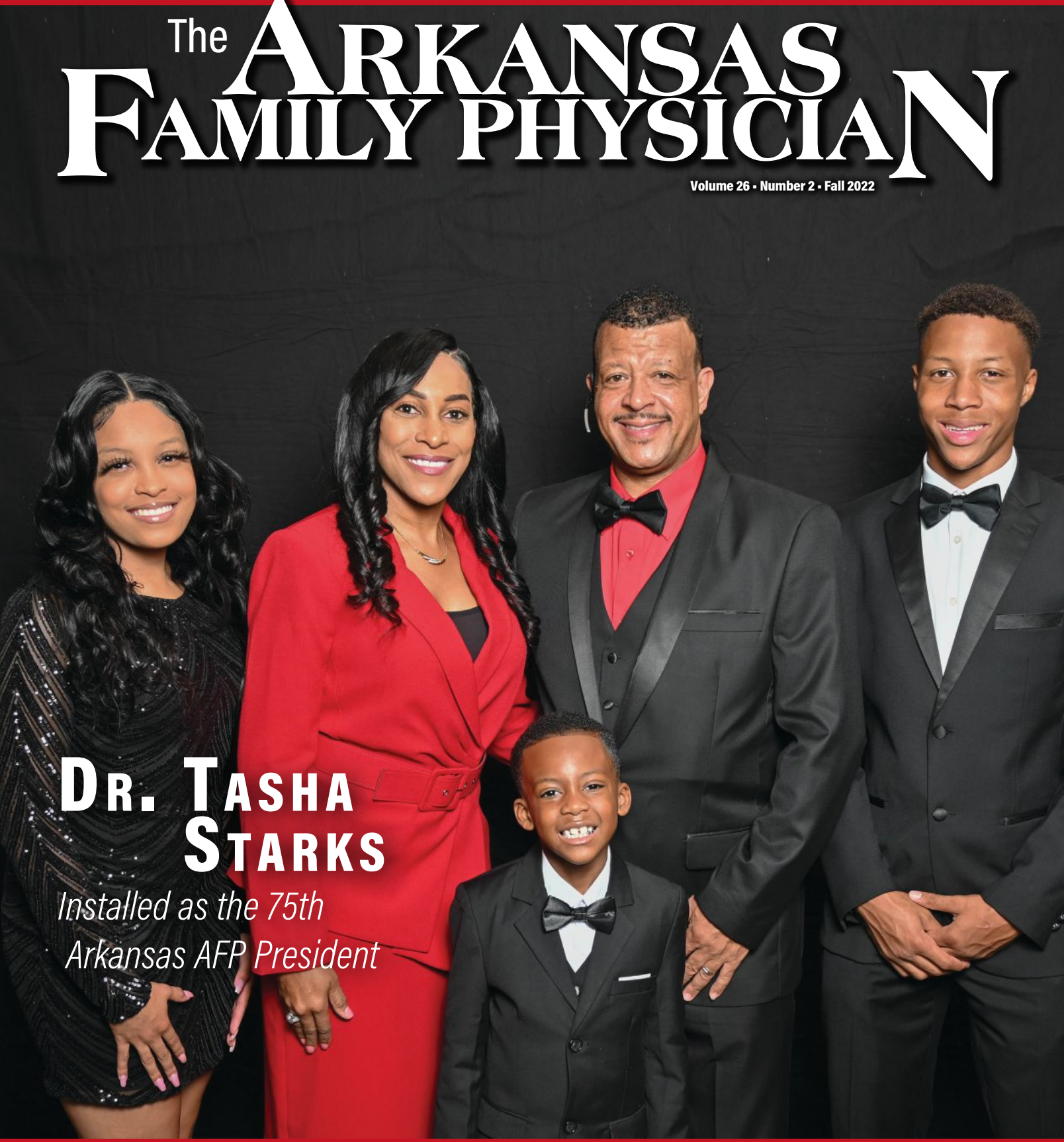
75th Annual Assembly Highlights

The Arkansas Family Physician

Volume 26 • Number 2 • Fall 2022



Dr. Tasha Starks

Installed as the 75th Arkansas AFP President

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

BREASTFEEDING
Benefits More than Just Babies

An expectant mom needs to know that breastfeeding six months can arm her baby against some chronic diseases and reduce the risk of severe asthma, SIDS, ear infections and even obesity.

But what about the benefits for her? Dr. Misty Virmani describes breastfeeding as the final stage of pregnancy. Feeding a growing baby inside her means increased fats, cholesterols and glucose are flowing through her body, making her "metabolically sick." Once she has the baby, these symptoms don't immediately reverse. But breastfeeding resets her metabolic clock and often returns it to a healthier baseline even before her pregnancy. This reduces her risk of heart attack, stroke and ovarian and breast cancers. **Breastfeeding is best.**

UAMS
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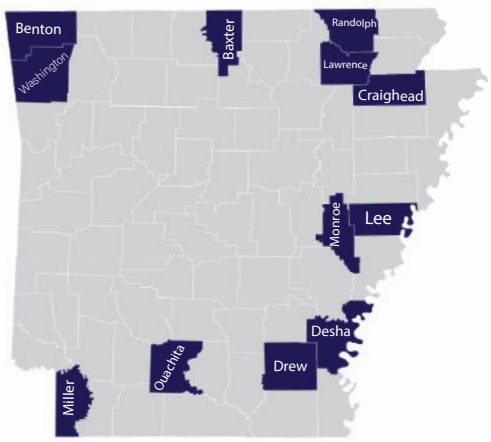
SPAN
State Physical Activity & Nutrition for Arkansas

UAMS.Health/HealthyBaby

Family physicians in 12 counties have committed to promoting breastfeeding. Join the Breastfeeding Initiative and you'll earn free CME at the UAMS Family Medicine Update October 25 - 28. Email wmitchell@uams.edu for details.



