The Arkansas Family Physician

The Official Publication of the Arkansas Academy of Family Physicians

Volume 28 • Number 1 • Summer 2024

ARKANSAS FAMILY PHYSICIANS SOLVING ARKANSAS' RURAL HEALTH CRISIS

RECRUITING AND RETAINING FAMILY MEDICINE PHYSICIANS FOR RURAL ARKANSAS

UAMS TAKES PRENATAL CARE ON THE ROAD TO RURAL ARKANSAS

Welcome!

MISSISSIPPI COUNTY
Hospital System

Great River Family Clinic in Blytheville:
Mable Prunty, APN
Chimere Ashley Hammett, MD
Stephen Pirtle, MD
Josh Hodges, APN

Mississippi County Primary Care Physicians in Osceola:
Peggy Darty, APN
Pratapji Thakor, MD
Kim Griggs, APN

Mississippi County Health System has joined UAMS' Partnerships in Colorectal Cancer Screening for Arkansas or PiCS-AR!

PiCS-AR! will work with their clinics in Blytheville and Osceola, using evidence-based interventions to increase colorectal cancer screening rates. Our aim is to reduce late-stage colorectal cancer, the second-leading cause of cancer in America.

PiCS AR!
Partnerships in Colorectal Cancer Screening For Arkansas

UAMS College of Medicine

Learn about PiCS-AR! at bit.ly/PiCSAR.

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

EDITION 108

The **Arkansas Family Physician** is the official publication of the Arkansas Academy of Family Physicians

Correspondence, articles or inquiries should be directed to:
ARAFP
2101 Congo Road, Suite 500
Benton, AR 72015
Phone: 501-316-4011
Email: info@arkansasafp.org

CONTENTS

VOLUME 28 NUMBER 1 • SUMMER 2024

Publishing Concepts, Inc.
Created by Publishing Concepts, Inc.
David Brown, President • dbrown@pcipublishing.com
For advertising info contact
Michelle Gilbert
mgilbert@pcipublishing.com • 1-800-561-4686, ext. 120

A MESSAGE FROM THE PRESIDENT

Leslye McGrath, M.D.
President 2023-2024

It is hard for me to believe that this is my fourth and final column as your president for the Arkansas Academy of Family Physicians. I have enjoyed the opportunity to share some of my yearly themes with you and I hope that you have been encouraged, maybe even challenged, in your careers as family physicians.

In this last column, the theme I would like for you to consider is COMMITMENT. For the purposes of this column, commitment is defined by Merriam-Webster dictionary as "something pledged." I hope that you will join me in pledging or committing to the following things:

To our patients: I encourage you to join me in committing to keep up to date on the latest medical information. Practicing in a way that is evidence based and up to date is a major way for us to show our patients we are committed to their wellbeing for the long haul. May we always make decisions that are in the best interest of our patients and may we serve those who trust us at their most vulnerable with inclusion and respect.

To the future of family medicine (students and residents): I commit to remain steadfast in promoting the specialty of family medicine to all interested students, beginning well before medical school. I hope that you will join me in developing long-term relationships with our future colleagues. After all, EVERYONE needs a family doctor…including you and me!

To our esteemed specialty: With steadfastness, join me in supporting policies that promote the betterment of family medicine and in becoming ever more involved in the activities of our academy on a state or national level. Join me in committing to be a life-long learner in family medicine. I hope you join me in making every attempt to collaborate well with other healthcare professionals, while still stepping up to be the head of your patients' healthcare teams when necessary.

To ourselves: I vow to take a little time every day to care for myself and I encourage you to commit to caring for yourselves as well. Let us all check frequently on those colleagues when we feel they may be struggling or just need an extra boost. We must care for ourselves to provide the very best care for our patients!

As always, thank you for the hard work that you do! It has been, and will remain, my honor to serve alongside you as an Arkansas Family Physician!

BEST CHILDREN'S HOSPITALS
U.S.News & WORLD REPORT
CANCER
2023–2024

Cutting-edge CANCER THERAPIES Close to Home

The nationally-ranked pediatric cancer care provided by Arkansas Children's is always improving. From diagnosis to helping cancer survivors thrive after successful treatment, Arkansas Children's supports our young patients and their caregivers every step of the way. With innovative treatments like:

- Proton therapy
- Allogeneic bone marrow transplants
- Fact Accredited Autologous stem cell transplants
- CAR T-cell therapy
- Nationwide clinical trials of new therapies for leukemia and brain tumors

Arkansas Children's team of pediatric cancer experts provides access to the high-quality cancer care they need close to home.

Learn more about cancer care at **archildrens.org/CancerBloodSpecialist**

Arkansas Children's

HOSPITALS · RESEARCH · FOUNDATION

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Fact ACCREDITED

1 Children's Way
Little Rock, AR 72202
501-273-1783

2601 Gene George Blvd.
Springdale, AR 72762
479-383-3353

Ronald K. Brimberry, M.D.
Program Director, UAMS Regional Centers RTP (Berryville/Eureka Springs).

Sarah Robertson, M.D.
Program Director, Conway Regional Medical Center RTP (Dardanelle).

Donya Watson, M.D.
Program Director, UAMS Regional Centers RTP (El Dorado).

Brad Walsh, M.D.
Program Director, UAMS Regional Centers RTP (Crossett)

Recruiting and Retaining Family Medicine Physicians for Rural Arkansas

There was a time when the UAMS campus in Little Rock was the only option for Family Medicine residency training, which did not meet the needs of all graduating students who wished to do Family Medicine and who had to leave the state to do so. Due to the efforts of influential leaders at the time, such as Governor Dale Bumpers, Arkansas HHS Director Dr. Roger Bost, and Deans of the College of Medicine, Dr. Winston Shorey and then Dr. Tom Bruce, the Area Health Education Centers (AHECs) came into being in the mid-1970s to open new

continued on page 8

"Coach said to get my physical."

A routine sports physical could be the lifeline for a teen struggling with a mental or substance use disorder. The National Center for Drug Abuse Statistics says opioid overdose deaths have jumped 500% since 1999 for ages 15 - 24.

Arkansas providers are recognizing that patients silently suffer from addiction issues and have integrated behavioral health into their practices.

Scan the QR code to hear their stories in the video "Integrated Care: The Weave of Addiction Recovery."

Learn more on integration:
Arkansas Behavioral Health Integration Network
abhinetwork.org

Patient resources in Arkansas:
bit.ly/ARSUDhelp

UA Little Rock MidSOUTH College of Business, Health, and Human Services

Arkansas Department of Human Services

UAMS College of Medicine

continued from page 6

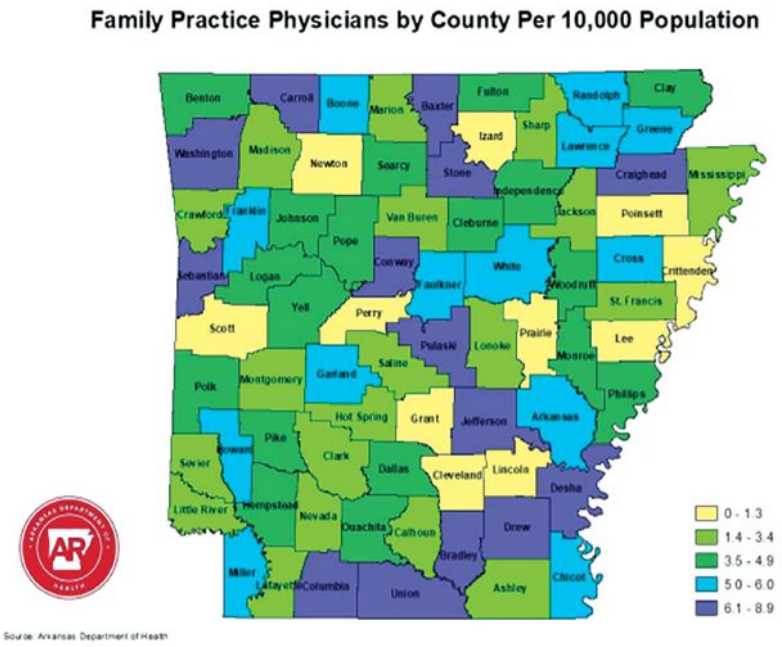
Family Medicine residency programs. Medical communities in Fort Smith, Fayetteville, Jonesboro, Pine Bluff, Texarkana, and El Dorado welcomed the development of Family Medicine residency programs with their affiliated community hospitals. (1) The mission to train more residents in Family Medicine became a reality, and the success of the AHEC programs has been remarkable in training and retaining UAMS students, followed by NYIT and ARCOM students in the state to practice in rural and underserved communities.

