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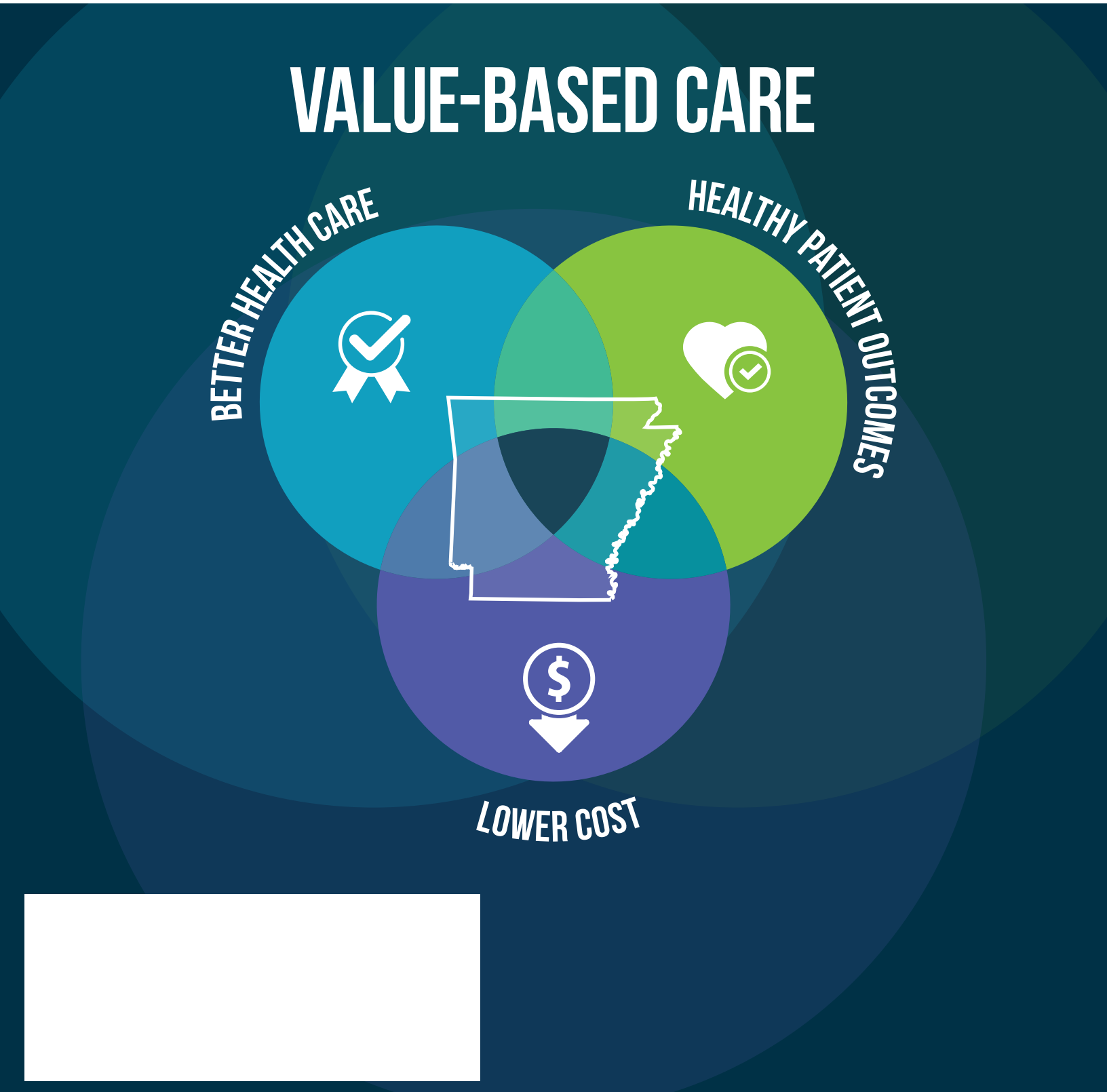


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FROM THE PRESIDENT

ONE COMMON GOAL

BY **SETH M. BARNES, MD, FACP**
AMS PRESIDENT, 2022-2023

This issue of the Journal focuses on population health and value-based care, and hopefully this information can help us learn how we can better take care of our local populations of patients. Population health in a nutshell is applying known scientific theories that have been proven to improve health and longevity. One of my attendings once claimed there are only two things that have really improved the lifespan of the human population: immunizations and enclosed sewer systems.

While this may be true, there are many other things we can do as physicians to help improve the health and well-being of our local and state population. Certainly immunizations, tobacco cessation, cancer screenings, diet and exercise counseling are important, but there are a host of other interventions that would offer great benefits to our patients.

How do we do in this endeavor? Probably not very well. Despite the recent attempts from Medicare and some payors on "pay-for-performance" initiatives, most of our health care system is still set up on a problem-based scenario for reimbursement. With financial incentive favoring point-of-care or problem-based care, the paradigm indeed would have to shift quite a way for true population health management to reach its fullest potential. This was obvious during the height of the pandemic when systems halted elective procedure, which brought about severe financial issues.

Finally, it would be hard for me to write my last article as your president without making just a few observations about the past year.

It's been a wonderful year on many levels. I've had a chance to observe the Arkansas Medical Society executive and support staff working daily on legislative issues, pandemic issues, membership expansion, meeting organization, and a host of other matters that allow us to truly make patient care in the state safer and more effective. There's so much work that goes on behind the scenes to protect our sacred relationship with our patients, and this organization should never be taken for granted.

I've had the chance to observe how hard the physicians of Arkansas work with tireless commitment in taking care of patients, sometimes under challenging circumstances with limited resources. Fortitude comes to mind here. I've had the chance to attend local medical society meetings and observe how effective this can be in working on local political matters. I've also had the chance to attend national meetings and see the work being done to improve patient care across the country, which is very reassuring to see how physicians are truly committed to excellent patient care despite obstacles.

It's been very gratifying to observe how the Arkansas Medical Society brings us all together with one common goal, to take great care of our patients and protect them from harm.

IT'S BEEN VERY GRATIFYING TO OBSERVE HOW THE ARKANSAS MEDICAL SOCIETY BRINGS US ALL TOGETHER WITH ONE COMMON GOAL, TO TAKE GREAT CARE OF OUR PATIENTS AND PROTECT THEM FROM HARM.

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FEATURE STORY

VALUE-BASED CARE: IMPROVING PATIENT OUTCOMES BRINGS SHARED SAVINGS

BY **CASEY L. PENN**

Over the past decade, a new health care delivery model has emerged that brings together the idea of providing better health care at a lower cost and rewarding physicians for promoting healthy patient outcomes. But what was once thought of as an "utopian vision,"[1] value-based care is now becoming a reality for many physicians and clinics in Arkansas.

The New England Journal of Medicine defines value-based care as a health care delivery model in which providers (hospitals and physicians) are paid based on patient health outcomes. Value-based care agreements reward providers for helping patients "improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way." [2]

The Centers for Medicare & Medicaid Services has been a big driver in transitioning away from fee-for-service to value-based care. To facilitate this change, the Medicare Shared Savings Program brought together groups of doctors, hospitals, and other health care providers as Accountable Care Organizations (ACOs) to take responsibility for improving quality of care, care coordination, and health outcomes for groups of beneficiaries.[3]

To participate in the Shared Savings Program, Medicare-enrolled providers and suppliers must form or join an ACO that then must be accepted into the program.

This care model transition can be labor-intensive, but accountable care organizations help facilitate the process so that physicians can focus more on preventative medicine for their patients without negative financial outcomes.

VALUE-BASED CARE

BETTER HEALTH CARE

LOWER COST

HEALTHY PATIENT OUTCOMES

SHIFTING TO A MORE PROACTIVE TYPE OF CARE HAS ALLOWED FOR MORE IN-DEPTH EVALUATION OF CHRONIC CONDITIONS SUCH AS HYPERTENSION AND DIABETES. OUR DATA BEARS THIS TO BE TRUE.

BY SEEING 10 LESS A DAY, THEY'RE SPENDING MORE TIME WITH EACH INDIVIDUAL PATIENT. THAT ALONE DRIVES QUALITY.

GIVING FEWER PATIENTS MORE ATTENTION

Located in El Dorado, SAMA Healthcare is a family practice clinic that has been known for its pro-active, team-based approach to care for many years. Its care model has evolved over time and has relied in part on funds from programs like Comprehensive Primary Care (CPC) and CPC+. Now they are a fully functioning, value-based care clinic with shared savings from CMS and other payors.

Both Susan Taylor, RN, SAMA population health manager, and Pete M. Atkinson MHA, SAMA chief executive officer, say transitioning to value-based care has benefited the clinic, its patients, and its physicians and other providers.

"It's been a culture change," said Atkinson. "Prior to this work, my providers were seeing roughly 30 patients a day. Ten years later, they're seeing about 20. By seeing 10 less a day, they're spending more time with each individual patient. That alone drives quality.

"Also, some of the work the physicians had to do has been taken away from them as the clinic has been able to add staff," he explained, noting that team-based care involves care managers and other vital staff additions. At SAMA, the provider staff alone includes seven physicians, six advanced practice registered nurses, and one physician assistant. Support staff additions have included five care managers, four care coordinators, a nurse to manage walk ins, and a population health manager. "These support staff are in addition to the three nurses on each team that pull patients and manage phones. So, while clinic providers are still putting in the same amount of work time, they're more satisfied in their work," said Atkinson.

SAMA partner Matthew Callaway, MD, confirmed that value-based care has led to a broader and more satisfying approach to treating patients from a physician perspective as well. "It has allowed us to step back and take a breath … address problems other than the chief complaint in an office visit," he explained. "Shifting to a more proactive type of care has allowed for more in-depth evaluation of chronic conditions such as hypertension and diabetes. Our data bears this to be true."