Hear more from Dr. Virmani on the benefits to breastfed babies *and* their moms.

Scan to view

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On the cover: Dr. Tasha Starks with family: Husband Tim, daughter Mia and sons TJ and Tre'.

Assembly Photography:
Roger Robinson
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ARKANSAS ACADEMY OF FAMILY PHYSICIANS

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Tasha Starks, M.D.
President

Greetings,

It was a proud moment for me to be installed at the 75th Scientific Assembly of the Arkansas Academy of Family Physicians. Our theme this year, A Family Reunion for Family Physicians, felt perfect as many returned to their first in person scientific assembly, since the beginning of the pandemic. It was a time to see those not seen in the last several years, to rekindle friendships, to enjoy the comradery of like-minded individuals, and to savor much needed in person continuing medical education. It was definitely a family medicine reunion.

To say the least the last several years have been challenging. An unknown COVID virus, later to be known as COVID 19 changed our world and the landscape of family medicine forever. Who knew that I would have an entire patient visit via telephone or see patients on a computer where I couldn't touch them. Who knew that patients wouldn't be able to be seen in the office for years, and some have still been slow to return to the clinic. Who knew that many would lose their practices at a time when many patients needed family physicians the most. Who knew that hospitals and clinics across the country would have to lay off employees at a time when they were needed most just to keep their doors open. Who knew.... but let me tell you what I know and that is – Family Medicine physicians have been consistent throughout all of this!

You have been on the front lines, many of you, like me who stood in the heat and cold with what felt like space suits on testing patients with cars lined down the street. You have been there when insurers told you that the 30-minute telemedicine visit wouldn't be covered or you coded it incorrectly, as you needed to add a special modifier. You were there and this didn't stop you from taking care of your patients. You were there to establish vaccine clinics and to fight for the healthcare needs of your patients. You were there on Skype, Microsoft Teams, Google and Zoom calls with the Dept of Health, the CDC, and a host of other lecturers to ask questions and to pose cases, and to fight for what you needed in your respective cities and towns. Family Medicine Physicians – You Were There!

You were there to fight for being called "A Provider" when the last time we checked you took the Hippocratic oath and went to medical school to become doctors, physicians. You have been there when you made that thousandth click in an EHR that was so cumbersome – you felt like you had finally developed it – hyperclickosis and unfortunately - in addition to COVID. Yes, you have been there! You have been present to ensure your patients receive high quality care and it hasn't been limited to COVID—now it's monkeypox, the Opioid Epidemic, fighting for improved access to care, and the list goes on. Many of you have made decisions to work in underserved populations, rural communities or saw your patients on days when your office wasn't open. You Have Been There!

I submit to you that Family Medicine Physicians are the cornerstone of our health care system. Our healthcare system needs you. Study after study has shown that just by having a family medicine physician in a community lowers healthcare costs, reduces hospitalizations and emergency room visits. Study after Study has shown that your care is not only cost-effective but more efficient. Family Medicine physicians have been called an anchor, a trusted source, a confidant, a healer, this is the way your patients see you.

Now as an upcoming legislative session looms – this is where we need you! As we want everyone to also see the value in you, Family Medicine Physicians. We may call upon you to share your experiences, to be subject matter experts, to help us in lobbying the cause that you be compensated fairly, and that the issues you hold near and dear are heard and acted upon. But we need You! So, when the call to action is placed, just remember that WE NEED YOU! My job is simple because I represent you and will make your voices heard. But I Need You!

Today, I want to encourage each of you to dream bigger. We are the family in family medicine, hard-working, dedicated, strong, resilient, compassionate, and patient centered. Because of you our patients are healthier, our communities are stronger, because you have been there every step of the way along this health journey. You have been Present! I want and need to hear from you, so that your voices are heard! I am so honored to serve with you and to represent you as the Arkansas Academy of Family Physicians President. You have my promise, that I too – will be there. Now let's move forward together, as we continue to advocate for our beloved specialty of Family Medicine.

Welcome, **Mid-Delta.**

MID-DELTA HEALTH SYSTEMS, INC

Front row — Deborah Clark, LPN; Elizabeth Spencer, LPN
Middle row — JaPassion Hampton, LPN; Sarah Beliew, Director of Nursing; Alli Lock, LPN; Katelyn Carlock, Phlebotomist
Top row — Curtis Schalchlin, MD; and Christopher Hopkinson, MD

Mid-Delta Health Systems has joined with UAMS' Partnerships in Colorectal Cancer Screening for Arkansas or PiCS-AR!

PiCS-AR! will work with Mid-Delta clinics in Clarendon and DeWitt to use evidence-based interventions that will reduce late-stage colorectal cancer, the second leading cause of cancer in the United States.

uams.info/PiCSAR

PiCS AR!
Partnerships in Colorectal Cancer Screening For Arkansas

Learn more about colorectal cancer screening at the UAMS Virtual Family Medicine Update October 25 – 28, 2022. Go to **cme.uams.edu** for details. For more information on PiCS-AR!, email **mcurtis@uams.edu.**

UAMS
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Installation of Officers & Directors

Doctor Tasha Stewart was installed as the 75th President of the AR AFP. Pictured is her taking the oath, her family and her delivering a very inspirational presidential address.

Doctor Ada Stewart, Board Chair of the American Academy of Family Physicians installed the Arkansas AFP 2022-2023 Officers and Directors at the Installation Ceremony on Thursday, August 4, 2022. The members listed below were installed.

Congratulations to our New Board Members!