Despite the success of the AHEC programs, Family Medicine physicians remain in short supply throughout many areas of the state. Like most rural states, Arkansas suffers from both a shortage and maldistribution of its physician primary care workforce. Arkansas Center for Health Improvement (ACHI) has previously noted that physician primary care demand exceeded 15% statewide, with regional shortages outside of Central and Northwest Arkansas being even greater than that. (2) Non-physician primary care providers only partially mitigate this imbalance. An additional challenge is the aging population of primary care physicians in Arkansas: estimates vary but most data indicate *more than half* of active Family Medicine physicians in Arkansas are over 55 years of age. Not surprisingly, a significant percentage (35%) of active Family Medicine physicians in the state are considered part-time.

Regarding the maldistribution of physician primary care workforce in the state, predictably the pattern follows the population centers of the state. Central and Northwest Arkansas rank highest in numbers of active Family Medicine physicians; however, with rapidly growing Benton and Washington Counties the population growth is outpacing the workforce. Other suburban/micropolitan communities across the state fall near the more appropriate ratios of physicians to patients like in Pulaski County, while the rest of the more rural areas of the state fall far below. In 2020, six counties in the state had only one full-time primary care physician. (2) While each of the five Arkansas Public Health Regions contain rural counties and a range of micropolitan to urban communities, the Southeast and Southwest regions only represent 10% (5% per each region) of the currently licensed primary care physicians in the state. (3) Geographically these regions comprise approximately 40% of the state.

Rural citizens are older and sicker than their urban counterparts, travel longer and further for their care, and have higher rates of morbidity and mortality. (4) The physician workforce issues within our state exacerbate these risk factors for our rural communities and will continue to do so in the foreseeable future. Efforts to increase rurally practicing Family Medicine physicians across the state are underway and include rural-based graduate medical education through Rural Track Programs. While rural residency training is not a new concept, Rural Track Programs formalize this training and increase the number of available residency positions within the state.

Consistent with its mission, the Accreditation Council for Graduate Medical Education (ACGME) seeks to enhance the development of the physician workforce in communities facing physician shortages through a framework of support and accreditation. This GME framework resulted in the development of Rural Training Tracks (RTT's) and Rural Track Programs (RTP's) which enhance access and availability of healthcare in medically underserved areas and populations. In 2019, the ACGME Board of Directors approved a separate accreditation process for Rural Track Programs. This separate accreditation requires that residents receive



greater than 50% of their residency training in rural areas. CMS defines rural as outside a metropolitan "core-based statistical area" or CBSA. (5) At the heart of the Rural Track Program (RTP) is a partnership between an urban hospital and a rural participating site (or sites) for medical residency training. RTP's give rural hospitals the opportunity to partner with larger, urban hospitals to utilize their resources and expertise to support residency training in rural areas. The intention of this framework is to encourage physicians to practice where they train, alleviating shortages of physicians in rural areas.

The development of RTP's is a lengthy process which requires collaboration between an urban hospital, a rural site, and a sponsoring institution. Initially a Program Director (PD) is chosen along with a suitable rural site to develop the infrastructure required for a successful application with the ACGME. Once the infrastructure is in place, the sponsoring institution's Designated Institutional Officer (DIO) opens an application with the ACGME. The process consists of application for RTP designation and program accreditation, which is not finalized until a formal site visit is performed by the ACGME. Once Initial Accreditation is achieved, recruitment of the inaugural class can begin.(6) Typically, programs are developed over two to four years' time, requiring the commitment and cooperation of members of the rural medical community as well as the urban hospital and its administration.

In 1997 the Centers for Medicare and Medicaid Services (CMS), to rein in the cost of graduate medical education (GME), capped existing GME teaching hospitals nationwide at their current resident positions at that time. This cap prevented growth of existing Family Medicine residencies in Arkansas, but did allow for new accredited programs to develop in communities like Searcy, Conway, North Little Rock, Batesville, and Fort Smith in GME naïve hospitals without a cap. Recent federal legislation has opened the opportunity to develop new residency programs in rural hospitals through the Rural Residency Program Development (RRPD) grants through the Health Resources and Services Administration (HRSA). RTPs are commonly funded via these grants, an award of $750,000 over a 3-year period that provide for startup costs to establish new rural residency programs including accreditation costs,

faculty development, resident recruitment, and administrative staffing. Grants were initially awarded in 2019 and the 6th cohort of applicants are awaiting award notification and funding. Currently, HRSA program has developed up to 569 new ACGME approved residency positions in rural residencies with RRPD funding.

While the development of formal RTPs across the state is a product of the more recent regulation shifts with CMS funding, Arkansas has been home to the RTP's predecessor in years past. In the mid-1980s, Rural Training Track (RTT) residency programs started developing across the nation, often utilizing a 1-2 model in which residents would complete the first year of training in an "urban" program, and the final two years in rural sites. In the late 1990s, Northeast Arkansas briefly had an RTT with the AHEC program in Jonesboro and a rural partner in Mountain View. A handful of residents completed this program before it closed due to financial constraints, and still practice in Mountain View, AR. (7)

More recently, two separate HRSA RRPD grants were awarded in the second year of the program in 2020 to develop new rural Family Medicine residency programs in small hospitals in rural communities within Arkansas. One of these grants went to Dardanelle Regional Medical Center and the other to UAMS Regional Programs in Northwest Arkansas (formerly known as AHEC Fayetteville). Resulting from these "Cohort 2" grant funds, two new Family Medicine Rural Track Programs now exist. These programs are designed in the common 1-2 model.

Dr. Sarah Robertson serves as the Program Director and Ethan Dolan as the Program Coordinator for the Conway Regional Medical Center RTP (Dardanelle). This Central Arkansas program received accreditation from the ACGME in 2021 and obtained approval to train two residents per year. Dr. Robertson recruited her first class of two residents who began their urban year in July 2023. Her second class of two residents will begin training in July 2024. Conway Regional Health System serves as the Sponsoring Institution and provides the urban training hospital for this program. Dardanelle Regional Medical Center hosts the Family Medicine Clinic for the residents' continuity clinic experience.

Dr. Ronald Brimberry serves as the Program Director and Michelle Moe as the Program Coordinator for the UAMS Regional Centers RTP (Berryville/Eureka Springs). This Northwest Arkansas program received ACGME approval for four residents per year and recruited the first class of two residents who started July 2023. In July 2024, the second class of two residents will begin their urban training. The program will expand to recruiting four residents per year in the third-year recruitment cycle. UAMS Regional Centers is the Sponsoring Institution for this program. Washington Regional Medical Center in Fayetteville serves as the urban training hospital, and Mercy Hospital Berryville as the rural hospital training site. UAMS NW Family Medical Center in Fayetteville houses the urban clinic site. Two rural clinics, Washington Regional Eureka Springs Family Clinic, and Mercy Clinic Berryville Family Medicine provide the rural sites for the residents' continuity clinic practices.

The HRSA RRPD program also awarded a three-year $750,000 grant as part of Cohort 3 in 2021 to Arkansas Rural Health Partnership

continued on page 10

continued from page 9

for development of a program with Ashley County Medical Center, which serves as the rural training hospital for this newest RTP in Southeast Arkansas, also a 1-2 model program. Dr. Brad Walsh serves as the Program Director and Christi Price as the Program Coordinator for the UAMS Regional Centers RTP (Crossett). University Hospital in Little Rock is the urban training hospital for the Crossett program. The UAMS Family Medical Center in Little Rock provides the urban clinic training, and Family Clinic of Ashley County in Crossett hosts his residents' rural clinic. The Crossett program received ACGME accreditation, and approval for three residents per year in 2024. This program has recruited their first class of three residents to begin July 2024. UAMS Regional Centers is the Sponsoring Institution for the Crossett RTP.