Taylor agrees that improved outcomes are becoming more obvious over time. "Sometimes, it's hard to grab that statistic, but we know we're preventing [illness]," she said. "One of our main goals have been reducing and controlling blood pressure of hypertensive patients. When the project started in 2017, 49% of such patients had a BP below 140/90 compared to 78% at the end of 2022. We can't say how many heart attacks or strokes we prevented but knowing the data and knowing how hypertension contributes to those things, we know we've prevented them."

Atkinson described another example of using data to measure positive outcomes. "Diabetic foot exams were a quality measure from 2012 to 2018, and we went from 7% of patients receiving exams in 2012 to 80% in 2018. You can't analyze the data as to how many amputations or how many wound care visits we prevented, but those numbers speak for themselves."

Illustrating the clinic's approach to preventative care, Taylor explained their regular outreach to high-risk patients. "The patient may go in for a knee replacement, but our care manager may also know that the patient doesn't have any help at home or that healing may be slow because of their diabetes. When a patient gets out of the hospital, we call them within two days to make sure they understand medication changes, have the appropriate equipment, and follow up with any home health visits," she said. With their value-based care protocols, the physicians will normally see the patients 7-14 days later, but SAMA's care managers can immediately get in-depth with patients, which can help improve their health and in turn improve their quality of life.

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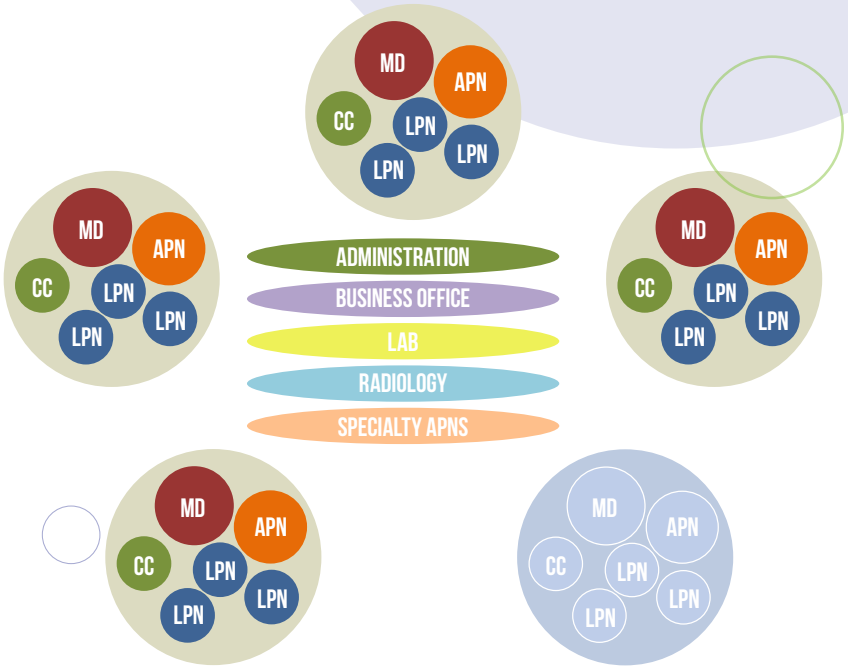
PATIENT-LEVEL DATA IS KEY

For SAMA, much of what makes this preventative care possible is the patient-level data made available to the clinic through its partner ACO, Aledade, a public benefit company representing more than 1,500 practices nationwide.[4]

Atkinson explained how they've been successful with Medicaid patients by working with Aledade. "The biggest difference between CPC and an ACO is that detailed data. With CPC, they'd tell me our clinic has a half-million spend with this cardiologist, but they wouldn't tell what patients. As a member of an ACO, I now get patient-level data that now tells me the 60 patients that were going to one cardiologist."

Patient-level data also tells the clinic when patients have been in the ER and so much more, Taylor noted. "If the Medicare patient is attributed to us, we see every specialist and every diagnosis, which gives us the whole picture of that patient's health care spend. There's a lot we've discovered, too. In a perfect world, we would know everything a specialist has told one of our patients, but that's not the way it happens. If the specialist makes a change to their medication, patients assume that we know and don't think to tell us. Now we can see that information through our ACO-provided data," she said.



THE BUSINESS SIDE OF SHARED SAVINGS

A 33% reduction in daily patient load may not seem like good business at first, but SAMA is sustaining itself financially through "shared savings" even without CPC funding. To benefit from shared savings payments as SAMA does, a provider must work through an ACO to determine how many Medicare patients they have and the cost of health care per patient.

AMS member Shawn Purifoy, MD, explained how he became involved with the business side of value-based care with his practice, Malvern Family Medical Clinic, which joined Aledade in 2014. By 2017, he believed so much in what the ACO was helping to accomplish that he went to work for them and now teaches clinicians in independent primary care clinics, community health centers, and hospital systems about how to transition to value-based care from the traditional fee-for-service model.

Explaining the basic Medicaid reimbursement, Dr. Purifoy says first CMS sets benchmarks based on patient claims over recent years, and if a physician can meet it, savings can be earned. "For example, CMS sets the average at $10,000 per patient. For some patients, it might cost a dollar, but for others, it might cost $100,000, depending on the diagnosis and treatment of the patient. CMS then agrees to split the cost savings with the ACO physician if the patient can be taken care of for less than the benchmark amount. Additionally, if a physician agrees to be responsible for any increasing cost based on risk, the physician will receive 75% of any savings, not just half.

Shawn Purifoy, MD

> THIS WAY OF PRACTICING MEDICINE EMPOWERS PCPS AND GIVES THEM OPPORTUNITY TO SHARE IN THE SAVINGS THEY CREATE THROUGH HARD WORK AND DEVOTION TO THEIR PATIENTS.

PATIENCE AND PERSPECTIVE

While the health benefits to patients are tangible, the financial benefits can take some time to accumulate. AMS member John Pounders, MD, draws on his experiences with value-based care at Autumn Road Family Practice in Little Rock. He also serves as an Aledade regional medical director, advising physicians across the state who are practicing within a value-based care model.

At first, the idea of being "responsible" for the medical spend of patients was too much for the clinic. "We said NO, for a full year," recalled Dr. Pounders, "but after multiple talks with Aledade and the assurance that the risk was minimal and fees only on the back end, our clinic partners decided to dip their toes in."

The clinic's initial contract was low risk, low benefit, and it took about three years to get the first shared savings check. "The clinics I'm seeing since [in my work for Aledade] are not waiting for three years for that first check. There's a lot more buy-in and help now than when we began," noted Dr. Pounders.

That potential success over time is what Dr. Pounders would like physicians to remember as they consider a value-based care model in their own practices. That and the fact that they can't escape the future. "When you look at the future of medical care – and not just in primary care – value-based care is coming," said Pounders.

Dr. Purifoy agrees that it's a shift in thinking and doesn't have to come with unsurmountable risk. He says that a physician in value-based care is taking control of costs by making sure patients get excellent service. "You are available and work hard to keep them out of the ER and the hospital, and at the end of the year you can make a significant return that becomes part of your annual budget," he said.

John Pounders, MD

"This way of practicing medicine empowers PCPs and gives them opportunity to share in the savings they create through hard work and devotion to their patients," believes Dr. Purifoy. "It can help support payroll for staff and good outcomes for patients, but also a renewed satisfaction in a physician's work as an advocate for their patients, which is why we went into medicine in the first place."

The Journal does not endorse or affiliate with any ACO but shares this information as a service to readers. We wish to thank the members and other sources who contributed to this article.

Is your clinic or practice already involved in value-based care or are you interested in learning more about this topic from the individuals from this article? Email lhaywood@arkmed.org to share your experience and perspective.

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SPOTLIGHT ON

POPULATION HEALTH INSTITUTE AT THE NYITCOM AT ARKANSAS STATE

AFFECTING HEALTH BEYOND THE MEDICAL SETTING

BY **CASEY L. PENN**

Led by Founding Executive Director Brook Laurent, DO, and her staff, The Delta Population Health Institute exists to reduce health disparities in Arkansas's Delta communities.

Brook Laurent, DO

Started in 2019, DPHI is the community-engagement arm of the New York Institute of Technology College of Medicine at Arkansas State University and works to improve health through education, research, policy engagement, and community engagement. Effecting health outcomes through these four pillars often involves work that happens beyond the traditional patient-doctor-bedside setting.

"Most of what drives health outcomes happens outside the clinical setting," explained Dr. Laurent, who has spent her career working in academic medicine and family practice medicine. She was appointed chair for the Department of Clinical Medicine at NYITCOM A-State in 2016, and has since expanded the development of the clinical medicine department by creating partnership linkages between academia and population health, including the development of DPHI four years ago. In addition to her academic and DPHI director roles, she also sees patients at the NYITCOM Medical Clinic on campus.

Dr. Laurent's understanding of population health is what fuels her passion to create better health outcomes, particularly in the Delta. "Substantial data supports that what really drives outcomes are what's known as the **social determinants of health**, or the conditions where we live, work, play, or worship," she explained. "However you define population – by race/ethnicity, gender, age groups, geography, zip code, etc., when you look at groups of people based on these categories, there's a lot of data pointing out disparities. Across the board, we see groups that are less healthy or healthier than other groups. **Population health** is studying that distribution of health outcomes. Not only that, but it's the study of the health determinants, policies and interventions that impact those determinants.

> MOST OF WHAT DRIVES HEALTH OUTCOMES HAPPENS OUTSIDE THE CLINICAL SETTING.

"So, when we look at, say, rural Arkansans, we see significant disparities [when compared to urban populations] when it comes to cardiovascular disease, preventive services, access to care, infrastructure, housing, and food security – to name a few."

