of Medicare patients with two or more chronic conditions outside of a face to face visit. The Medicare allowance will be approximately \$42 and the service can be billed no more frequently than once per month per qualified patient.

As part of this regulations release, CMS issued three fact sheets discussing overall payment policy proposals, outlining changes to the quality reporting programs and summarizing proposals on the Value Modifier. The AAFP will send CMS extensive regulatory comments on this proposed regulation before the comment period closes on September 2, 2014. The final 2015 Medicare Physician fee schedule is expected to be released in November.

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