Officers Installed:
President: Tasha Starks, M.D. of Jonesboro
President-Elect: Leslye McGrath, M.D. of Paragould
Vice-President: Brian Bowlin, M.D. of Vilonia
Sec/Treasurer: Nicole Lawson-Rounds, M.D. of Newport
Delegate: Lonnie Robinson, M.D. of Mountain Home
Alt. Delegate: Daniel Knight, M.D. of Little Rock

Directors Installed:
Joshua Clark, M.D. of Ft. Smith
Dichelle George, M.D. of Warren
Jason Lofton, M.D. of DeQueen
Resident Rep: Timothy Baty, D.O.
Student Rep: Erica Olson

Pictured left to right: Dr. Ada Stewart and Doctors Leslye McGrath, Brian Bowlin, Nicole Lawson-Rounds, Daniel Knight, Jason Lofton, Dichelle George, Joshua Clark, Resident Representative, Timothy Baty and Student Representative Erica Olson.

We are also so very thankful to Dr. Garry Stewart and Dr. J.P. Wornock as they roll off the board after many years of service and leadership. Their work to advance the mission of the Academy has truly made a difference.

Thank you for Dr. Stewart and Dr. Wornock for leading us with your strong guidance and devotion to your profession.

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SCAN HERE
Family Medicine Opportunities

Mary Beth Rogers,
ArAFP Executive Director

After an amazing 75th Scientific Assembly filled with innovative CME, a stellar line-up of speakers, and with strong participation from our family doctors, exhibitors and residency programs we are invigorated to continue moving forward. Exactly how we do that is largely up to you under the guidance of our board. This summer our board embarked on a very productive strategic planning meeting that will help us to refocus on our mission and be more purposeful in prioritizing our efforts, allocating resources, and ensuring that our goals are backed by data and sound reasoning.

that we were finally able to meet with medical students in-person. Our chapter has sponsored a few dinners for the Family Medicine Interest Group (FMIG) but were happy to meet them face-to-face in August when we hosted a lunch at UAMS. If you feed them, they will come, and they also joined! Here's a big thank you to our new student representative Erica Olson for giving a dynamite presentation! We hope to visit other campuses and residency programs soon.

Another piece of good news is that our chapter was awarded a grant from AAFP for OUD/SUD training. We plan to use these funds to

2022 Strategic Planning Meeting.

One of the recommendations that came from our meeting was to find out exactly what the priorities and needs are of our members. Therefore, by the end of the year, we will be asking you for some specific feedback, comments, and opinions to assist us with our planning. Ok, let's call it what it is, it is a membership survey, but I dare say that it is one of the easiest and most important ways you can facilitate change. Be on the lookout for more about that project soon.

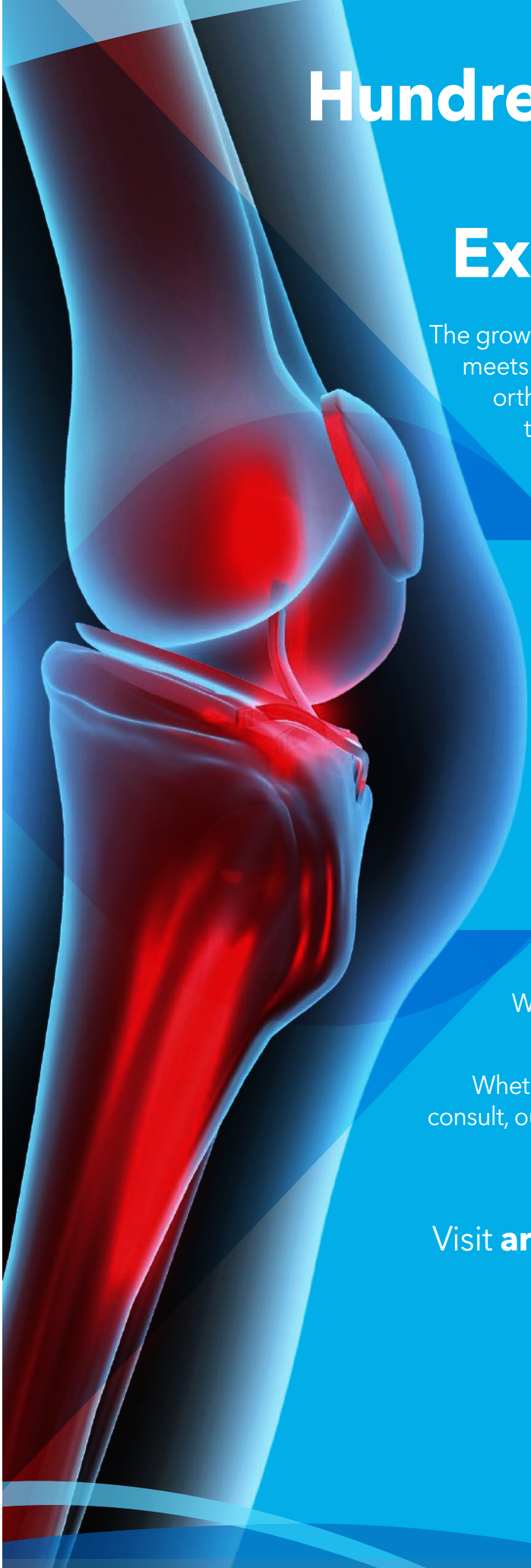
In August I attended the AAFP Chapter Executive Leadership Conference in Nashville and one thing we all agree on is that administrative burden = physician burnout. While it doesn't take a lot to figure that out, it does a lot to figure out the fix to that problem. It is a multi-pronged problem that will take a multi-pronged solution. By the time this journal lands in your mailbox, we will have worked with our partner organizations on prior authorization legislation that will help ease that burden. Primary care spending is another concern that we are addressing and will have more information to share soon. In the meantime, please follow our social media and read your Membership Matters email to stay up to date.