With the understanding that outcomes are driven largely by the conditions where we live, work, etc., NYITCOM/DPHI work together to teach medical students the discipline of population health and give them leadership training. "When they are getting the medical histories of their patients, they must include and screen for things like food security, housing, transportation, socioeconomic status, literacy (including digital)," said Dr. Laurent. "And as a physician in a community, they can create partnerships that help the community think in integrated ways … to not only address disease when it happens but to also consider, 'What can we do before an illness happens to create opportunities of health?'"

Barriers related to areas of community life must be addressed before an ultimate culture of health can be achieved, according to Dr. Laurent. For that reason, in its **education efforts**, DPHI offers a Population Health Certificate Program to all NYITCOM students.

"Each student graduates with a certificate in population health, with successful completion of the program. That means a lot to us, especially with a workforce shortage of doctors in the Delta," added Tiffny Calloway, who works with Dr. Laurent and is the DPHI director of operations. "Our doctors are trained in communities throughout the Delta. Typically, when you look at a medical school, there's a big, anchor hospital attached to it where students are trained. Our students are in Mena. They're down in Helena. We have students in the boot heel of Missouri. They're getting integrated in these communities. We hope, when they go to residency, they'll remember the impact they made and come back and work toward those shortages in the Delta."

In **community engagement**, DPHI works with a variety of stakeholders to envision what a healthy community looks like and to implement new policies and environment changes to achieve

better community health. “Initiatives involve community capacity building with “non-traditional health partners” such as economic and community developers, educators, or elected officials, to name a few. “No one entity can do what we’re trying to do alone, so community engagement is essential,” said Calloway. “We [all] saw, during the pandemic, how when we worked together – as opposed to everyone trying to do the same thing but working in little silos – we really made a difference.”

Through DPHI’s Congressional Health Policy Fellowship Program, NYITCOM’s students collaborate with Congressman Rick Crawford (District 1) to serve as health-policy liaisons. This gives them opportunities to analyze policies that can affect health disparities and health outcomes. “As students look at qualitative and quantitative data, they work with the local office and in Washington, D.C. with a team to address key priorities in the Delta, specifically in the first district,” explained Dr. Laurent, mentioning food security as just one of those key priorities. “Students can then make recommendations about which policies within the first district will advance or deter health.”

Finally, around **research**, DPHI is committed to using principles of community-based, participatory research to ensure that any information being gathered is primarily for the use of the community.

Through all of her work in support of population health, Dr. Laurent and her DPHI staff share one predominant and continuous goal: is to change the way providers and community stakeholders look at health care outcomes to ultimately improve outcomes by changing the health care responsibility mindset: “We’re trying to relay to folks that it’s not just the hospital’s or physician’s or health care professional’s role, to deliver health to a community; it’s everyone’s responsibility.”

Learn more at https://delta-phi.org.

THE PATIENT RIGHT TO KNOW ACT

BY **DAVID WROTEN**
AMS EXECUTIVE VICE PRESIDENT

During the 2017 Arkansas General Assembly, AMS asked State Representative Deborah Ferguson to sponsor legislation known as the **Patient Right to Know Act**. The bill passed the Arkansas House of Representatives by a vote of 74-13 and by a vote of 33-0 in the Senate. It was signed by Governor Asa Hutchinson and became Act 754 of 2017.

Why am I bringing up a law passed six years ago? Well to be honest, I'm not sure how many AMS members are aware of this statute and its importance to you and your patients. Also, we are amending the law in the current legislative session, which is bringing some new attention to the Act.

So what does this statute do? Let me start by simply re-printing the stated purpose found in the Act:

The purpose of this subchapter is to remove and prevent impediments to patients maintaining continuity of care and keeping their treatment relationship with their chosen healthcare provider.

AMS sponsored this legislation to address an all too frequent occurrence when a physician changes practice locations. Let's say you've notified your former practice location/employer, usually a hospital but could be a clinic, of your new address and contact information. But, when patients call to ask where they can find you, they are told, "we have no idea." A few stories were more egregious such as, "we think he moved to California," or "we think she lost her license."

The point is that (a) patients have a right to continuity of care and the physician of their choice; and (b) physicians have an ethical and legal obligation to avoid abandoning patients in the middle of treatment. It is called the patient-physician relationship for a reason.

The Act addresses this in two ways. First, by prohibiting former locations (i.e., an employer) from misleading patients or failing to provide new practice location information to patients, if requested by a patient, and only if the physician has provided the new information to the entity. Secondly, the Act requires the former location, if requested by the physician, to provide a list of the physician's existing patients names and addresses, or alternatively, the former location can choose to send a notice of the new practice information to those patients. Generally speaking, "existing patients" are defined as those patients seen by the physician within the previous twelve-month period.

AMS STRONGLY SUPPORTS THE PATIENT-PHYSICIAN RELATIONSHIP, AND YOU CAN RARELY GO WRONG WHEN YOU PUT PATIENTS' NEEDS FIRST.

In this legislative session, AMS is seeking to amend the Act in two primary ways, each to address legal issues that have come up since passage in 2017.

We are adding language to clearly define "how" a physician provides notification to the former employer of their new location and when the physician wishes to request the list of patients. The amendment states that this notice must be sent by certified mail to the chief executive or administrative officer. This avoids disputes over when and whether a phone call, text message, or other informal notice was received.

The other significant amendment is adding a cap on potential damages that can be awarded if the physician (or patient) is forced to file suit against a former employer who fails to comply with the provisions of the Act. Currently, there is a $1,000 per day damage award with no cap. There is at least one pending case where an aggressive trial attorney was able to file a class action suit on behalf of a large number of patients, creating a potential liability of several hundred million dollars. That was never the intent of the legislation. The amendment places a $500,000 cap on any civil action.

AMS worked closely with the Arkansas Hospital Association in 2017 to develop language that everyone thought was reasonable. The amendment under consideration in this legislative session went through the same process and the language was agreed to.

AMS strongly supports the patient-physician relationship, and you can rarely go wrong when you put patients' needs first.

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BOOSTING ACCESS TO NALOXONE WILL SAVE LIVES

BY **SCOTT FERGUSON, MD**
AMA BOARD OF TRUSTEES

Naloxone saves lives. Naloxone has saved the lives of more than 1,700 individuals in Arkansas, and I encourage all of my colleagues to prescribe naloxone to their patients at risk of an opioid-related overdose. I also encourage friends and family members of individuals at risk of an opioid-related overdose to get naloxone.

This safe and effective medication has been saving lives for decades. It will no doubt save the lives of even more people in our state when naloxone becomes available on an over-the-counter basis to anyone who wants it. The FDA is considering multiple applications from naloxone manufacturers to make it available OTC.

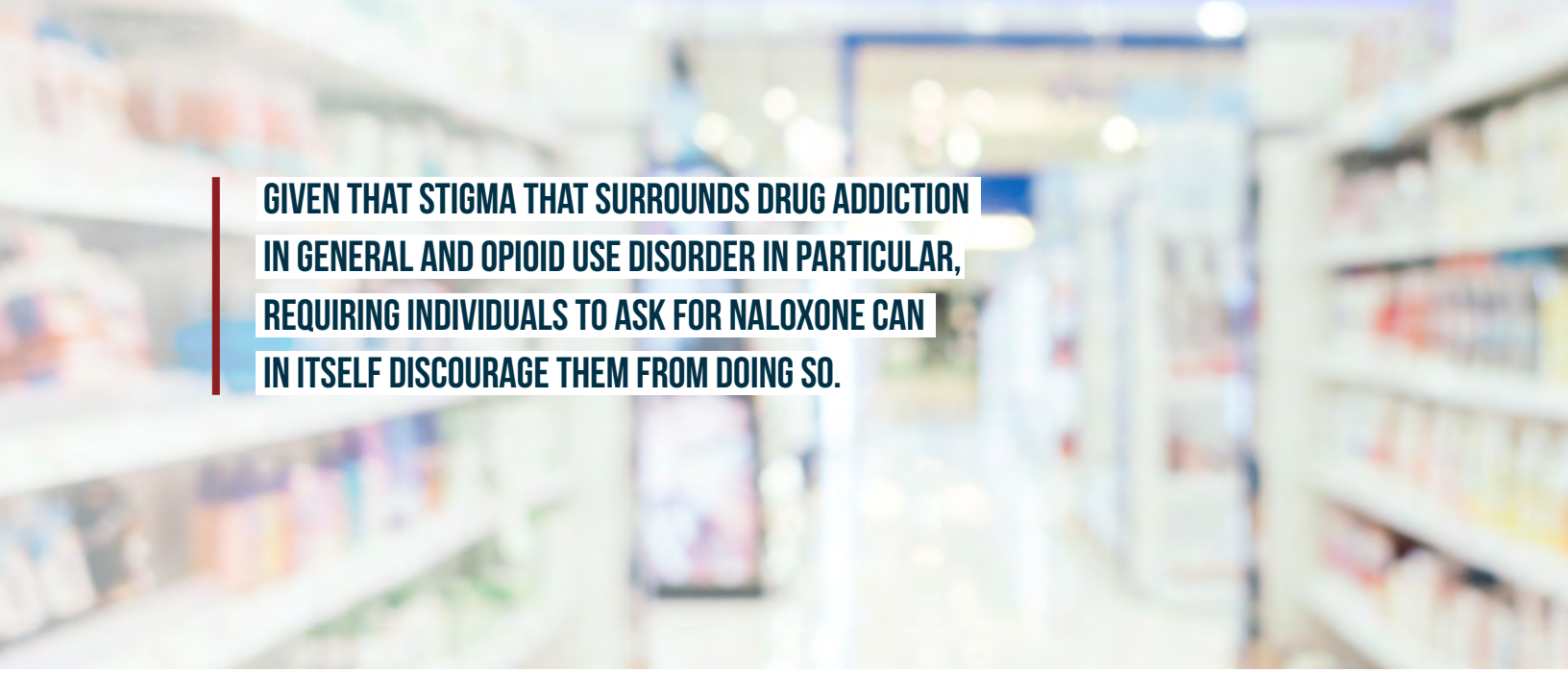
The severity of the drug overdose problem cannot be overstated. Overdose deaths have risen fivefold over the past two decades, according to data compiled by the Centers for Disease Control and Prevention (CDC), to the point where overdoses claimed the lives of 107,622 people nationwide in 2021 – nearly 300 people every day. That number is higher than it has ever been. In Arkansas alone, 546 people died from a drug overdose in 2020, as tracked by the CDC.