The original AHEC program in El Dorado closed many years ago and the program was shifted to Magnolia. Recent changes within the El Dorado medical infrastructure have led to efforts to restore this program and to develop Arkansas' fourth RTP in the state. Dr. Donya Watson serves as the Program Director and Janie Ward as the Program Coordinator for the UAMS Regional Centers RTP (El Dorado). South Arkansas Regional Hospital, now under new ownership, is the rural affiliated teaching hospital. Dr. Watson has applied for one of the HRSA RRPD grants to be awarded in Cohort 6 to help with the further development of this new rural program. Dr. Watson is preparing her ACGME application for program accreditation, seeking a complement of four residents per year. Her program will be unique from the others in Arkansas in that there will be a strong obstetrical emphasis with six months of training in Family Medicine Advanced Obstetrics practice. UAMS has opened a new clinic to serve as the resident continuity clinic in El Dorado, and faculty have been hired to teach in the program. UAMS University Hospital and the Family Medical Center in Little Rock will be utilized for about eleven months of urban training. The remainder of RTP training will occur in El Dorado.

Because of the development of these RTP residency programs in Arkansas, the active RTP Family Medicine residency slots either already in existence or planned will provide thirty-nine new resident positions and will graduate thirteen licensed and board-certified Family Medicine physicians annually. The mission of all Arkansas RTP residencies is to recruit and train residents who may already have rural roots, who want to train in rural sites, and to retain them to practice in rural underserved communities in Arkansas.

With these great accomplishments within the state, supporting infrastructure builds for rural residency training and collaborating with health entities for development and success of residency training for future rural physicians, there remain challenges in the recruitment of students who wish to pursue this as their life's work. The pipeline of students entering the study of medicine who have a desire to practice in rural communities is not as robust as it once was.

Trends in the numbers of medical students who apply to Family Medicine residency training programs, especially those whose goals of practice after training is to provide care to these much-needed areas, are decreasing. Even those students who are interested in this future practice goal lose their interest over their medical school careers. Reasons behind this are complex and varied, and some of the most common concerns are that students do not get enough exposure to the rewarding practice of rural primary care during their medical school experiences and that the financial remuneration for such practice does not provide adequate compensation for the financial jeopardy involved in such training in the accumulation of student loans.

We are fortunate indeed in the state of Arkansas to have medical schools who are supportive of the mission to provide excellent medical care to underserved and rural areas. Some states do not have this. While on the one hand, the circumstance of having a primarily rural state such as Arkansas brings with it a certain set of challenges, we also know that 80% of students with rural roots who train in rural areas will end up practicing in rural areas. Therefore, we can draw from a largely rural pool of future physicians to subsequently provide care.

Building interest and enthusiasm around the rewarding practice of rural primary care calls upon the participation of several groups of people and has been shown to be more beneficial when those efforts can begin early. Programs such as those for high school students to gain knowledge, skills, and exposure to the intrinsic value of rural health care have been demonstrated to be highly successful in setting students on the path to accomplish these common goals we share. MASH camps, HOSA activities for high school students, as well as building collaborative engagement with undergraduate college students, are methods that can be utilized to encourage young people to enter the medical career pathway. Opportunities for clinical experiences with rural physicians through primary care preceptorships, rotations and clerkships, as well as promotion of involvement of Arkansas students in state and nationwide events exemplifying and promoting the rewards of future practice in rural areas can augment recruitment efforts as well.

While Arkansas is not alone with its challenges to recruit, train, and retain primary care physicians into rural areas, we are fortunate to be one of several states addressing this challenge head-on through the development of Rural Track Programs and student pipelines to primary care. Through early exposure to health care and active engagement and recruitment of students throughout their education, as well as offering opportunities for training in rural locations, collectively we hope to usher in the next generation of rural Family Medicine physicians.

Citations:

1. Arkansas Academy of Family Physicians, For Every Family, A Family Doctor, Taggart, Sam; "Area Health Education Centers", copyright 2023, pp 42-43.
2. ACHI. (2023). Profile of the Primary Care Physician Workforce in Arkansas. Arkansas, Center for Health Improvement. Little Rock, AR.
3. Arkansas Health Professions Manpower Statistics 2020; Arkansas Department of Health (ADH) Health Statistics Branch.
4. Garrison HG, Heck JE, Basnight LL. Optimal care for all: The critical need for clinician retention in rural North Carolina. N C Med J. 2018;79(6):386–389.
5. AAMC. *Rural Track Programs. A Guide to the updated Medicare Requirements*. Washington, DC: AAMC; 2023
6. ACGME. *Medically Underserved Areas/Populations and Graduate Medical Education Initiatives*. Chicago, IL: ACGME;2022
7. Oral history of RTT and the AHEC program in Jonesboro, AR; Dickson, Scott, 2024

The scores have been tallied and the results prove that primary care in the US is losing the healthcare game. The first Primary Care Scorecard developed by researchers at the American Academy of Family Physicians Robert Graham Center and co-funded by the Milbank Memorial Fund and The Physicians Foundation explained that the systematic lack of support was harming people's health and weakening the overall health system. Now here we are, one year later, and the news headlines and social media are full of stories about increasing wait times for patients and a decreasing work force. The second scorecard report identifies five reasons why primary is inaccessible for so many Americans.

Reason 1: The primary care workforce is not growing fast enough to meet population needs.

- The number of primary care physicians (PCPs) per capita has declined over time from a high of 68.4 PCPs per 100,000 people in 2012 to 67.2 PCPs per 100,000 people in 2021.
- While the rate of total clinicians in primary care, inclusive of nurse practitioners (NPs) and physician assistants (PAs), has grown over the past several years, it is still insufficient to meet the demands of overall population growth,[9] a rapidly aging population with higher levels of chronic disease,[10] and workforce losses during the pandemic.[11] Compared to Canada, which boasts a primary care physician-only density of 133 per 100,000 people, the US primary care total clinician (physician, NP, and PA) density was only 105 per 100,000 people in 2021.[12]

Reason 2: The number of trainees who enter and stay on the professional pathway to primary care practice is too low, and too few primary care residents have community-based training.

- In 2021, 37% of all physicians in training (residents) began training in primary care, yet only 15% of all physicians were practicing primary care three to five years after residency. More than half of residents with the potential to enter primary care subspecialized or became hospitalists instead.
- In 2020, only 15% of primary care residents spent a majority of their time training in outpatient settings where a majority of the US population receives their care.13 Fewer than 5% of primary care residents spent a majority of their training with the most underserved communities in the United States.
- The number of medical residents per person in primary care has risen at a slower pace than all other specialties, increasing by only 21% compared to 26% in other specialties.

Reason 3: The US continues to underinvest in primary care.

- The investment in primary care as a share of total health care spending has dropped from 5.4% in 2012 to 4.7% in 2021.
- Medicaid and commercial insurer investment in primary care has decreased since 2012, and Medicare investment remains low. Since 2019, primary care investment has steadily declined for all payers; this decline is most pronounced in the Medicare population.

Reason 4: Technology has become a burden to primary care.

- Data limited to family physicians demonstrate that health care technologies do not serve primary care physicians adequately; more than 40% of family physicians report unfavorable scores in electronic heath record (EHR) usability, and over 25% report overall dissatisfaction with their EHR.

Reason 5: Primary care research to identify, implement, and track novel care delivery and payment solutions is lacking.

- Since 2017, only around 0.3% of federal research funding (administered through the National Institutes of Health and the Agency for Healthcare Quality and Research, for example) per year has been invested in primary care research, limiting new information on primary care systems, payment and delivery models, and quality.
- Lack of adequate data about the primary care infrastructure hinders this Scorecard's capacity to fully track progress on the NASEM report objectives: (1) Pay for primary care teams to care for people, not doctors to deliver services; (2) Ensure that high-quality primary care is available to every individual and family in every community; (3) Train primary care teams where people live and work; (4) Design information technology that serves the patient, family, and the interprofessional care team; (5) Ensure that high-quality primary care is implemented in the United States.