Sometimes it feels like we are still just putting one foot in front of the other while trying to walk out of this pandemic. One sign of progress is create an educational video that you can use to complete your licensure requirements as needed. This will be our first step in building an online learning portfolio to meet member needs through all the stages of your career. The video recordings from each of the 75th Scientific Assembly presentations will also be available as on-demand learning tools.

We hope you will continue to use your Academy as a professional resource. We strive to meet you at all levels of membership through collaboration and professional leadership. We are stronger together so we must stay connected as we work and advocate together. Don't forget to look out for that membership survey coming your way soon!

Mary Beth Rogers

Please be advised that a portion of your due's payment may not be tax deductible. Check your annual dues statement for details and consult your tax preparer.



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- *Sports medicine and general orthopedic injuries*

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Visit **archildrens.org/ortho** for referral information.

Arkansas Children's

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75th Annual Scientific Assembly in Pictures

A Family Reunion for Family Physicians

If a picture is worth a thousand words, then you can only imagine the stories these past presidents have! To commemorate and celebrate our 75th Annual Scientific Assembly we invited our past presidents to the Installation Dinner on Thursday evening. It was a wonderful time to reflect, honor and commemorate the foundation they built over the years.

Top Row (L to R): Doctors Danny Proffitt, Matthew Nix, Scott Dickson, Daniel Knight, Ted Lancaster, and Elton Cleveland

Bottom Row (L to R): Doctor Eddy Hord, Carla Coleman, Doctors Bala Simon, Michael Young, Joe Stallings, Charles Rodgers, Harold Hedges, Les Anderson, and John Alexander

Newly installed President Tasha Starks, M.D. presents Eddy Hord, M.D. with a plaque from the Academy to commemorate his term as President.

75th Annual

Scientific Assembly

August 3-5, 2022

Little Rock, AR

President Tasha Starks, M.D. was installed by Dr. Ada Stewart, AAFP Board Chair on August 4, 2022.

A Thank You to Our Friends

On the anniversary of our 75th Assembly we took a moment to recognize our loyal supporters with a "Friend of AR AFP" award as a small token of our appreciation. We simply could not do this event without them.

Peggy Starling and Dr. Bala Simon

Phillip Wallace

Dr. Mark Jansen

Dr. Eddy Hord, Sharon Theroit and Melony Hilton

A Few of the New Innovative Sessions

Culinary Medicine Demonstration

Legislative Town Hall

Residency & Job Fair

By Kim Shuler, LCSW

Suicide Prevention in Primary Care

A patient walks into your office and…

- Has a blood pressure of 170 over 110
- Reports labs of 9.4% on an A1C
- Notes left-sided chest pain and dizziness
- Is having irregular contractions about 30 minutes apart

You and your team spring into action. You know exactly what to do next, whether it is an urgent direct admission or a medication or other intervention. You are confident in the care your patient receives next and that your clinical decision-making and support for that patient is grounded in evidence and best practices. *But what if someone walks into your office with some form of suicidal ideation.* Do you know what to do? Do you know if they are suicidal? Does your staff know what to do? How do you feel when that patient leaves your office? Like they are safe?

> "Ultimately, the training we received [in residency] was how to admit someone to inpatient care at the hospital... it was pretty minimal".
>
> -Dr. Jason Lofton

Data shows that you are likely to encounter these patients more often than you think. Forty-five percent (45%) of those who die by suicide visited their primary care provider in the month prior to death (Luoma, Martin, & Pearson, 2002). Thirty percent (30%) of people who die by suicide visited a healthcare provider in the week prior to their death (Ahmedani, et. al, 2019). At the same time, only 24% of patients are assessed for suicidal ideation (Hepner et al., 2007). This points to a serious gap in clinical practice and population needs. Dr. Jason Lofton, a rural family medicine physician, says he would recommend screening all patients for suicidal ideation to help prevent suicides. However, he notes "there just aren't enough resources sometimes" for those that do need assistance.

"I feel like we are handcuffed... we just don't have a lot of resources to address suicide."

-Dr. Jason Lofton

Integrated behavioral health also offers an opportunity to bring in support for those patients (and providers!) in managing patients with suicidal ideation, along with managing chronic disease and other behavioral health issues. Thus, primary care is well-positioned to be a central mechanism for identifying patients at risk and getting them to the right point in the care spectrum for management of suicidal symptoms.

Yet primary care teams often receive little, if any, training on how to identify and address suicidality, the resources and placement of patients in the appropriate level of care, and what constitutes effective follow-up for these patients. This is why the Arkansas Behavioral Health Integration Network has partnered with HRSA and family practices across the state to deliver training, institute evidence-based screening protocols, and develop practice specific procedures to support care providers and their staff in being better prepared to address suicide risk at any level. Some key resources for providers and care teams include:

- Arkansas Chapter of the American Foundation for Suicide Prevention
- Arkansas Suicide Prevention Resource Center
- 988 Suicide Line
- UAMS AR Connect Now
- Suicide Prevention, Arkansas Department of Health
- Teen Suicide Prevention, AAFP Foundation Resources

To get started, ABHIN recommends family physicians review at least four (4) hours of training, begin doing universal screening (PHQ-2) for patients, and develop protocols for positive screens (non-eminent danger and eminent danger, pediatric patients, and other populations).

For more information on accessing technical assistance to manage suicide risk in your practice or to inquire about more general behavioral health integration resources and services contact the ABHIN Chief Executive Officer, Kim Shuler, (email-kim.shuler@abhinetwork.org and cell-479-871-3611).