More than two-thirds of overdoses today are due to illicitly manufactured fentanyl, according to the DEA (https://www.dea.gov/fentanylawareness)

This is where naloxone comes into play. In the half-century since it first became available, naloxone has been incredibly effective in saving the lives of those who experience an opioid-related overdose. Available as a nasal spray or an injection, naloxone is an opioid receptor antagonist that binds to opioid receptors in the brain and blocks or reverses the effects of opioids. It can quickly restore breathing, according to the National Institutes of Drug Abuse: https://nida.nih.gov/publications/drugfacts/naloxone.

Naloxone only works on an individual who is experiencing an opioid-related overdose. It can and should be administered to anyone who displays the signs of an opioid overdose – or even if an overdose is suspected, according to the National Institute on Drug Abuse. And of course, call 911 immediately. The Arkansas "Good Samaritan" law is designed to provide immunity from arrest or prosecution for a person who experiences or witnesses an opioid-related overdose and seeks medical help.

Providing greater access to naloxone is critically important. In Arkansas, as in nearly every other state, naloxone is available without a patient-specific prescription. While I encourage my colleagues to prescribe naloxone to all patients at risk of overdose, I also urge us all to remind our patients, families, and friends that they can get naloxone directly from the pharmacy through the Arkansas Standing Order rules. However, not every pharmacy stocks naloxone, and even those that do carry it are required to keep it behind the pharmacy counter. Given that stigma that surrounds drug addiction in general and opioid use disorder in particular, requiring individuals to ask for naloxone can in itself discourage them from doing so.



GIVEN THAT STIGMA THAT SURROUNDS DRUG ADDICTION IN GENERAL AND OPIOID USE DISORDER IN PARTICULAR, REQUIRING INDIVIDUALS TO ASK FOR NALOXONE CAN IN ITSELF DISCOURAGE THEM FROM DOING SO.

However, an advisory panel to the U.S. Food and Drug Administration (FDA) voted unanimously earlier this year to recommend the agency make the nasal spray form of naloxone available over the counter. A final FDA decision is due this spring.* Last year, the FDA took down regulatory obstacles that had previously prevented harm reduction organizations, such as Central Arkansas Harm Reduction Project, from purchasing naloxone directly from its manufacturers.

The effort to turn the tide of fatal opioid overdoses will not end with taking naloxone out from behind the pharmacy counter and onto a drug store's retail shelves. My organization, the American Medical Association, continues to advocate that Arkansas and other states use funds they have obtained through the national opioid litigation settlement to purchase naloxone and place it into the hands of emergency medical technicians, police officers and other first responders. The AMA urges schools, health clinics, community centers, restaurants, and others to have naloxone in their first aid kits. We urge employers to hold overdose awareness events. The more naloxone we have in our communities—particularly in public places and in the hands of harm reduction organizations—the more lives we will save.

At the same time, health insurance plans must continue to cover naloxone at little or no cost to their insured. This life-saving drug should be immediately added to the list of preventive health medications payers already cover. Manufacturers can advance this cause by pricing naloxone responsibly, and by working with payers and pharmacy benefit managers to guarantee that over-the-counter naloxone is affordable to everyone, regardless of their insurance status.

Ending the overdose epidemic will take time, increased access to treatment, and a commitment to help all those with a substance use disorder. As we work on those issues, we must do everything possible to keep people alive. Naloxone saves lives—and we must do everything to make it available, affordable, and widely used.

**Editor's Note: On March 29, 2023, the Food and Drug Administration approved Narcan, 4 milligram (mg) naloxone hydrochloride nasal spray, for over-the-counter (OTC), non-prescription use – the first naloxone product approved for use without a prescription.*

FOR YOUR PRACTICE

BUILDING A GENERATIONAL BRIDGE IN MEDICAL PRACTICES

BY **TEREASA HOMES, CMPE**
AMS DIRECTOR OF PRACTICE AND HEALTH POLICY

If you've been through downtown Little Rock recently, then you've seen the impressive construction that is happening at the I-30 River Bridge. The Arkansas Department of Transportation's largest project to enhance one of the most traveled roads in the state includes lots of large equipment, changes in traffic patterns, and congestion, but how can we relate this into caring for different generations in medical practices?

When building a bridge, one of the first steps is to investigate the landscape of where the bridge will go. Because a person's individual age is one of the most common predictors of attitudes and behaviors, it's very important that we look at the differences in generations, especially within a practice's patient load.

HERE'S A BRIEF OVERVIEW OF THE FIVE GENERATIONS YOU MOST LIKELY HAVE IN YOUR PRACTICE AND HOW THEY WANT TO CONNECT WITH CLINICS AND PHYSICIANS:

1. ### THE SILENT GENERATION OR TRADITIONALIST (BORN PRIOR TO 1942)
There is an intrinsic trust that a Traditionalist has with his or her physician. Despite only being 2% of the total population, their clinical visits are more frequent, not only because of their age, but they want to receive health information directly from their doctor. They strongly believe in good service, having grown up during a time when "the customer is always right."

2. ### BABY BOOMERS (BORN BETWEEN 1943 AND 1964)
This generation will ask their physicians health-related questions directly but will also research information online because they have adopted technology into their everyday lives. Boomers typically adhere to a physician's instructions given at an in-office visit, but appreciate the information to be also written and available online. This population makes up about 25% of all doctor visits, which will continue to grow as they age.

3. ### GEN X (BORN BETWEEN 1964 AND 1979)
Known as the Latch Key generation, this group is not only managing their own health, but they're also caregivers for both their aging parents and their children. While they're generally healthy, Gen Xers make health care decisions like they're shopping for the best value that has the most convenient options.

4. ### MILLENNIALS (BORN BETWEEN 1980 AND 1994)
Probably the most connected generation, they will have a positive personal relationship with their physician while valuing health information from multiple sources. They will consider the cost of health care when making decisions and place a high value on patient testimonials. Millennials are now the largest generation, but they use traditional health care the least because they're too busy to visit the doctor.

5. ### GEN Y (BORN BETWEEN 1995-2012)
For the adults of this group, they have grown up with the internet and social media, and they want digital options in health care including telemedicine and online payments. While less than half have a primary care physician, Gen Y care a lot about mental health and holistic wellness but will still consult their parents when making health care decisions.

Now that you've inspected the patient generational landscape, it's time to work on the infrastructure of the generational "bridge." A Medscape Education survey revealed that the generational group of the patient had a big impact on patient engagement, which included the use of electronic health record systems. While EHRs are common today, it's important to remember that patients' generation can determine how they feel about and how they use technology. Medical practices should adopt the flexibility and convenience that younger generations want while continuing to serve the older generations who value personal connections.

Finally, the last step in building your "bridge" is to perform the final quality and safety inspections. The last thing anyone wants is for the bridge to collapse, so the system must be tested for any flaws. Clinic staff often have more opportunities to communicate with all patients, and those interactions can make or break a medical practice, especially with the younger generations. Providing staff training opportunities to improve their patient communication skills can help build loyalty and improve health outcomes among patients.

The next time you cross the Arkansas River bridge in downtown Little Rock, take a minute to think about the different generations within your patient population and how your practice can best serve each of their needs. By creating generational engagement strategies, you'll build a bridge that your patients will be proud to travel.

Thanks to AMS Membership and Communications Specialist Laura Haywood for her assistance with this article.

References:

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TURN YOUR SPARE CHANGE INTO ACTION FOR ARKMED-PAC

BY **H. SCOTT SMITH, JD**
AMS DIRECTOR OF GOVERNMENTAL AFFAIRS

Over the past two centuries, innovation in health care has been the cornerstone of physicians providing the best patient care. Today we're applying that same innovation to take our ArkMed-PAC fundraising efforts to the next level, which is why we are thrilled to offer you an exciting new way to make regular donations and all it takes is your spare change.

Headquartered in Arkansas, GoodChange is a new online giving platform that creates spare-change fundraising campaigns. With a similar set up process to that of Venmo or CashApp, the ArkMed-PAC GoodChange campaign is a simple three-step automated process. To get started, you will:

1. Create an ARKMED-PAC account at https://goodchange.app/donate/arkmedpac.

2. Register your credit card, debit card, or bank account on your account.
   Note: GoodChange or AMS does not keep or store any of your personal financial information - all of that data is encrypted for your protection.

3. Every time you make a purchase with that card, the spare change will be calculated to the even dollar. At the end of the week, all change will be added up and a one-time charge will be placed on your account.

For the average person, this will total up to about $32/month or $8/week in contributions. It is a recurring donation that naturally fluctuates with your own budget - when you are spending more, you give more and when you spend less, you give less. You will also be able to press "pause" anytime you need to, giving you control of your contribution.

Imagine the impact we could have on the political climate for Arkansas physicians if every member of the Society gave their spare change to the ArkMed-PAC. $32 per month per member would change our ability to support those lawmakers who support physicians and common sense governing in Arkansas.

By partnering with GoodChange, physicians will be able to painlessly and regularly contribute to our advocacy efforts, and in return AMS will be able to provide more resources to those physician-friendly candidates who support the Society's mission of empowering physicians and improving medicine in Arkansas.