The recently released 2021 NASEM report offers promising solutions to improve access to primary care in the United States. By implementing the proposed reforms, Americans will have the opportunity to receive primary care services when and where they need it, leading to longer, healthier, and more productive lives. The report outlines systemic changes that policymakers can make to support the primary care workforce and pipeline, paving the way for a brighter, healthier future for all. With the NASEM report, we have a roadmap to significantly improve access to primary care, and it is up to policymakers to take action and make it a reality.

What is the Score in Arkansas?

The report features a comprehensive state-by-state data dashboard, evaluating critical metrics such as Access, Workforce, Training, and Funding. Here is a snapshot of how Arkansas compares to the nation:

continued on page 12

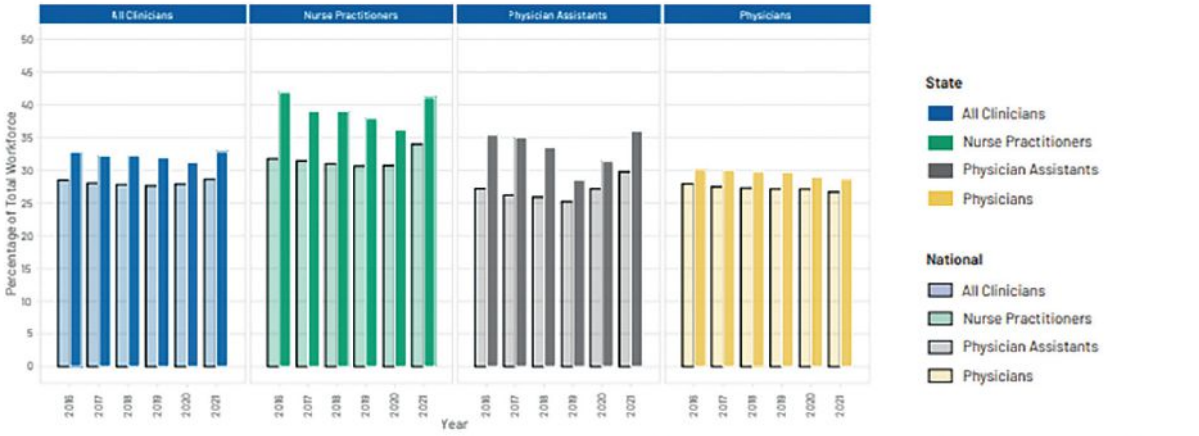
continued from page 11

Figure 1: Primary Care Physician Density in High-SDI and Low-SDI Areas in Arkansas (2016–2021)

Notes: SDI=Social Deprivation Index.

Data Source: Analyses of American Medical Association (AMA) Masterfile, 2012–2021; Center for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System (PECOS) Data, 2016–2021; National Plan and Provider Enumeration System (NPPES) Data, 2016–2021; Center for Medicare and Medicaid Services Physician and Other Practitioners Data, 2012–2021; Robert Graham Center Social Deprivation Index (SDI), 2012–2021 constructed from the American Community Survey (ACS) Five-Year Summary Files, 2012–2021; and Area Health Resource File (AHRF), 2021.

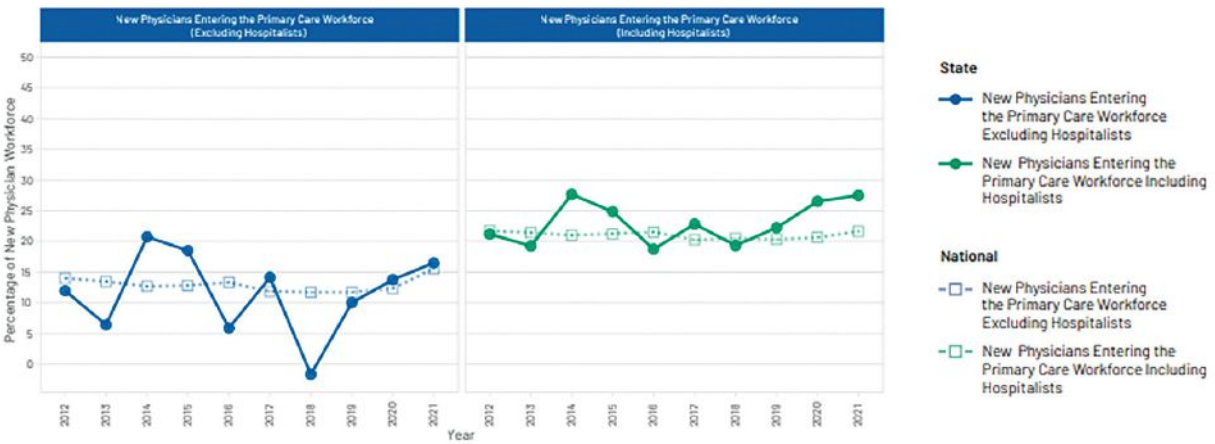
Figure 2. Percentage of Arkansas Clinicians Working in Primary Care (2016–2021)



Notes: Primary care specialties included family medicine, general practice, internal medicine, and pediatrics. All Clinicians comprises NPs, PAs, and physicians. NPs = nurse practitioners, PAs = physician assistants.

Data Source: Analyses of American Medical Association (AMA) Masterfile, 2016–2021; Centers for Medicare and Medicaid Services Medicare Provider Enrollment, Chain, and Ownership System (PECOS) Data, 2016–2021; and Centers for Medicare and Medicaid Services Physicians and Other Suppliers Data, 2016–2021.

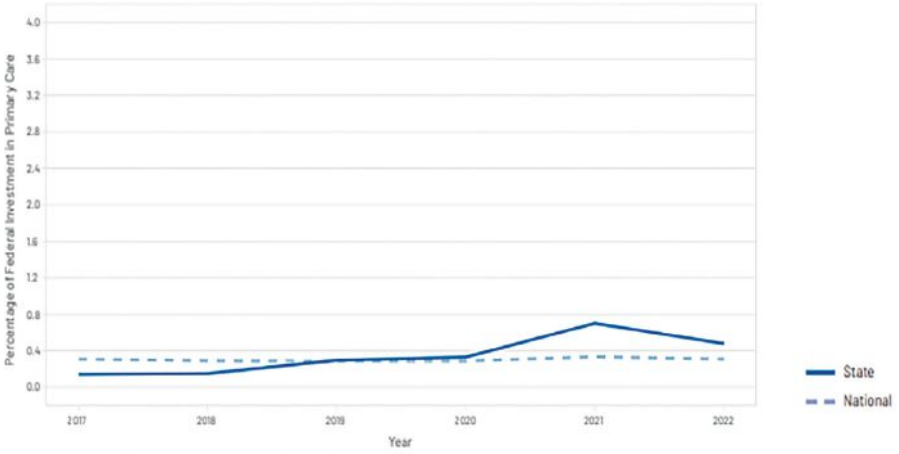
Figure 5. Percentage of New Physicians Entering the Primary Care Workforce in Arkansas (2012–2021)



Data Source: Analyses of site-level information from publicly available Accredited Council for Graduate Medical Education (ACGME) Data and Area Health Resource File (AHRF) Population Data; Medically Underserved Area (MUA) Health Resources and Services Administration (HRSA) Data Warehouse; Medically Underserved Area (MUA) Dataset, 2012–2021; United States Department of Agriculture (USDA) Rural-Urban Continuum Codes (RUCC), Centers for Medicare and Medicaid Services Medicare Physician and Other Practitioners by Provider and Service Public Use Files (PUF), 2021.

NASEM RECOMMENDATION: Ensure that high-quality primary care is implemented in the United States.

Figure 6. Federal Investment in Primary Care as a Percentage of Total Research Funding in Arkansas (2017–2022)



Data Source: National Institutes of Health (NIH) RePORTER, 2017-2022.

ACCESS

NASEM RECOMMENDATION: Ensure that high-quality primary care is available to every individual and family in every community.

TRAINING/WORKFORCE

NASEM RECOMMENDATION: Train primary care teams where people live and work.

RESEARCH

NASEM RECOMMENDATION: Ensure that high-quality primary care is implemented in the United States.

The latest report underscores the critical need for immediate policy reforms to safeguard primary care access from further deterioration. It serves as a stark reminder of the urgency to address the challenges faced by the primary care sector, highlighting the importance of swift and decisive actions to ensure equitable healthcare for all. We urge Arkansas family physicians to remember this report as we head into the next legislative session. It is imperative that your voice be heard, understood and your ideas be put into action. We have already started working on some critical legislation that will address some of these issues wein our state. We encourage you to send this report to your state representative and state senator to let them know this is not only important to you but also to give your patients the care that they need.