References

1. Luoma JB, Martin CE, Pearson JL. Contact With Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. *American Journal of Psychiatry*. 2002;159(6):909-916. doi:10.1176/appi.ajp.159.6.909
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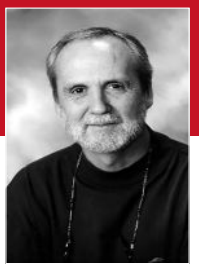
By: Sam Taggart, M.D.
Family Physician and Author

For Every Family, A Family Doctor

Part three



At the beginning of the 20th century, two reasonably unbiased independent surveys were conducted of health and disease in Arkansas. Neither of these surveys cast a positive light on the health or the state of medicine as practiced at that time in Arkansas.

The first of these studies was completed in 1906 by the Prudential Life Insurance company. **Dr. Walter Allen Jaquith,** Secretary of the Chicago Medical Examiners Association and a medical inspector for Prudential, arrived in Arkansas on March 30th, 1906. Over the next two and one-half months he traveled the state, visiting more than one-hundred small and large towns. During the survey he interviewed one hundred and fifty physicians, one hundred of those physicians were on contract with the company to do physicals for life insurance. He kept a detailed diary of his tour commenting on the nature of the communities, the weather, the obstacles to travel and the physicians he interviewed. In general, he commented that most of the state suffered from a great deal of illness especially in the swampy areas of east and southern Arkansas. Malaria in the summer was considered endemic with almost everyone suffering at some point in the year. An especially virulent form of malaria called "congestive malaria" was disabling and many times fatal. He recorded that many of his physician interviewees related that pneumonia was common in the winter and was thought to have a fatality rate of fifty percent. Travel was difficult and unreliable at best. As for the physicians, he was not impressed with most of the physicians outside of the larger towns. One of the primary tasks that was asked of the physicians was a urinalysis that checked for protein and glucose. He found that many of the men who were on contract for the company, had no idea of what was required and didn't seem interested in learning. Based on his observations, he advised the company to cease using thirty-five of the one-hundred physicians they had under contract. One of his impressions was that the state needed much stricter rules on who could call themselves a physician. One other point he made was: with the overall level of illness he questioned whether it was wise for his company to promote their insurance policies in the state at all.

Walter Allen Jaquith

The second study was performed by Abraham Flexner. In 1904, the American Medical Society created the Council on Medical Education. The Council established a set of standards by which to judge medical schools and their ability to train physicians. The standards included a requirement of two years of post-secondary education before acceptance into medical school; medical school should consist of two years of anatomy and physiology followed by two years of clinical work in a teaching hospital. In 1908, the Carnegie Foundation was hired to survey all of the medical schools in the nation in order to promote the CME's reform agenda. The Carnegie Foundation hired Mr. Flexner to do the study.

At the time of the study there were 151 medical schools in north America. The goal of the CME was to reduce the number to thirty-one schools.

Abraham Flexner

At the time of the survey there were two recognized medical schools in Arkansas. The Medical Department of the University of Arkansas was organized in 1879 and the College of Physicians and Surgeons, a proprietary school owned by a number of Little Rock physicians, was created in 1906. Flexner surveyed the two schools in November of 1909 and in a two-page scathing summary he came down hard on both schools. *"Both of the Arkansas schools are local institutions in a state that has at this date three times as many doctors as it needs; neither has a single redeeming feature."*

To their credit the Arkansas State Medical Society, under the leadership of **Dr. Morgan Smith** had already begun making preparations to combine the two schools under the masthead of the University. When the Legislature met in 1911, a bill was introduced, passed and signed by the governor on May 11th, 1911, making the medical school an official part of the University of Arkansas. The Physicians and Surgeons school was eventually folded into the University Medical School.

The Flexner's report and the Jaquith Survey clearly indicated that the state of health in the Arkansas was not good. The level of competency among the physicians was poor and this burden fell heaviest on the rural areas of the state. As with many other states in the Union there was a need to improve the quality of medical education. The Flexner report gave the physicians who were pushing for improvement a leg up in pushing the legislature and the University in the right direction.

Sadly, the Flexner Report had several significant un-intended consequences especially in rural states like Arkansas.

At the time of the Flexner Report there were seven medical schools in the U.S. that were devoted to African American students that had been created at or around the Civil War. All but two of those institutions ceased to exist making it increasingly difficult for the African American populations to establish their own physicians, clinics, and hospitals. This was especially true in the rural south, and it created a crisis of care that would not be resolved until the real beginning of desegregation and integration in the 1950s.

Women had not been accepted into medical training in the United States until about the time of the Civil War. For the next 40 years, increasing numbers of women had entered medicine and were becoming a force in the day-to-day practice of medicine at the time of the Flexner Report. With publication of the report, many of the schools that admitted women ceased to exist. There were more

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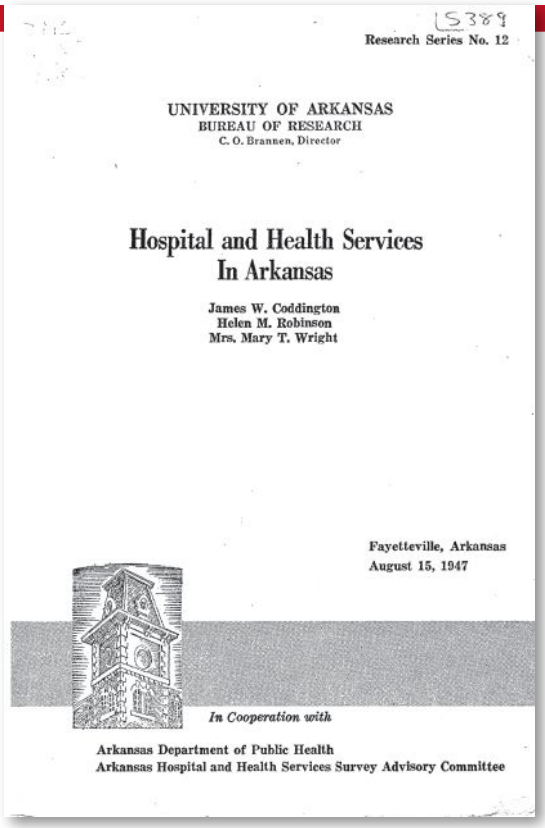
women practicing medicine in the U.S. in 1900 than would be in 1950. There were long periods in the teens and twenties where no women applied or were accepted to the University of Arkansas Medical School. In fact, in the 1940s the University of Arkansas Medical School, by name, was accused of a having a quota system for women that limited them to 1 or 2 per class. This began to change during the 1950s. A major change occurred in 1972 with passage of Title IX Act by the federal government that prohibited discrimination based on gender. As late as the early 1970s, there were only 4-5 female students graduating from UAMS each year. By 2000, women made up 50 percent of the graduating medical school classes.