IMPROVING ACCESS TO TREATMENT

FOR OPIOID USE DISORDER

Visit our website for more information.

UAMS.Info/Opioid

Scan to visit.

In collaboration with the Arkansas Department of Human Services, the UAMS Center for Addiction Services and Treatment (CAST) is providing funds to facilities across Arkansas offering medication-assisted treatment to patients with opioid use disorder. The money will allow medical providers to offer treatment to patients without insurance or the ability to pay for services.

Medication-assisted treatment involves the use of medication to relieve cravings and withdrawal symptoms along with counseling and support to overcome the use of opioids. This includes methadone, which can only be dispensed through an opiate treatment program, products containing buprenorphine that require a federal waiver for prescribers and injectable naltrexone, which does not require special qualifications for prescribing.

The funds will cover expenses including the cost of medication, hiring peer support specialists, providing treatment services and even travel costs for patients using medication-assisted treatment.

To learn more about these funds and how to receive them:
call (501) 526-8459 or (833) 872-7404
or e-mail Anner Douglas at ADouglas2@uams.edu.

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A CLOSER LOOK

EDITORIAL ADVISOR: Chad T. Rodgers, MD, FAAP, CPE

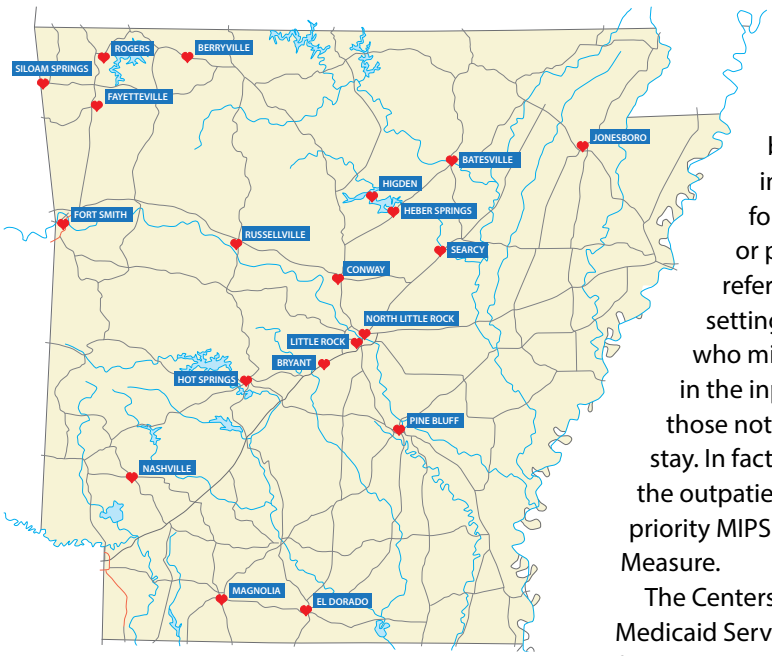
Cardiac Rehab: An Underutilized Class I Treatment for Cardiovascular Disease

AMANDA XAYSUDA, MPH

What do Aspirin, beta-blockers, statins, ACE inhibitors, and cardiac rehabilitation have in common? All have a Class 1A recommendation for treatment following acute coronary syndrome. Nationally, ASA is prescribed 95% of the time with a 0.71–0.78 relative risk of mortality.[1] In comparison, cardiac rehab (CR) has a 0.53-0.82 relative risk of mortality yet is only utilized 10–30% of the time.[1] In Arkansas, only 19.3% of eligible patients participate in CR.[2] To be eligible, patients must have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, percutaneous coronary intervention (PCI), cardiac valve surgery, heart transplant, or have chronic stable angina (CSA) or congestive heart failure (CHF) with reduced ejection fraction less than 35%.

CR is a comprehensive secondary prevention intervention consisting of team-based exercise and education sessions designed to improve cardiovascular and overall health. Patients are monitored via continuous ECG telemetry during exercise sessions and provided education on lifestyle modification. Patients typically attend 36 visits to a hospital outpatient setting or physician's office.

There is strong evidence to show that CR benefits patients in many ways. Individuals who complete a full dose of CR have a 47% lower risk of death and are 31% less likely to have another cardiac event.[3] CR reduces the chance of being readmitted to the hospital, helps patients recover strength, and builds skills in managing medications and activities of daily living. Patients who complete CR show a reduction in depression and cardiac risk factors such as cholesterol, hemoglobin A1C, blood pressure, BMI, and waist circumference. For many, CR improves their quality of life and helps patients get back to living their best life.



Cities in Arkansas with cardiovascular rehabilitation programs

CR commonly begins with an inpatient referral following a cardiac event or procedure. However, a referral from the outpatient setting helps capture those who might have been missed in the inpatient setting or those not requiring a hospital stay. In fact, referral to CR from the outpatient setting is a high-priority MIPS Clinical Quality Measure.

The Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control & Prevention

co-lead *Million Hearts®*, an initiative to prevent one million acute cardiovascular events by 2027. The initiative includes a national goal of 70% participation in CR for eligible patients.[3] We have a lot of work to do to meet that number.

Physicians should be aware of qualifying diagnoses for CR and should be referring eligible patients to the nearest CR center. Many organizations find using an "opt-out" automated referral process from the hospital setting an effective way to capture eligible patients. Another best practice is to talk to patients at hospital follow-up appointments and ask if they participate in CR. According to *Million Hearts®*, **the greatest predictor of participation is the strength of the physician's recommendation**. And while cardiology may be the easiest and most common practice to refer from, any physician can refer to CR.

TELEHEALTH TO EXPAND ACCESS

During the COVID-19 pandemic, CMS released a series of temporary flexibilities that allowed CR to be delivered virtually to patients at their homes instead of the CR center. While the intent was to provide access to those who could not participate in person because of the risks related to COVID-19, virtual programming opened doors that would address other barriers to CR participation. Transportation, distance to the nearest facility, and time, work, or family commitments are barriers historically contributing to poor utilization of CR by patients. Virtual CR, although at risk of coming to a halt with the end of the Public Health Emergency in May, has the potential to create equitable access to CR services that otherwise may not be available to patients in rural and underserved areas. This will continue to be an opportunity to explore in the upcoming future.

To locate CR programs in your area: www.aacvpr.org/Program-Directory or email stronghearts@arheart.com. ▲

Diagnosis	Clinical Recommendation Statements
Coronary Artery Revascularization	2011 ACCF/AHA Guideline for Coronary Artery Bypass Grafting Surgery Class I. Level of Evidence: A CR is recommended for all eligible patients after CABG. 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention Class I. Level of Evidence: A CR should be recommended to patients after PCI, particularly for moderate- to high-risk patients for whom supervised exercise training is warranted. 2021 ACCF/AHA/SCAI Guideline for Coronary Artery Revascularization Class 1. Level of Evidence: A In patients who have undergone revascularization, a comprehensive CR program (home-based or center-based) should be prescribed either before hospital discharge or during the first outpatient visit to reduce deaths and hospitalizations and improve quality of life.
Acute Myocardial Infarction	2013 ACC/AHA Guideline for the Management of STEMI Class I. Level of Evidence: B Exercise-based CR/secondary prevention programs are recommended for patients with STEMI. 2014 ACC/AHA Guideline for the Management of Patients with NSTE-ACS Class I. Level of Evidence: B All eligible patients with NSTE-ACS should be referred to a comprehensive CR program before hospital discharge or during the first outpatient visit.
Congestive Heart Failure	2013 ACCF/AHA Guideline for the Management of Heart Failure Class I. Level of Evidence: A Exercise training is recommended as safe and effective for patients with HF who are able to participate to improve functional status.

Amanda Xaysuda is the Director of Strong Hearts Rehabilitation Center at the Arkansas Heart Hospital and is the current Vice President of the Arkansas Cardiovascular and Pulmonary Rehabilitation Association. She is a Subject Matter Expert and collaborative partner with AFMC in the area of Cardiac Rehabilitation.

Sources:
1. 2021 ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines | Circulation (ahajournals.org)
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3. Million Hearts. Cardiac Rehabilitation Change Package. https://millionhearts.hhs.gov/tools-protocols/action-guides/cardiac-change-package/index.html

UAMS: RESEARCH ENRICHES MEDICAL SCHOOL STUDENTS' EXPERIENCE

For Davis Campbell, a second-year medical student at the University of Arkansas for Medical Sciences (UAMS), scientific research and learning how to take great care of patients go hand-in-hand. That's why he and many of his peers in the College of Medicine carve out time for mentored research.

"For me, medical practice, teaching and research are all significantly important in being a well-rounded doctor," said Campbell, a Fayetteville native who took home top poster presentation honors at UAMS Student Research Day in March for his research into the development of Artificial Intelligence (AI) applications to predict outcomes of kidney transplants.

Campbell was one of 175 students and postdoctoral fellows to present research posters at the event, and one of 14 finalists to compete in the "Three Minute Thesis" competition. Classes are canceled on Student Research Day so UAMS learners and faculty can focus on the intersection of science and health care.

Campbell found the "perfect fit" in the lab of nephrologist and transplant immunologist Shana Coley, MD, PhD, an adjunct assistant professor in the Department of Internal Medicine, Division of Nephrology at UAMS and director of Transplant Translational Research at Arkana Laboratories. Campbell plans to eventually train in anesthesiology and take what he is learning now with Coley to work on the forefront of AI applications in anesthesia.

Campbell is one of 390 UAMS medical students currently working to graduate with Honors in Research. In 2022, 69 students graduated with the honor, including 57 who had published manuscripts and 29 who were first authors. The program requires eight to 10 weeks of mentored summer research after the freshman year, participation in Student Research Day, submission of a manuscript and at least six additional weeks of research after the first summer.