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR ARKANSAS

2024

SCIENTIFIC ASSEMBLY

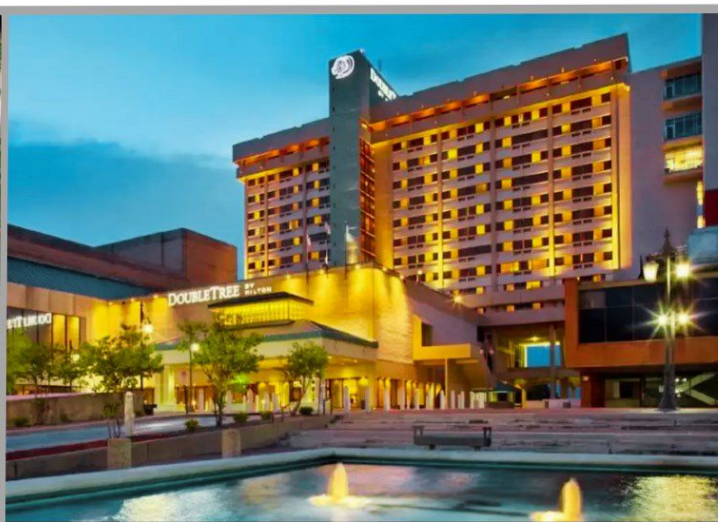
Bringing Family Medicine Together

AUGUST 21 - 24

DoubleTree Little Rock

AUGUST 23

Play It Forward Foundation
Fundraiser at Robinson Center



SCIENTIFIC ASSEMBLY

Bringing Family Medicine Together

Join us at the 2024 Scientific Assembly!

I want to take this opportunity to extend a heartfelt invitation to attend the 2024 Scientific Assembly this August. The Assembly will feature a keynote address by AAFP President, Dr. Steven Furr as well as a variety of topics pertinent to every day practice in the areas of infectious disease, cardiovascular health, geriatrics, pharmacology, urology, endocrinology and more! Exhibitors will be on hand on Wednesday and Thursday to showcase helpful programs and businesses as well as the latest medical products and innovations.

Don't worry, we aren't all business and no play! Bring your family because each evening you will have plenty of time to explore some of Little Rock's best restaurants and activities just steps from the assembly's headquarters at Doubletree by Hilton in downtown Little Rock. The Broadway musical "Hello Dolly" is showing at Robinson Auditorium August 22-24 and features the Arkansas Symphony Orchestra. If outlaw country is more your style, then head across the bridge to North Little Rock to hear Chris Stapleton in concert on August 22nd at Simmons First Bank Arena.

Speaking of concerts, the Arkansas AFP Foundation will host "Play It Forward," a concert featuring Erin Enderlin and Cliff & Susan on Friday evening, the 23rd. Prior to the show, we will hold a welcome reception and concert pre-party to honor our incoming president, Dr. Nicole Lawson. We invite you to come by and meet her, wish her well, and then join us in raising funds to support an endowed scholarship in family medicine. It will be a fun night!

I look forward to learning and celebrating alongside you in downtown Little Rock this August!

Leslye McGrath, MD, FAAFP
President, Arkansas Academy of Family Physicians

2024 SCIENTIFIC ASSEMBLY

Join us for the premier family physician event of the year! The Arkansas Academy of Family Physicians is excited to invite you to our annual conference, specifically tailored to meet the needs and interests of family physicians. This event promises to be an enriching experience with a lineup of relevant and innovative CME presentations designed to enhance your clinical practice and keep you updated on the latest developments in family medicine.

SCHEDULE OF EVENTS

WEDNESDAY

7:00 - 5:00	Registration
8:00 - 5:00	Exhibits Open
8:45 - 9:00	Welcome & Opening Remarks
9:00 - 9:45	**Managing Staphylococcus Aureus Bactermia** - Ryan Dare, MD
9:45 - 10:30	**Improving Safety for Older Adults: Preventing Falls, Managing Delirium and Hospital at Home -** Franklin John Gray, MD
10:30 - 11:00	Break and Exhibitor Time
11:00 - 11:15	**Resident Presentation: Bell's Palsy: Case Presentation** - Gregory Kwon, DO
11:15 - 12:00	**More Things We Do for No Reason in the Hospital** - Nick Gowen, MD
12:00 - 1:30	Lunch and Exhibitor Time
1:30 - 1:45	**Resident Presentation: Pulmonary Embolism** - Roy Eapen, MD
t2p® 1:45 - 2:30	**Women's Cardiovascular Health - A Primer for Family Physicians** - Rajalakshmi Cheerla, MD, FAAFP
2:30 - 3:00	Break with Exhibitors
3:00 - 5:00	**Cutting Edge: Mastering Lesion Removals through Procedural Practice** - Lauren Gibson-Oliver, MD, MBA **** WORKSHOP PROVIDED AT NO EXTRA COST TO MEMBERS!****
5:30 - 6:30	**Waterside Welcome Reception -** Join us poolside for drinks and appetizers

THURSDAY

7:00 - 5:00	Registration
7:00 - 8:00	Breakfast compliments of Arkansas Foundation for Medical Care
8:00 - 8:15	Opening Ceremony
8:15 - 9:15	**AAFP Update** - AAFP President Steven Furr, MD, FAAFP
9:15 - 10:00	**Empowering Patients to Take Control of Their Diabetes** - Chad Rodgers, MD, Tina Hedrick & Jamey Mantz
10:00 - 10:45	Exhibitor Break
10:45 - 11:00	**Resident Presentation: Improving Patient Colorectal Screening Participation Rates at Rural Clinics** - Taylor Dilday, MD
11:00 - 11:45	**Human Trafficking: Do You Know Who is in Your Exam Room?** - Melony Hilton, RN, MBA, FACMPE
11:45 - 12:00	**Annual Membership Meeting** - Leslye McGrath, MD, FAAFP, 2023-2024 ARAFP President
12:00 - 1:30	Lunch and Exhibitor Time - Lunch compliments of SVMIC
t2p® 1:30 - 2:15	**You are Getting on My Nerve: Review of Upper Extremity Weakness, Tingling or Numbness -** Elton Cleveland, MD, DVM, FAAFP
2:15 - 3:00	**EveryONE Should Have a Family Physician: The Value of Inclusion in Family Medicine** - Margo Savoy, MD, MPH, FAAFP
3:00 - 3:30	Last Exhibitor Break
3:30 - 4:15	**When All Else Fails, The Skin Will Too -** Angela Driskill, MD, ABFM, FAAFP, ABPM-UHM, WCPC
4:15 - 5:00	**Pediatric Obesity: Strategies on the Approach and Management of the Epidemic** - Adam Hurst, MD

*Schedule is subject to change.

Bringing Family Medicine Together

This conference offers a unique chance to connect with fellow family physicians from across the state. Share your experiences, exchange ideas, and build a supportive network with your peers. It's the perfect setting to recharge your passion for family medicine, surrounded by professionals who share your dedication to providing exceptional care.