The most significant un-intended consequence of the Flexner Report was the shift from general practitioners to specialists in the United States. In 1900, there was one general practitioner for every 600 people in the United States and by the 1960s there was only one General Practitioner for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Hospital and Health Services
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James W. Coddington
Helen M. Robinson
Mrs. Mary T. Wright

Fayetteville, Arkansas
August 15, 1947

In Cooperation with

Arkansas Department of Public Health
Arkansas Hospital and Health Services Survey Advisory Committee

J. Coddington study of Health Manpower

every 3000 people. By shifting the focus of medical education to universities, the emphasis moved from one of producing generalists to producing specialists, research, and technology. General Practice gradually lost prestige as the specialists rose in honors and accomplishments. These trends happened slowly; a generation of physicians had to come and go before change was felt. In the 1930s, 80+ percent of the physicians in the United States were Generalists (in Arkansas, the number was well over 90%). By 1969, that number had dropped to only 20% of practicing physicians and half of those General Practitioners were over the age of 55.

There were those within the fold of Family Medicine who clearly saw this negative trend developing, early in the process. In 1917, the first medical specialty board was created with the formal establishment of the Board of Ophthalmology. Two years later, a resolution was introduced at the meeting of the American Medical Association to create a distinct specialty of General Medicine or 'family

continued on page 18

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EQUAL HOUSING LENDER

continued from page 16

practice.' This proposal was soundly defeated. By 1940, sixteen other specialty boards had been created. In 1941, twenty-two years after the first attempt, a resolution was introduced before the House of Delegates of the American Medical Association calling for a Board of General Practice. Like the first resolution, this was rejected. At the conclusion of WWII, with the return of a large number of Generalists from the war, the AMA partially acquiesced to their demands and created a Section of General Practice but continued to oppose creating a separate Board of General Practice.

Like in the rest of the nation, starting in the 1910's, the University of Arkansas Medical School was dominated by technology and the specialists who held forth in urban areas over the next 3-4 decades. The focus was increasingly on new technologies and their use. The training of generalist and family doctors took a back seat in this process most of the time. By the 1930s, there were rumblings within the Arkansas medical profession and the general population about the aging of the small-town family doctors and country doctors.

In 1947, a state-wide study was commissioned by Dr. J. T. Herron at the Arkansas Department of Health and performed by J. Coddington at the University of Arkansas in Fayetteville; the study was designed to look at the adequacy of healthcare manpower and facilities in Arkansas. As expected, the study revealed that health services in the state were well below the accepted national standards. It demonstrated that there had been a substantial loss in the physician population and an aging of those who were left. Only seventeen percent of the physicians in the state were under the age of forty and thirty-five percent were over the age of sixty-five. At the time of the study, national statistics suggested that physicians over the age of sixty-five saw only 1/3 as many patients as younger physicians. The numbers quoted in the study were for the entire state, urban and rural, but clearly the situation in rural settings paralleled and outpaced the population losses in general. Only three counties, Pulaski, Garland and Logan were considered to have an adequate number of physicians.

At the end of World War II, there was a feeling of despair among the General Practice medical community of Arkansas and the rest of the United States that maybe the experts were correct; that the time of the generalist had passed, to be replaced by internists, pediatricians, gynecologists, and general surgeons. Hospital privileges in large metropolitan communities were being limited. According to Dr. Stanley Truman of Oakland, California, *"Our privileges are being taken away from us, not because we are incompetent but simply because we are listed as general practitioners; we can't get on hospital staffs because we are general practitioners; we are coming home from military service, and we are cut off because we are general practitioners."*

With this as the setting, in the next article we will begin looking at the emergence of the modern family medicine movement in the United States and in Arkansas.

Kellie Cornelius, MAP, CPHIMS
AFMC
Supervisor, Provider Relations, Outreach Services

Medicaid Primary Care Provider Referrals

Most Medicaid clients, including ARKids First-B clients, must enroll with a PCP to receive covered services. Medicaid clients may obtain services only from their PCP unless their PCP refers them to another provider or they receive a service that doesn't require a PCP referral.

Few services are covered without a PCP referral. Section 172.100 of all Medicaid provider manuals provides a complete list of services that don't require a PCP referral.

The PCP is responsible for referring clients to other Arkansas Medicaid providers and deciding whether a referral is medically necessary. PCPs accept co-responsibility for the ongoing care of clients they refer to other providers. Medical and rehabilitative professionals treating a referred client are required to report to or consult with the PCP so the PCP can coordinate care and monitor a client's status, progress and outcomes.

PCP referrals may only be made for medically necessary services, supplies or equipment. A client's PCP determines whether it is necessary to see the client before making or renewing a referral. A PCP is not required to make a referral because it's requested, and PCPs aren't required to make retroactive referrals. Medicaid and ARKids First-B clients are responsible for any charges incurred for services obtained without PCP referrals except for those services listed in Section 172.100 of all Medicaid provider manuals.

PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP, or in six months, whichever occurs first. This requirement varies in some programs. Applicable regulations are outlined in the appropriate Arkansas Medicaid Provider Manuals.

There is no limit on the number of times a provider may renew a referral, but renewals must be medically necessary and at least every six months. This requirement varies in some programs. Applicable regulations are outlined in the appropriate Arkansas Medicaid Provider Manuals.

A PCP referral can be given orally or in writing. When giving a referral in writing, the PCP completes the **DMS-2610** form. Written referrals may be faxed to the referred-to provider. Client free choice must be ensured by naming two or more providers of the same type of specialty when completing the PCP referral DMS-2610 form. Medicaid requires all referrals to be documented in the client's medical record.

Rural health clinics (RHCs) are clinics where a Medicaid-enrolled RHC provider employs licensed nurse practitioners or licensed physician assistants. They may not function as PCP substitutes. They may provide primary care for a PCP's enrollees, with certain restrictions. The PCP affiliated with the RHC must issue a standing referral, authorizing primary care services to be furnished to the PCP's assigned clients by nurse practitioners and physician assistants in or on behalf of the RHC. The PCP must maintain a supervisory relationship with the nurse practitioners and physician assistants. Nurse practitioners and physician assistants may not make referrals for medical services except for pharmacy services per established protocol.

Single-entity PCPs are clinics where the facility is the PCP rather than individual PCP qualified providers in the

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clinic. Single-entity PCPs include Federally Qualified Health Centers (FQHCs), UAMS Regional Programs (formerly known as Area Health Education Centers (AHECs)), and family practice and internal medicine clinics at the University of Arkansas for Medical Sciences (UAMS). Because the single-entity clinic is the PCP, PCP referrals given by single-entity clinics will list the clinic as the PCP. The entity's internal bylaws determine which licensed providers can sign a PCP referral on behalf of the clinic.

Effective February 18, 2022, Arkansas Medicaid allows up to ten behavioral health counseling level services each state fiscal year (SFY) before a PCP referral is required. The eleventh and subsequent visits in the same SFY require a PCP referral. Crisis intervention does not count toward the ten counseling level services. No services, except crisis intervention, will be allowed to be provided without the appropriate PCP/PCMH referral. Crisis intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible client experiencing a psychiatric or behavioral crisis.

Most Medicaid clients, including ARKids First-B clients, must enroll with a PCP to receive covered services. Medicaid clients may obtain services only from their PCP unless their PCP refers them to another provider or they receive a service that doesn't require a PCP referral.

A PCP referral requirement for services received in a hospital emergency department (ED) is dependent on the type of services rendered to the client in the ED. Arkansas Medicaid is the only insurance carrier in Arkansas that reimburses for three different ED service types provided to an Arkansas Medicaid client. The three service types are outlined below.

Assessment is an evaluation of the client's complaint or presenting condition. **Emergent** treatment is based on the prudent layperson's definition of "emergency medical condition." A prudent layperson has an average knowledge of health and medicine who would expect the lack of immediate treatment to cause significant deterioration of the client's health. Neither an assessment nor emergent treatment requires a PCP referral to the hospital ED for the hospital to be reimbursed by Arkansas Medicaid.

Non-emergent treatment occurs after an assessment has been performed and the client is deemed non-emergent, but the client wants to receive treatment in the ED rather than being seen by their PCP after being discharged from the ED. A PCP referral is required for the hospital ED to be reimbursed by Arkansas Medicaid.

Mid-Delta Health Systems Joins UAMS' Colorectal Cancer Screening Effort

The University of Arkansas for Medical Sciences' (UAMS) Partnerships for Colorectal Cancer Screening in Arkansas (PiCS-AR!) recently joined with Mid-Delta Health System to expand the number of clinics working to reduce late-stage colorectal cancer in the state. Mid-Delta has a clinic in Clarendon and DeWitt, which are in Monroe and Arkansas counties.

PiCS-AR! is a project of the UAMS Department of Family and Preventive Medicine's Community Health and Education Division. In 2020, the division received a $2.5 million grant from the Centers for Disease Control and Prevention to increase colorectal cancer screening and reduce late-stage colorectal cancer, the second leading cause of cancer deaths in the United States.

"We thought Mid-Delta would be a good partner because their demographics reflect those at high risk for colorectal cancer," said Marybeth Curtis, BSN, program manager for the grant. "Looking at the counties they serve, they have some of the highest rates of cancer in the state. Also, the percentage of uninsured at each clinic is 12% at DeWitt and 9% in Clarendon, which hinders patients from getting a colonoscopy, the gold standard for colorectal cancer screening."

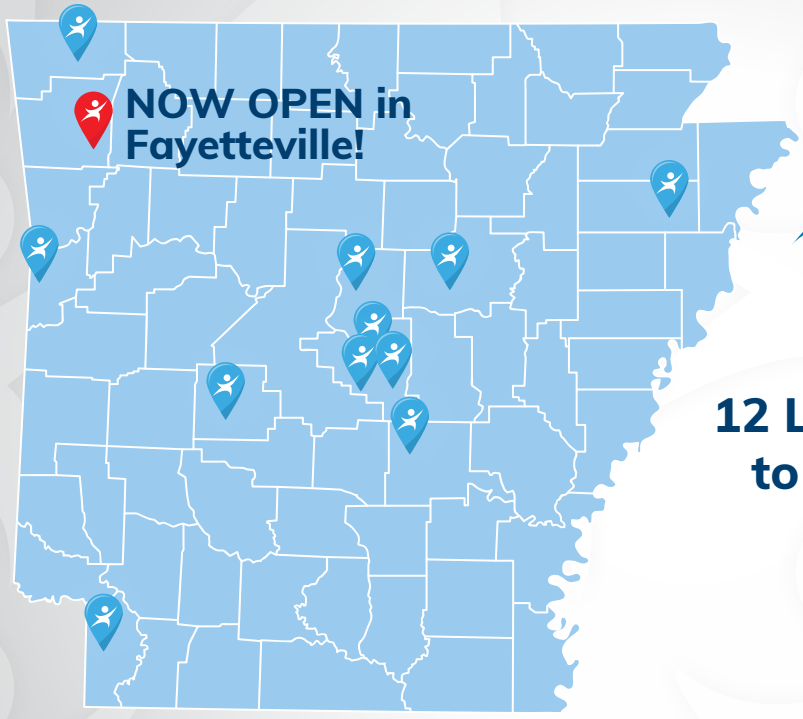
Curtis said the rate of colorectal cancer screening in both the Clarendon and Dewitt clinics is low with Dewitt at 29.5% and Clarendon at 44%. The national goal is 80% as set by the National Colorectal Cancer Roundtable. Adults should be screened for colorectal cancer beginning at age 45.