FOR ME, MEDICAL PRACTICE, TEACHING AND RESEARCH ARE ALL SIGNIFICANTLY IMPORTANT IN BEING A WELL-ROUNDED DOCTOR

Second-year medical student Davis Campbell discusses his research into the use of AI applications to predict outcomes in kidney transplants as a finalist in the Three-Minute Thesis competition during Student Research Day at UAMS.

"Our Honors in Research program provides a robust research experience for future physicians," said Robert E. McGehee Jr., PhD, a distinguished professor in the Department of Pediatrics and dean of the UAMS Graduate School. "We also know that research participation is an important factor for successfully matching into residency programs in some of the most competitive specialties."

UAMS is also home to a rigorous MD/PhD combined degree program, with 17 students currently enrolled. Established in 1991, the program has graduated 43 students to date, most of them from Arkansas. As of 2018, the program's graduates had published 138 peer-reviewed papers and contributed to tens of millions of dollars of extramural grant funding to faculty at UAMS alone.

"This dynamic combination of medicine and science training puts graduates firmly on the bridge between bench and bedside and beyond," said Sara Shalin, MD, PhD, director of the MD/PhD program and chair of the Department of Dermatology. "Our program invests in the research potential of our students, and consistently, our students are paying back on that investment through their success and achievements."

Faculty throughout the College of Medicine and UAMS serve as mentors for student research. Hanna Jensen, MD, PhD, an assistant professor of clinical research in the departments of Surgery and Radiology, is highly regarded as a champion and facilitator for student-faculty collaborations.

"Research requires a different skillset than structured classwork and provides an educational experience that is useful for any versatile doctor," said Jensen. "There is no doubt that being engaged with research will lead to improved critical thinking skills, awareness of the pitfalls of science and the ability to recognize true 'evidence-based medicine,' which can otherwise remain just a buzzword."

NYITCOM: TAYLOR TO FOCUS ON COMMUNITY MENTAL HEALTH CHALLENGES AFTER RESIDENCY

For Brittany Taylor, a fourth-year medical student at NYIT College of Osteopathic Medicine at Arkansas State University, the road to becoming a physician has been anything but smooth. Thanks to a lot of hard work, perseverance, and mentors who have invested in her, Taylor will earn the title of "doctor" in May, and she couldn't be more grateful.

"To be on the cusp of graduating from medical school, it's a little shocking to me, considering where I've come from," Taylor said. "I've had a lot to overcome. It's been difficult, but it's just a matter of how much you want it. I've dreamed of being a physician for a long time, and this step is a little surreal."

Taylor was raised in Monticello where she experienced disadvantages such as poverty and inadequate resources in her community. It was around the age of 10 that she developed a dream of becoming a physician.

"Growing up, I didn't really see any representation of me in medicine," Taylor said. "Even at a young age, I knew that there were real needs in my community and I was aware of the disparities. My family and neighbors were suffering a lot of preventable diseases, and I felt the best way I could help people in a meaningful way was to become a doctor."

Taylor earned her biology degree from Philander-Smith College. She became a single mother while in college, where she found the balance between motherhood and her academics to thrive.

She spent a year as a research assistant at Arkansas Children's Nutrition Center before heading to Jonesboro to study at NYITCOM at A-State. Taylor returned to Central Arkansas for her clinical rotations, unsure of exactly what specialty she planned to pursue. During her final rotation of her third year, that decision became abundantly clear thanks in large part to a compassionate preceptor.

I WANT TO HELP BE A PART OF THE SOLUTION TO SOME OF OUR MENTAL HEALTH CHALLENGES BY BEING THAT COMPASSIONATE LEADER THAT GOES OUT INTO THE COMMUNITY TO SERVE.

Dr. Abeer Washington, a psychiatrist with Jefferson Regional Medical Center in Pine Bluff and the Rice Clinic in Little Rock, showed Taylor the tremendous opportunity that exists in the mental health sector.

"As a black female physician, Dr. Washington gave me a connection that I always wanted," Taylor said. "She talked to me and mentored me and gave me such a great experience in my psychiatry rotation. The patient population was just an instant connection for me as well. I want to be able to provide that medical care while helping people deal with some of the unique challenges life throws at us."

Specifically, Taylor wants to become a community psychiatrist and practice in her home state, where the needs are so significant. Taylor will begin her Psychiatry residency at the University of Oklahoma School of Community Medicine in Tulsa with plans to return to Arkansas after she finishes her training.

"There's a shortage there, and it's only increased since the pandemic," Taylor said. "I want to help be a part of the solution to some of our mental health challenges by being that compassionate leader that goes out into the community to serve."

ARKANSAS MEDICAL SOCIETY'S

Annual Membership Meeting

May 11-12 | Embassy Suites | Rogers, AR

We are delighted to invite all physicians and practice administrators to the Arkansas Medical Society's Annual Membership Meeting where you can meet and connect with colleagues and peers **IN PERSON** for the first time since 2019!

This year's educational meeting will feature essential topics on population health, diversity, legislative updates, and critical conversations.

Practice Administrators - You're invited to attend on Friday beginning at 12:15 for a networking lunch and a special breakout session just for you!

REGISTER TODAY!

Scan QR code for online registration. To receive the AMS member discount code, check your email, log into your AMS Info Hub account, or call 501-224-8967.

AMS MEMBER PHYSICIAN	**$225**
NON-MEMBER PHYSICIAN	**$325**
PRACTICE MANAGER (Friday only)	**$40**
PHYSICIAN GUEST (Thursday only)	**$60**
MEDICAL STUDENT/RESIDENT	**$25**

For more information, visit ARKMED.org.

ARKANSAS MEDICAL SOCIETY

THANK YOU TO OUR CONTRIBUTORS & EXHIBITORS.

Agenda

THURSDAY, MAY 11

2:00 pm	Registration Opens
3:00 pm	**State Licensing Required Opioid Training**
4:00 pm	**3 Important Financial Decisions Doctors Need to Make**
5:30 pm	Welcome Reception Hosted by AFMC
6:30 pm	President's Inaugural Gala

President's Inaugural Gala

Anthony Johnson, MD, a pediatrician from Little Rock, will be installed as the 2023-2024 AMS president during the President's Inaugural Gala.

Dr. Johnson is a 32-year member of the Society and has served on the AMS Board of Trustees since 2019.

FRIDAY, MAY 12

7:30 am	Breakfast with Exhibitors
8:30 am	**AMS Board of Trustees Meeting (All members welcome to attend).**
9:30 am	**Diversity, Equity, & Inclusion Statement Presentation**
10:00 am	Break with Exhibitors
10:30 am	**Diversity, Equity, & Inclusion Discussion**
11:30 am	**Can They Be Salvaged? Critical Conversations with Physicians and Staff**
12:15 pm	Lunch with Exhibitors
1:00 pm	**PHYSICIAN BREAKOUT: Population Health**
1:00 pm	**PRACTICE MANAGEMENT BREAKOUT: Don't Let Your HR Problems Turn into Nightmares**
2:30 pm	Break with Exhibitors
3:00 pm	**AMS Legislative Update**
4:30 pm	Adjourn

GOLD CONTRIBUTORS

AFMC
SVMIC
AMS Benefits, Inc.

SILVER CONTRIBUTORS

Arkansas Blue Cross Blue Shield
Home for Heroes

BRONZE CONTRIBUTOR

State Health Alliance for Records Exchange

CONTRIBUTORS

First Security Bank
Destination Rogers

EXHIBITORS

Arkansas Children's
Arkansas Diamond Plan
Arkansas Medical Foundation
EngageMED
First Horizon Bank
Panacea Financial
UAMS Physician Relations

MEMBER NEWS

PHYSICIAN LEADERS ELECTED FOR NEW TERMS ON AMS BOARD

The elections for the AMS executive committee, AMA delegates, and AMS district trustees concluded on February 28, 2023. The following physician members will be sworn in at the AMS Annual Membership Meeting on Thursday, May 11, 2023. (*indicates incumbent).

Executive committee officers are elected for one term beginning in May 2023 through April 2024.

PRESIDENT:
Anthony Johnson, MD – Little Rock (elected in 2022)

PRESIDENT-ELECT:
George Conner, MD - Forrest City

VICE PRESIDENT:
Brad Bibb, MD - Jonesboro

SECRETARY:
Samuel Bledsoe, MD – Little Rock

TREASURER:
Jacob Dickinson, MD* – Mountain Home

The following AMA Delegates were elected for two-year terms beginning in January 2024 through December 2025.

AMY CAHILL, MD
Pine Bluff

STEPHEN MAGIE, MD*
Conway

EUGENE SHELBY, MD
Hot Springs

ALAN WILSON, MD
Monticello (Alternate)

DANNY WILKERSON, MD
Little Rock (Alternate)

The following district trustees will serve a two-year term beginning on May 11, 2023, at the Board of Trustees meeting in Rogers. These are only the trustees who were elected for this term. For a complete list of physician leaders, visit ARKMED.org/about/physician-leaders/.

DISTRICT 1:
Emma Jacobs, MD - Jonesboro

DISTRICT 2:
Edward (E.J.) Jones, MD - Batesville

DISTRICT 3:
Willard Burks, MD* – Forrest City

DISTRICT 4:
Darrell Over, MD* - Pine Bluff

DISTRICT 5:
Mimo Lemdja, MD* – Camden

DISTRICT 6:
Randy Walker, MD* - DeQueen

DISTRICT 7:
John Bouldin, MD - Alexander

DISTRICT 8:
Srikant Das, MD – Little Rock
Riley Lipschitz, MD – Little Rock
Sujit Kotapati, MD – Little Rock
Randy Maddox, MD – Little Rock
Issam Makhoul, MD – Little Rock
Nirvana Manning, MD* – Little Rock
Naveen Patil, MD* – Little Rock
Markus Renno, MD – Little Rock
Bala Simon, MD – Little Rock
Kathryn Stambough, MD – Little Rock

DISTRICT 9:
Tim Paden, MD* - Mountain Home
Alan Schumacher, MD – Pea Ridge
Stacy Zimmerman, MD - Fayetteville

DISTRICT 10:
Anthony Davis, MD* - Russellville
Jeremiah Rutherford, MD* - Russellville

STUDENT TRUSTEE:
Olivia Tzeng – Little Rock

MEMBER NEWS

DON'T GET LOCKED OUT OF YOUR AMS MEMBERSHIP!