SCHEDULE OF EVENTS

FRIDAY

7:00 - 5:00	Registration
7:00 - 8:00	Breakfast compliments of Arkansas Foundation for Medical Care
8:00 - 8:45	**An Introduction to Ehlers-Danlos Syndrome** - Scott Lucchese, MD
8:45 - 9:45	**Advances in the Treatment of Cardio-Renal-Metabolic Disorders** - Jay Shubrook, DO
9:45 - 10:00	Break
10:00 - 10:45	**Things Not Taught in Medical School: Financial Competency for Family Physicians** Lonnie Robinson, MD, FAAFP
10:45 - 11:30	**Cases from the Battlefield - 2024 Legal Update** - Jennifer Smith, JD, RN
11:30 - 12:15	**Everything I Should Have Learned in Medical School about Dentist Stuff, The Medical/Dental Interface** - Mark Jansen, MD
12:15 - 1:30	Officer & Director Installation | Fellowship Convocation - Lunch provided by Baptist Health & Arkansas Blue Cross & Blue Shield
1:30 - 2:15	**Demystifying Buprenorphine: Practical Application of Medications for Opioid Use Disorder** Amber Norris, MD
t2p® 2:15 - 3:00	**New Drug Update** - Dosha Cummins, PharmD
3:00 - 3:15	Break
3:15 - 4:00	**Maternal Health - An Update for Arkansas** - William Greenfield, MD, MBA, FACOG
4:00 - 5:00	**Dermatology and Skin Surgery Tips** - Scott Dinehart, MD
6:00 - 7:00	**President Reception** to honor Dr. Nicole Lawson-Rounds and Pre-Party for the "Play it Forward" Concert Event
7:00 - 9:00	**Foundation Fundraiser "Play it Forward" Concert** featuring award winning musical acts Cliff & Susan and Erin Enderlin to benefit the scholarship endowment fund

SATURDAY

7:00 - 8:00	Breakfast compliments of Arkansas Foundation for Medical Care
8:00 - 8:45	**Prostatic Artery Embolization for BPH and Other Ventures** - Adam Berry, MD
8:45 - 9:30	**Minimizing the Impact of Maternal Depression on Young Children** - Nikki Edge, PhD
9:30 - 9:45	Break
t2p® 9:45 - 10:30	**10 Things I Wish Family Doctors Knew About Infectious Diseases** - Maxine Seales-Kasanga, MD
10:30 - 11:15	**Understanding Peripheral Arterial Disease** - Kapil Yadav, MD, FACC, RPVI
11:15 - 12:00	**Resident Presentations:** **Primary Hyperaldosteronism: A Delayed Diagnosis in a Patient with Long-Standing Resistant Hypertension** - Madhu Murali, DO **QI Case Study: Improving Tobacco Use Screening and Smoking Cessation in a Primary Care Setting** Trey McClain, MD, MPH **Management of Severe Pneumocystis Pneumonia in a Non-HIV Patient: A Case Study** Eric Lembke, MD

CONFERENCE INFORMATION

The Annual Business Meeting of the Arkansas Academy of Family Physicians will be held at the DoubleTree Hotel in Little Rock on Thursday, August 22, 2024 at 11:45 in the main lecture hall. All AR AFP membership business and elections will be held at this time. This year members will be voting on the slate of officers and directors as well as one by-law amendment. Installation of officers and directors, as well as the fellowship convocation, will be held Friday, August 23 at 12:15.

2024-2025 BOARD OF DIRECTORS CANDIDATES

President
Nicole Lawson-Rounds, MD
Searcy, AR

President-Elect
Justin Voris, MD
Ft. Smith, AR

Vice-President
Amanda Deel, DO
Jonesboro, AR

Treasurer
Jason Lofton, MD
DeQueen, AR

Delegate
Lonnie Robinson, MD, FAAFP
Mountain Home, AR

Alternate Delegate
Daniel Knight, MD, FAAFP
Little Rock, AR

Directors
Marcus Poemoceah, MD (2nd term)
Jordan Weaver, MD (2nd term)
Brian Bowlin, MD
Stephen Foster, MD

Resident Co-Directors
Olivia Loiacano, DO
John Mitchell, MD

Student Co-Directors
Katherine McTigrit - UAMS
Avianne Robinson - NYIT

PROPOSED BYLAW AMENDMENT

The proposed amendment aims to transfer the responsibilities of the chair of the Scientific Program Committee from the Immediate Past President to the Vice-President. This adjustment is intended to streamline our operational structure and ensure a more efficient distribution of tasks within our leadership team.

HOTEL INFORMATION

The DoubleTree by Hilton Hotel Little Rock at 424 Markham is our host hotel for the conference and hotel rooms. We have negotiated a special room rate for our guests of $142 for single and double rooms. For reservations call 800-222-8733 and reference the AR Academy of Family Physicians room block to receive the discounted price.

A link is provided on our website at arkansasafp.org for online reservations. **Reservation Deadline is July 24, 2024.**

REGISTRATION

Online registration is open through the website at arkansas-afp.org. Click on the CMF and events tab. If you prefer to register by phone, call us at 501-316-4011. All conference meals, breaks and online syllabus are included with your registration. As a valued AR AFP member we are happy to report your CME for you!

REGISTER TODAY!

CME INFORMATION

Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

Translation to Practice® or t2p®: The following lectures are available for two additional credits each upon completion of required steps:

Wednesday at 1:45 - **Women's Cardiovascular Health**
Thursday at 1:30 - **You are Getting on My Nerve**
Friday at 2:15 - **New Drug Update**
Saturday at 9:45 - **10 Things I Wish Family Medicine Doctors Knew about Infectious Diseases**

The Future of Family Medicine is up to us...

The Arkansas Academy of Family Physicians Foundation would like to express our sincere gratitude to the individuals who have generously donated and encourage all members to support funding the endowment. We are very close to reaching our initial goal of $100,000. We hope to achieve this milestone before the end of 2024!
Consider making a tax-deductible contribution today.

Thank you to those that have contributed in 2024:

Ahmed Abuabdou, M.D.
Les Anderson, M.D.
Ron Brimberry, M.D.
Lori & Jeff Carfagno, M.D.
Chris Collier
Amanda Deel, D.O.
Elizabeth & Stephen King, M.D.
Deanne & Ted Lancaster, M.D.
Connie A. Meeks, M.D.
Steve Strode, M.D.
Samuel Taggart, M.D.
Janet Titus, M.D.
Michael Young, M.D.

REGISTER TODAY

8TH ANNUAL ACES & RESILIENCE SUMMIT

LIVING IN A HOUSE OF CARDS – DEALING WITH ACES IN OUR LIVES

ARKANSAS ACEs & RESILIENCE COALITION

afmc℠
Healthy People. Healthy Businesses. Healthy Communities.

ACEs24

Thursday
August 8th, 2024

Benton Event Center
17322 I-30, Benton, AR 72019

VISIT **AFMC.ORG/ACESUMMIT**
FOR MORE INFORMATION

Host Your Next Event in Style at the

Capitol District Event Center

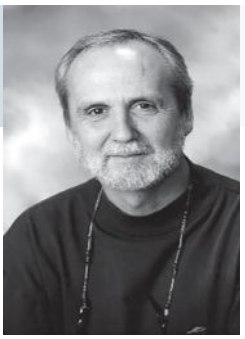
Conveniently located in downtown Little Rock, our newly renovated event space offers free parking, seating for up to 100 attendees, a state-of-the-art A/V system, virtual conferencing options, and a fully equipped catering kitchen.

Let us help you plan your next conference, meeting, or community event – contact us to reserve your spot!

Visit **afmc.org/events**
for more information.

CAPITOL DISTRICT
EVENT CENTER
afmc

Sam Taggart, M.D.
Family Physician and Author



50th anniversary of Family Medicine Residency Completion

In the Spring of 2024, we are celebrating the 50th anniversary of the first completion of a three-year family medicine residency in the state of Arkansas.

In 1974, the Family Medicine Department at the University of Arkansas Medical School graduated a class of eight young physicians. Among that group was Dr. Mike Moody of Salem, Arkansas: he would go on to be long-time stalwart of the Arkansas of Academy of Family Physicians. Mike completed his residency that spring and, along with his fellow resident, Dr. Jim Bozeman, returned to his hometown of Salem Arkansas to join Dr. Carl Arnold. Dr. Moody practiced in his hometown until his death from cancer two years ago.

Dr. Mike Moody

The Arkansas Academy of General Practice was created in 1948. The three enunciated goals of that organization were: (1) to increase the number of general practice physicians in the state, especially in the rural areas, (2) to enhance opportunities for continuing education for its members, and (3) to create an Academy Newsletter to keep the members up-to-date on local and national issues.

From the very beginning, the leadership of the new organization began lobbying for continuing education for practicing physicians and enhanced family medicine training for medical students. In the early 1950s, Dean Hayden Nicholson, who had been raised in a rural town in Minnesota, was receptive to these ideas and began proposing and implementing programs aimed at increasing the number of Generalists in the state.