PiCS-AR! team member, Stacey George, APRN, with Arkansas Foundation for Medical Care, works directly with PiCS-AR! clinics to maximize their electronic medical records to flag patients 45 and older who need screening. She also coaches the patient navigators on best practices and monitors how well the clinics are faring with screening rates.

"Mid-Delta Health Systems wanted to join PICS-AR! to increase their colorectal screenings and get our patients the care needed in the early stage of diagnosis," said Monica Lindley, CEO of Mid-Delta Health Systems.

PiCS-AR! has also been working with 1st Choice Healthcare in northeast Arkansas since the project began late in 2020. Since 1st Choice joined the partnership, they've seen a 9% increase overall in colorectal cancer screening at their six clinics.

Front row -- Deborah Clark, LPN; Elizabeth Spencer, LPN
Middle row -- JaPassion Hampton, LPN; Sarah Beliew, Director of Nursing; Alli Lock, LPN; Katelyn Carlock, Phlebotomist
Top row -- Curtis Schalchlin, MD; and Christopher Hopkinson, MD



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2022 Fellowship Convocation

The American Academy of Family Physicians Degree of Fellow was established in 1971 as a special honor bestowed upon AAFP members who have distinguished themselves among their colleagues by their service to Family Medicine and their commitment to their professional development through medical education and research. The Criteria for receiving the AAFP Degree of Fellow consist of a minimum of six years of membership in the organization, extensive continuing medical education, participation in public service programs outside medical practice, conducting original research and serving as a teacher in family medicine.

Dr. Ada Stewart, Chairman of the Board of the American Academy of Family Physicians presented three members of the Arkansas Chapter their Fellowship Degree on Thursday, August 4, 2022, at the Annual Scientific Assembly. The following members received the honor:

Scott Dickson, M.D., Jonesboro
Lynnette Morrison, M.D., Springdale
Nicole Scally, M.D., Rogers

Scott Dickson, M.D.

Lynnette Morrison, M.D.

Nicole Scally, M.D.

If you wish to participate and obtain your degree, please complete the Fellowship application that can be found on the American AFP website at www.aafp.org/fellow or contact our office at 501-316-4011 and we will be happy to help!

Foundation Awards Two Scholarships for 2022

The Arkansas AFP Board of Trustees awarded a resident scholarship in the amount of $2500.00 and a medical student scholarship in the amount of $1000.00. The mission of the Foundation is to support activities which enhance the education and training of prospective family physicians throughout their careers. Scholarships are possible through generous member donations and fundraisers. Trustee Doctor Scott Dickson presented the scholarships to this year's recipients: Dr. John Mitchell and Erica Olson at the Annual Installation Dinner held on Thursday, August 4, 2022.

2022 Resident Scholarship

John W. Mitchell, Jr, M.D. is a first-year resident with the Baptist Health-UAMS Residence program in North Little. He completed his undergraduate degree at the University of Arkansas on Monticello and attended UAMS for medical school. He was very active in the UAMS FMIG, serving as President this past year as well as the student representative to the Board of Directors. He volunteers his time at high school football games, Arkansas hospice, participates as an AHEC Scholar, and an MD mentor. Dr. Mitchell looks forward to continuing to be active in the AFP.

2022 Student Scholarship

Erica Olson is a 4th year medical student at UAMS. She attended the University of Arkansas at Little Rock obtaining a BS in Biology, BA Chemistry, BA in Spanish, and a certificate in workplace Spanish. Erica has held several officer positions including current President of the FMIG at UAMS and was just installed as the new student representative to the Board of Directors. She is a volunteer with the 12th Street Clinic and a student MD mentor for premedical students at UALR. Erica stated in her scholarship application that she enjoyed a little bit of everything during rotation, continuity of care was central in her passion for medicine and the relationships formed in Family Medicine were everything she desired for her future career….to be in the heart of medicine.

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Fun was had by all at the Foundations 2022 Fundraiser event at the Installation of Officers Dinner during the Annual Assembly! Bingo was a hit and raised well over $2000.00 for scholarships! A special Thank You to Baptist Health's Phillip

ARKANSAS ACADEMY OF FAMILY PHYSICIANS FOUNDATION

Wallace for emceeing the event!

The Arkansas Academy of Family Physicians Foundation is recognized by the Internal Revenue Service as a 501 © 3 tax exempt organization able to receive grants and tax-deductible gifts and contributions. Contributions to the Foundation can be made in memory of family, friends, patients, partners, and colleagues. Your contributions are used by the Foundation to promote Family Medicine in the state of Arkansas!

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Thank you to everyone that participated in the Fundraisers and contributed to the Foundation!

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(Note: 1-800-QUIT-NOW still works and will be routed to the Be Well Call Center.)

Online
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