Thank you for your membership in the Arkansas Medical Society. Physician membership for those who have not yet renewed will expire May 1. If you haven't renewed yet, please do so soon to ensure your benefits are not interrupted.

The AMS works hard to create value for your membership, and as we strive to improve health care in Arkansas, your involvement and advocacy strengthens physician voices, and provides a strong avenue for physicians to be advocates for patients.

Have you recently retired or moved out of state?

Please let us know by contacting the AMS office at **ams@arkmed.org** or **501-224-8967**.

Please note: if you are a Life or Emeritus member, your membership renews automatically without dues every year. You do not need to take any steps to renew.

thank you

TO ALL AMS MEMBERS WHO HAVE RENEWED FOR 2023!

Your membership matters, and what you get from your AMS membership matters even more. The mission of AMS is to empower physicians and improve medicine and we thank every member and for what you do for the patients of Arkansas.

Scan the QR code to set up your free AMS Info Hub member profile and get started discovering all the benefits of your AMS membership.

PRESERVING HISTORY

AMS ANNUAL SESSION 50 YEARS AGO

As we began preparing for the upcoming AMS Annual Membership meeting, we decided to take a nostalgic look back 50 years ago to the 97th Annual Session of the Arkansas Medical Society that was held at the Arlington Hotel in Hot Springs on April 1-4, 1973. During the four-day meeting, the AMS House of Delegates approved resolutions, committees presented reports, specialty groups hosted section meetings, and the AMS Woman's Auxiliary discussed their various community projects. The incoming president for that year, John P. Wood, MD, said in his inaugural address, "We have endeavored to be conscientious and responsible toward our obligation to provide better medical care. Our course has been consistently toward progress to improve medical care."

1973 Executive Committee and Wives: Members of the Executive Committee and their wives formed a receiving line for the Council reception on Sunday evening. L to R: Dr. and Mrs. Elvin Shuffield, Dr. and Mrs. John Wood, Dr. and Mrs. C.C. Long, and Dr. and Mrs. Robert Watson.

1973 Presidental Oath: The oath of office of president of the Arkansas Medical Society is taken by Dr. John P. Wood of Mena. Dr. Robert Watson, 1972-1973 president, administers the oath.

1973 Dinner: About 200 people attended the Inaugural Banquet on Tuesday evening of the convention.

CAROLYN REEVES, DO, FACOI

OWNER, REEVESMED

City:
Centerton

Specialty:
Internal Medicine, Hospice & Palliative Care

AMS Member since 2012:
Currently serves as trustee for AMS District 9.

Why are you an AMS member?
AMS provides the most consistent legislative advocacy in Arkansas for all physicians regardless of specialty.

Who or what inspired your career in medicine?
My grandfather was an osteopathic physician who completed medical school in 1943 when he was in his 40's and had also lost his sight to Tuberculosis prior to medical school.

What do you like most about being a doctor, or your specialty?
Primary care allows us to develop relationships with patients with great continuity.

What advice do you have for young people considering a career in medicine?
Try to get experience from real experiences, not just TV shows. The best professional advice I received was plan to grow and change your interests in your career – it keeps you engaged.

What is the most critical health care issue facing Arkansas today?
Access to affordable care for low- and middle-income people and reproductive health care for women.

Do you have a personal motto or favorite quote?
Treat people, not symptoms!

What is an important cause to me?
Preventative health care including good nutrition and exercise.

What do I like to do on my days off or weekends?
Be outdoors running or hiking.

What is my favorite restaurant?
KFC – even doctors have a guilty pleasure.

What is my dream car?
Currently I drive a 2013 Nissan Pathfinder and I love it, but sometime soon I will need a new one.

What is something surprising or interesting about you?
Our family likes to host exchange students and our 4th student is currently living with us. Our former students were from Germany, Brazil, Thailand, and Spain.

Left: Dr. Reeves' daughter Grace served as a page in the Senate. **Top Right:** Daughter Grace, husband James, and exchange student Ines. **Bottom Right:** Dr. Reeves with her staff dressed up on Halloween.

JACOB L. DICKINSON, MD, FACS

City:
Mountain Home

Specialty:
General and Vascular Surgery

AMS Member since 2003:
Currently serves on the AMS Executive Committee as Treasurer.

Why are you an AMS member?
I joined the Arkansas Medical Society because I feel that physicians and our patients are not well represented to those that make policy, and we need an advocate to represent us. I am involved because I believe we should all work to be a part of the solution rather than the problem.

What do you like most about being a doctor, or your specialty?
I appreciate the confidence and trust our patients place in us to make and keep them well.

What advice do you have for young people considering a career in medicine?
Study, keep your grades up, and find a local physician to shadow.

What is the most critical health care issue facing Arkansas today?
The disappearing of independent physician practices. I certainly understand that running a medical practice has become very complex and physicians want to spend their time in patient care rather than administrative tasks, but in many cases, there has become too much hospital influence.

What do I like to do on my days off or weekends?
Floating the Buffalo River, hiking in the Ozarks, and fishing White and North Fork Rivers.

What is my favorite restaurant?
Low Gap Café

ARKANSAS MEDICAL SOCIETY BOARD OF TRUSTEES MEETING MINUTES: FEBRUARY 1, 2023

BY **DANNY WILKERSON, MD**
AMS CHAIRMAN OF THE BOARD

The Arkansas Medical Society Board of Trustees met virtually on February 1, 2023. Members attending the meeting were Drs. Seth Barnes, Brad Bibb, George Conner, Jacob Dickinson, Chad Rodgers, Danny Wilkerson, Dale Blasier, Samuel Bledsoe, Lyle Burdine, Willard Burks, Joshua Chance, Kay Chandler, David Dobies, Gina Drobena, Matthew Haustein, James Hunt, John Hunton, Anthony Johnson, Nirvana Manning, Simon Mears, Amanda Novack, Darrell Over, Naveen Patil, Mark Ramiro, Carolyn Reeves, Jeremiah Rutherford, Alan Schumacher, Courtney Sick, Bala Simon, Jerakaycia Smith, Shane Smith, Shannon Swift-Cooper, Randy Walker, Mark Wren and Stacy Zimmerman. Past Presidents were Drs. Omar Atiq, Amy Cahill, Scott Ferguson, Larry Lawson, and Gene Shelby. AMS staff present were David Wroten, Scott Smith, Mary Ann Mansfield, Tereasa Holmes, Laura Hawkins, Laura Haywood, Nicole Richards, and Kenna Harris. AMS Legal Counsel present was Mike Mitchell. Guests were Maddy Pollock, Emily Wineland, and Rep. Lee Johnson, MD.

CHAIRMAN, DR. DANNY WILKERSON CALLED THE MEETING TO ORDER, AND THE FOLLOWING BUSINESS WAS RECEIVED AND TRANSACTED:

1. The Chair welcomed everyone to the board meeting and reminded all in attendance of their responsibility to declare and disclose any conflicts of interest.

2. Following disclosures, the board approved the minutes of the November 4, 2022, Board of Trustees meeting.

3. The Chair asked Scott Smith to introduce Emily Wineland, Cofounder, CRO, COO of GoodChange. Following her presentation there was a motion to refer the implementation of this program to the PAC committee for their review and final approval. The motion was seconded and approved.

4. The Chair called on David Wroten to give his Executive Vice-President's report.

5. The Chair called on Scott Smith, Director of Legislative and Governmental Affairs to give a legislative report. There was discussion with Dr. Lee Johnson and Scott Smith regarding Gold Card legislation that is before the Arkansas State Legislature.

6. Having no other business, the Chair adjourned the meeting.

ARKANSAS MEDICAL SOCIETY: 2023 BUDGET

BY **JACOB DICKINSON, MD**
AMS TREASURER

INCOME

Dues	$1,005,358.00
Journal	46,000.00
Annual Meeting	34,000.00
Website & Grants	241,000.00
Interest /Investment Income	60,000.00
Specialty Services	62,000.00
Educational Programs	62,000.00
Building Operating	416,289.00
ADH- Covid Sub Grant	928,363.00
TOTAL REVENUE	**2,855,010.00**

EXPENSE

Salaries	782,500.00
Contract Labor	112,428.00
Travel and Convention	30,000.00
AMA Delegation	32,000.00
President's Account	6,000.00
Taxes	57,960.00
Retirement	85,500.00
Stationery & Printing	17,000.00
Office Supplies & Expenses	43,000.00
Telephone - AMS	13,000.00
Postage, Communications, Web	20,000.00
Insurance & Bonds	159,550.00
Auditing	5,460.00
Board, Fall & Executive Comm	4,000.00
Journal	25,000.00
Dues & Subscriptions	23,770.00
Gifts & Contributions AMS	4,000.00
Legal Services	91,800.00
Public Relations	1,500.00
Miscellaneous Expense	4,000.00
Office Equipment & Furniture	9,000.00
AMS Resident & Student	6,000.00
Annual Meeting	30,000.00
Educational Programs	40,000.00
Investment Fees	20,000.00
Contract Lobbyist	24,000.00
Building Operating Exp	246,711.00
ADH- Covid Sub Grant Exp	810,669.00
TOTAL EXPENSE	**2,704,848.00**

AMS BENEFITS: 2022 ANNUAL REPORT

BY **STEPHEN MAGIE, MD**
AMS BENEFITS CHAIRMAN OF THE BOARD

AMS Benefits is a for-profit subsidiary of the Arkansas Medical Society established in 1991 to provide insurance benefits to AMS members. The company operates as a licensed insurance agency that markets life, health, dental, vision and disability products.