In September of 1951, Dean Nicholson proposed a General Practice Residency. This was greeted with enthusiasm by the Arkansas Medical Society and the Arkansas Academy of General Practice. The program made friends for the school within the state but when it was presented to the AMA Council on Medical Education it was turned down. Not to be deterred, in 1952 he proposed an eight-week preceptorship as part of the senior year of medical school. The university sent out a call through the Arkansas Medical Society and the Arkansas Academy of General Practice for volunteers to serve as mentors. The stated purpose of these preceptorships was to allow students to be exposed to and share in all phases of general practice. During the first year of the program, sixteen physicians, scattered around the state, provided enough preceptorship slots for all of the seniors to rotate through at 8-week intervals. At the end of the first year a survey of the students judged the preceptorship was a success on many levels.

In December of 1957, Dr. John Riggin of the Dean's office at the medical school reported to the Academy Board on the plans for developing a two-year General Practice residency. The program was launched in 1959. Apparently because of lack of structure, the first year of the program was successful but the second year was not. By July of 1962, 10 of the 19 residents in the program resigned to go elsewhere. Their complaints revolved around two issues: (1.) According to the residents, the second year was "nothing but scut work." and, (2.) There were no general practitioners on the medical center staff. On paper the program continued to exist until the mid-1960s but in short order the program faded away.

In a 100-day period in 1966, life changed for the specialty of General Practitioner/ Family Physician in the United States based in part on four studies: The **Folsom Commission**, the **Millis Report**, the **Willard Report** and the the **Committee on Requirements for Certification of the American Academy of General Practice**. These reports established the need for every individual to have a personal physician and the need for comprehensive care. They called for the establishment of a specialty called family physician and began to formulate the requirements for core content of an ideal family medicine training program.

Like Dean Nicholson in the early 1950s, Dr, Winston Shorey, UAMS Dean from 1960-1974, was fully supportive of the needs of family medicine and rural health. On January 16th, 1969, Dr Harold Hedges, a young family physician from Little Rock and member of the Arkansas Academy of General Practice sat in on a series of joint meetings involving the Arkansas Medical School and the hospital administrators of Little Rock in regards to setting up a new Family Medicine Residency at UAMS.

Dr. John Tudor

In 1968, Dr. John Tudor, a Pine Bluff resident, had just completed a three-year family medicine residency in Miami. After finishing his training he returned to Arkansas looking for a practice opportunity. Dr. Jasper McPhail, a cardiovascular surgeon, was working as an assistant in Dean's Office. He enticed Dr. Tudor to sign on for the task of developing a family medicine program at UAMS. His first year was spent developing a plan for a three-year residency involving the University of Arkansas Medical Center, St. Vincent Infirmary and Baptist Hospital. Space for an outpatient clinic was rented from the St. Vincent in the School of Nursing. The residency plan included a novel approach. At that time the fourth year of medical school was a 36-week all elective schedule. With this new plan, fourth year students could begin their family medicine training but would do a 50-week year where they would function as acting-interns for the two large private hospitals. In November of 1969, Dr. Tudor received provisional approval from the AMA Council on Medical Education for the Residency Plan. (The Senior year portion of the program was in place until 1975 when the American Board of Family Practice and the Residency Review Board recommended discontinuing the fourth year option for medical students.) In the summer of 1972, the first full contingent of family residents beginning as senior students began their residency. Among those young doctors were Dr. Mike Moody and Dr. Jim Bozeman. Throughout their training, these two physicians worked as a team especially relating to their out patient load. Dr. Moody did the lion's share of his hospital work at Baptist and Dr. Bozeman did most of his inpatient work at St. Vincent.

Within two years, under the leadership of Dr. James Dennis, Vice President of the University system and Dr. Shorey, the AREA HEALTH EDUCATION CENTERS had begun.

Kellie Cornelius, MAP, CPHIMS

Early Intervention Day Treatment (EIDT) Program Changes

Early Intervention Day Treatment (EIDT) facilities offer a comprehensive range of clinic-based services for children with significant intellectual and developmental disabilities. These services include up to eight (8) hours a day of evaluation, therapy, development, and prevention. EIDT services encompass day habilitative services focusing on cognition, communication, social/emotional, motor, and adaptive self-care skills. Additionally, the facilities provide activities to reinforce skills learned in occupational, physical, or speech-language therapy, nursing services for medically fragile children, and occupational, physical, and speech-language pathology therapy services.

Eligibility for EIDT services requires more than just a developmental delay. Sections 212. 400 and 212.500 of the AR Medicaid EIDT manual provides the comprehensive developmental evaluation scoring requirements for beneficiaries yet to meet school age, and the list of qualifying diagnosis for school age beneficiaries which is defined in Ark. Code Ann. § 20-48-101(4). In addition to meeting the requirements in section 212.400 and 212.500, one of the following services must also be medically necessary for a beneficiary to be eligible to receive covered EIDT services: Physical therapy, occupational therapy, speech-language pathology, or nursing. Medical necessity for occupational therapy, physical therapy, and speech-language pathology services is established in accordance with sections 212.300 and 212.400 of the AR Medicaid EIDT manual and section II of the AR Medicaid Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services manual.

Effective April 1, the child's PCP will now administer and analyze the required developmental screen for initial EIDT eligibility determination purposes rather than an outside vendor. A PCP-administered developmental screen is not a prerequisite to demonstrate continued eligibility for children already receiving EIDT services. A list of validated screening tools can be found in the Screening Tool Finder in the American Academy of Pediatrics "Screening Technical Assistance and Resource (STAR) Center" at: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/

Procedure code 96110 is billable at a rate of $8.80 per screen by PCPs for the administration and analysis of this required initial developmental screen. PCPs will be allowed to bill procedure code 96110 as follows:

- One (1) unit before twelve (12) months of age
- Two (2) units (but no more than one per year) between the ages of thirteen (13) to forty-eight (48) months
- One (1) unit between the ages of forty-eight (48) to sixty (60) months

PCPs are encouraged to administer additional development screens to children in accordance with Bright Futures/American Academy of

Pediatrics Periodicity Schedule (or as needed to evaluate developmental concerns) regardless of whether the additional screens are billable. The Bright Futures/AAP Periodicity Schedule can be found at the following link: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Form DMS-642 EIDT Initial Evaluation Referral (ER)

If, after reviewing the results of the developmental screen and conducting other relevant medical surveillance and diagnostic activities, the PCP believes that the child should be referred to an EIDT program for evaluation, the PCP will complete and sign a DMS-642 ER, which is the new EIDT specific evaluation referral form. The PCP must have administered the developmental screen within the twelve (12) months preceding the date of the child's initial DMS-642 ER to meet the requirement.

If a beneficiary already has an active treatment prescription for occupational, physical, or speech-language pathology services through a private clinic or school at the time of their initial evaluation referral for EIDT services, then a new evaluation is not required. The PCP's active DMS-640 treatment prescription related to the private clinic or school occupational, physical, or speech-language pathology treatment services will be accepted in place of a DMS-642 ER evaluation referral for the therapy service unless the active therapy prescription(s) are set to expire.

A detailed example of when and how a DMS-642 ER is needed and should be completed can be found in section 212.200 of the EIDT Medicaid manual. The EIDT Medicaid manual can be reviewed in its entirety at the following link: https://humanservices.arkansas.gov/wp-content/uploads/EIDT_II.doc

Form DMS-642-EIDT Year-Round Treatment Prescription (YTP)

If the results of those evaluations ordered on the DMS-642 ER demonstrate the child is eligible for EIDT services, then the child's PCP may prescribe the medically necessary amount of EIDT services using a new EIDT treatment prescription form DMS-642 YTP. EIDT core services require an annual treatment prescription signed and dated by the beneficiary's primary care provider.

A prescription for core EIDT services is valid for twelve (12) months unless a shorter period is specified. The prescription must be renewed at least once a year for covered EIDT services to continue. Beneficiaries who are already enrolled in an EIDT pursuant to a valid treatment prescription (on a DMS-640) as of April 1 are not required to obtain a new treatment prescription on a form DMS-642 YTP until their existing EIDT treatment prescription expires.

continued on page 26

continued from page 25

Form DMS-642- EIDT Summer Only Treatment Prescription (STP)

EIDT services may be provided to school-age beneficiaries (i.e., beneficiaries who have met the age requirement for kindergarten) during the summer when school is not in session to prevent a beneficiary from regressing. The annual treatment prescription for EIDT services during the summer when school is not in session must be on a form DMS-642 Summer Only Treatment Prescription STP.