AMS Benefits currently provides services for group and individual life, health, dental, vision and disability insurance policies covering more than 2,000 physicians, staff, and families. I would like to encourage all Arkansas Medical Society members to take advantage of this specialized service that was created by request from you to meet the needs of Arkansas physicians.

AMS Benefits provides support at all AMS meetings as well as at specialty society meetings, clinic manager meetings and educational workshops. AMS Benefits contracts with Farris Agency to provide property and casualty products to AMS Members and refers all Medical Malpractice leads to State Volunteer Mutual Insurance Company, the Arkansas Medical Society endorsed medical malpractice carrier.

AMS Benefits has one full-time licensed employee agent and contracts with four independent sales agents.

I would like to give a special thanks to the AMS Benefits for their service to the Arkansas Medical Society and its members by providing the best service available for those products they provide.

AMS Benefits Staff

Alanna Scheffer
Alan White (Contract Agent)
Travis Mulhearn (Contract Agent)
John Gillenwater (Contract Agent)
David M Coussens, MD (Contract Agent)

Board Members

Stephen Magie, MD (Little Rock)
Anthony Johnson, MD (Little Rock)
Seth Barnes, MD. (Hot Springs)
Brenda Powell, MD (Hot Springs)
Jacob Dickinson, MD (Mt. Home)
Barry Pierce, MD (Mt. View)
David Wroten (AMS Executive Vice President)
Jan Hundley (Little Rock)

ARKANSAS STATE MEDICAL BOARD: 2022 ANNUAL REPORT

BY **SYLVIA SIMON, MD**
ASMB CHAIRMAN OF THE BOARD

THE 2022 MEMBERS AND OFFICERS OF THE ARKANSAS STATE MEDICAL BOARD ARE AS FOLLOWS

Sylvia D. Simon, MD, Chairman
Brian T. Hyatt, MD, Vice Chairman
Veryl D. Hodges, DO, Secretary
John H. Scribner, MD, Treasurer
Mrs. Elizabeth Anderson
Rhys L. Branman, MD
Christopher D. Davis, PA
Edward K. Gardner, MD
Rodney L. Griffin, MD
Ms. Betty Guhman
Brian L. McGee, MD
Timothy C. Paden, MD
Don R. Phillips, MD
Brad A. Thomas, MD

The Board met bi-monthly and addressed complaints, hearings, and other pertinent business affecting health care in the State of Arkansas.

2022 LICENSING STATISTICS

Medical Doctors and Doctors of Osteopathy Licensed	**1,226**
Medical Doctors and Doctors of Osteopathy (total)	**12,710**
Medical Doctors and Doctors of Osteopathy (in state)	**7,424**
Occupational Therapists Licensed	**126**
Occupational Therapists (total)	**1,939**
Occupational Therapy Assistants Licensed	**98**
Occupational Therapy Assistants (total)	**1,126**
Physician Assistants Licensed	**95**
Physician Assistants (total)	**719**
Respiratory Care Therapists Licensed	**144**
Respiratory Care Therapists (total)	**2,242**
Radiologist Assistants (total)	**6**
Radiology Practitioner Assistants (total)	**3**
Medical Corporations Registered	**44**
Medical Corporations (total)	**799**
Licensed Genetic Counselors Licensed	**108**
Licensed Genetic Counselors (total)	**354**
Surgical Technicians Registered	**8**
Surgical Technicians (total)	**226**
Withdrawn Applications	**21**

SUMMARY OF BOARD PROCEEDINGS FOR 2022

Individual Discussions and Issues (total)	**441**
Complaints (including investigations and other issues involving licensed practitioners)	**396**
Issues	**45**

2022 BOARD ACTIONS

Suspension	**17**
Revocation	**2**
Revocation/Stayed	**0**
Surrendered in lieu of further action	**4**
Reprimand	**3**
Consent Orders	**11**

COMPLAINT ALLEGATIONS (INCLUDING INVESTIGATIONS)

61	Attestation/Renewal Affirmative Answers
4	AMF Monitoring Report
8	Behavior/Attitude
18	Billing/Insurance Issues
3	Boundaries
6	Criminal Allegations
4	Lack of Communication
2	Death Certificate Non Compliance
1	Discrimination/Harassment
1	Dispensing Permit
144	Dissatisfaction with Treatment/Procedure
7	Ethics
3	HIPAA Issues
8	Hospital Reporting/Privileges
7	Improper Dispensing
2	Inmate Allegations
10	Inappropriate Prescribing
3	Inquiry from practitioner
5	Lack of Attention to Medical Needs
3	Malpractice Regulation 23
11	Misdiagnosis/Failure to Diagnose
7	Medical Marijuana
11	Medical Records
22	Miscellaneous
2	Practicing Medicine without a License
9	Patient felt Offended /Violated by physician
5	Over Prescribing
16	Actions taken by other states
1	Patient Abandonment
3	PDMP Violation
1	Doctor Refuses to Prescribe/refill Pain Meds or Other Meds
3	Didn't or Won't Comply with Patient's Request to Complete Paperwork
1	Rule 35
1	Staff Generated Issues
1	Sexual or Romantic Relationship
1	Telemedicine
2	Terminated Patient
1	Misidentification/treatment of patient
2	Unauthorized Delegation of Duties
1	Unsanitary Treatment Conditions
5	Update

ARKANSAS MEDICAL FOUNDATION: 2022 ANNUAL REPORT

BY **DANNY WILKERSON, MD**
AMF EXECUTIVE DIRECTOR

MISSION STATEMENT

The Arkansas Medical Foundation is in existence to provide for the identification and treatment recommendations of health care professionals who suffer from impairment, in order to promote the public health and safety and to insure the continued availability of skills of highly trained medical professionals for the benefit of the public. The activities of the Foundation shall be confined to the extension of medical knowledge, the advancement of medical science, and the evaluation of the standard of medicine, all to benefit the public. The Physicians' Health Committee is formed pursuant to the Arkansas Medical Society peer review program for detection, intervention, and monitoring of impaired physicians to identify and offer professional assistance to Arkansas physicians who are afflicted with mental/emotional illness or the disease of chemical dependency, such as alcohol use disorder, or drug use disorder.

The AMF provides assessments, referrals, monitoring and advocacy to the following:

- Medical Students
- Residents
- Physicians
- Podiatrists
- Veterinarians
- Dentists
- Dental Hygienists and Assistants
- Licensed Respiratory Care Practitioners
- Occupational Therapists and Assistants
- Physician Assistants
- Chiropractors
- Any other Healthcare Professional is welcome to contact the Arkansas Medical Foundation.

REFERRALS

Health care Professionals are referred to the AMF by self-report, hospitals, licensing boards, medical schools, residency programs, family members, colleagues, and patients. The AMF provides support throughout the monitoring process to ensure that the health professional is maintaining their contract compliance. With proper monitoring, a solid substance use disorder recovery program, and enrollment in a state PHP, health professionals can safely return to work. The AMF will ensure that the health professionals remain involved in activities that promote long term recovery.

2021
79 Healthcare Professionals were referred to the AMF

- 43 Signed monitoring contracts
  - 17 Voluntary
  - 26 Board ordered

2022
80 Healthcare Professionals were referred to the AMF

- 33 Signed monitoring contracts
  - 12 Voluntary
  - 21 Board ordered

CONFIDENTIALITY

Any client information and other public information acquired, created, or used in good faith by the Physicians' Health Committee and the Arkansas Medial Foundation shall not be subject to discovery. All information acquired, held, and transmitted in any fashion to the Foundation and Committee will be held in compliance with federal and state regulations. The AMF complies with the Federal Confidentiality Regulations 42 C.F.R. Part 2.

YOUR DONATION CAN MAKE A DIFFERENCE.

The AMF is a 501 (c) 3 corporation, part of the funding for the AMF comes from a legislated assessment onto the annual physician licensing fee collected by the Arkansas State Medical Board. Contributions are also received from two of the medical schools in the state, and some private donations. Your support is invaluable to us, please join us in continuing to provide a lifeline for Arkansas health professionals. All donations are accepted and tax-deductible.

If you or someone you know is battling substance abuse problems, are embroiled in an ill-advised relationship with a patient, or have complicated psychiatric issues that might interfere with your practice or the safety of patients, we encourage you to contact us for assistance. Help is just a call away.

ARKANSAS MEDICAL FOUNDATION

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Little Rock, AR 72205
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Fax: 501.224.9966
Website: www.arkmedfoundation.org
Email: staff@arkmedfoundation.org
director@arkmedfoundation.org

WILKERSON JOINS AMF AS EXECUTIVE DIRECTOR

Please join the Arkansas Medical Foundation in welcoming Dr. Danny Wilkerson, MD, as our new Executive Director. He has served as our Interim Executive Director since March 2022, and after giving consideration to the skills, experiences and expertise needed to guide the AMF in it next phase of growth, he was unanimously elected to serve in a permanent leadership role.

We are confident that under his leadership, the organization's success and impact in achieving its mission and vision to support health care professionals will continue to flourish.

Please join the AMF staff and Board of Directors in welcoming Dr. Wilkerson as we usher in an exciting new chapter for this organization.

YOU TAKE CARE OF ARKANSAS. WE TAKE CARE OF YOU.

We are a legal team that understands the complexity of the healthcare industry. Our team of lawyers are 100% devoted to representing healthcare providers. Whether you need assistance with regulatory work or representation in the courtroom, we know the business of healthcare inside and out.

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