A school-age beneficiary attending an EIDT during the summer when school is not in session does not require a new DMS-642 ER evaluation referral if they attended an EIDT the summer immediately before the beneficiary's current school year. Treatment prescriptions relating to summer-only EIDT occupational, physical, and speech-language pathology treatment services must be in the form of DMS-642 EIDT Summer-Only Treatment Prescription.

The DMS-642 EIDT evaluation and referral forms are in section V and can be found at the following link: https://humanservices.arkansas.gov/wp-content/uploads/Section_V.doc

Evaluation referrals and prescriptions for standalone (i.e., not at EIDT) occupational, physical, or speech-language pathology services will continue to be completed using the DMS-640.

AFMC hosted webinars on March 1 and May 17 for primary care providers featuring behavioral health integration, independent assessments (IA) and referral processes, and Early Intervention Day Treatment (EIDT) referral process changes for children with the Arkansas Division of Medical Services (DMS). Links to the webinar, slide decks, and other resources can be found at https://medicaid.afmc.org/provider-relations-policy-education/webinars under the "Primary Care Providers/Specialists" heading.

Sources: AFMC Provider Relations SFY 2024 3rd Quarter Physician Medicaid Update; Arkansas Medicaid Early Intervention Day Treatment (EIDT) policy manual

Ms. Cornelius is the supervisor of the provider relations outreach specialists for AFMC. She has a master's degree in applied psychology and a health information-technology certification as a certified professional in healthcare information and management systems (CPHIMS). Kellie has worked with the Arkansas Medicaid system for 25 years, and she currently assists Arkansas health care providers with Medicaid issues and guidelines, including those pertaining to PCMH.

UAMS Takes Prenatal Care on the Road to Reach Rural Arkansas

The University of Arkansas for Medical Sciences (UAMS) Institute for Community Health Innovation is bringing quality prenatal care to maternal health deserts in Arkansas as part of an initiative to improve the health outcomes of women, babies and families across the state.

As part of its mobile prenatal care initiative, the institute is launching CenteringPregnancy®, a group prenatal care program that includes a pregnant woman's routine provider visit, along with extra time for group learning and sharing, in 15 counties in Arkansas over the next two years. The program is currently offered by UAMS in Little Rock, El Dorado and Fayetteville, with the UAMS Institute for Community Health Innovation expanding the service to Madison County last year through its mobile health initiative.

The program will be deployed to medically underserved counties considered "maternal health deserts" — areas that lack adequate resources and health care for mothers before, during and after pregnancy. Women enrolled in CenteringPregnancy® will also receive wellness benefits for participating in the educational portion of the program, such as breast pumps, portable cribs and car seats.

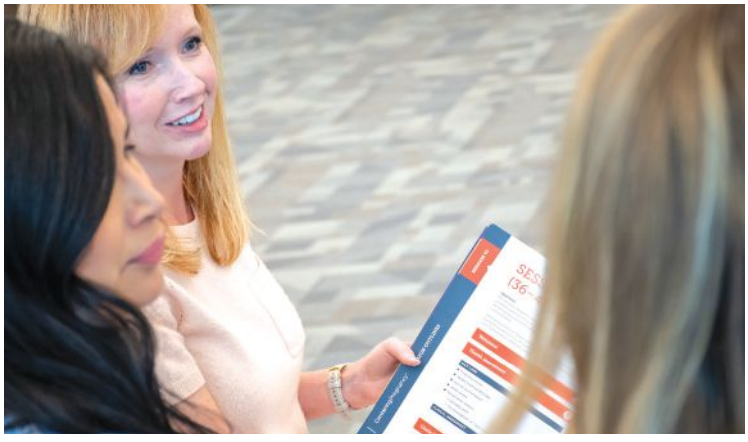
"Our mobile prenatal care programs will not only address the issue of access for women in rural counties in Arkansas, but they will also connect women to social support networks in their community," said Krista Langston, executive director of community programs at the UAMS Institute for Community Health Innovation. "By utilizing our mobile health units to expand services into these rural areas, we can provide unique solutions to the immediate need for prenatal care in Arkansas."

In addition to offering the group prenatal sessions to mothers in those counties, the institute will also provide training to rural providers to facilitate the program during and after the project's two-year period. Training will be provided to more than 50 rural providers.

"We want to prioritize community engagement and collaboration with local community partners to sustain prenatal care services for years to come," Langston said. "We will involve local partners, such as rural health care providers and community-based organizations, so that together, we can take a collaborative approach toward addressing Arkansas' systemic barriers to care."

According to a report released last year by the National Center for Health Statistics, Arkansas has the worst maternal mortality rate in the country with more than 43 deaths per 100,000 births, nearly twice the national average. A report released earlier this year by Heartland Forward found a direct correlation between the state's pregnancy-related death rate and the average number of prenatal visits a woman in Arkansas receives during her pregnancy. Those with fewer prenatal visits faced significantly higher chances of death and other medical issues.

"We want to bring care to women who may not be able to access care early in their pregnancies or who have significant challenges in getting



regular care due to barriers such as a lack of reliable transportation or an inability to take off work for a half day or more in order to travel to a provider," said Kelly Conroy, senior director at the UAMS institute. "We know that the sooner a woman can get into prenatal care, the sooner any potential health concerns or complications can be addressed, and the woman will have a healthier pregnancy and a healthier baby. That benefits everyone in the community."

The Core Content Review of Family Medicine

Why Choose Core Content Review?

- Online and Print Editions Available
- Cost Effective CME with No Travel
- Stay Medically Relevant - Make sure you are ready for the new FMCLA (Family Medicine Certification Longitudinal Assessment) Exam alternative
- 98% Board Exam Pass Rate - Pass or get your Money Back
- For Family Physicians by Family Physicians
- Core is produced by the CT Academy of Family Physicians

The Core Content Review of Family Medicine

North America's most widely recognized program for:

- Family Medicine CME
- ABFM Board Preparation

Ordering is Easy

- Visit **www.CoreContent.com**
- Call **888-343-CORE (2673)**

Follow us on Facebook:
Core Content Review of Family Medicine

The 1st Annual Transition-to-Practice Resident Retreat was held the first weekend in May in beautiful Hot Springs. We had 29 Residents registered who enjoyed presentations from malpractice to investing on Friday. Saturday was our community connections day where residents could go to Lake Hamilton, stroll Bath House Row or make a day of it at Oaklawn. Special thanks to Dr. Sam Taggart for serving as our activities director and a big thank you to EngageMed, SVMIC, Merrill Lynch and Mark Hagemeir for your sponsorship and excellent presentations. We have taken your ideas on how to make next year even better so mark your calendar for May 2-4, 2025 and we will see you in Hot Springs!

ABQAURP

American Board of Quality Assurance and Utilization Review Physicians®

Promoting Health Care Quality and Patient Safety Through Education and Certification

Use Promo Code: ARFPAPA24, and receive a 10 % discount when you register for the Advanced Physician Advisor Certification Exam by August 15, 2024

ABQAURP IS EXCITED TO ANNOUNCE THE

Advanced Physician Advisor Certification!

The **Advanced Physician Advisor Certification** was developed to validate the knowledge and skills of physician advisors fulfilling leadership roles in advising the medical team and ultimately improving patient care, quality, utilization, and patient safety. After working tirelessly with our esteemed panel of seasoned Physician Advisor subject matter experts and psychometricians, we have completed development of this new ABQAURP board certification and we are now taking applications.

The Advanced Physician Advisor Certification Domains Include:

- Medicare Compliance and Regulatory Obligations
- Utilization Review
- Care Management/Coordination
- Quality Measures and Metrics
- Clinical Documentation Integrity
- Leadership, Ethics, and Regulatory Guidance

LEARN MORE & DOWNLOAD THE HANDBOOK

SCAN HERE

*Promo Code: **ARFPAPA24** discounts an additional 10% off your exam registration fee. Offer valid through 8/15/2024 and cannot be combined with other offers.

Call (800) 998-6030 today to take advantage of this special offer!

Arkansas Academy of Family Physicians
2101 Congo Road
Building D2, Suite 500
Benton, AR 72015