75th Annual Assembly August 3-6, 2022

The Arkansas Family Physician

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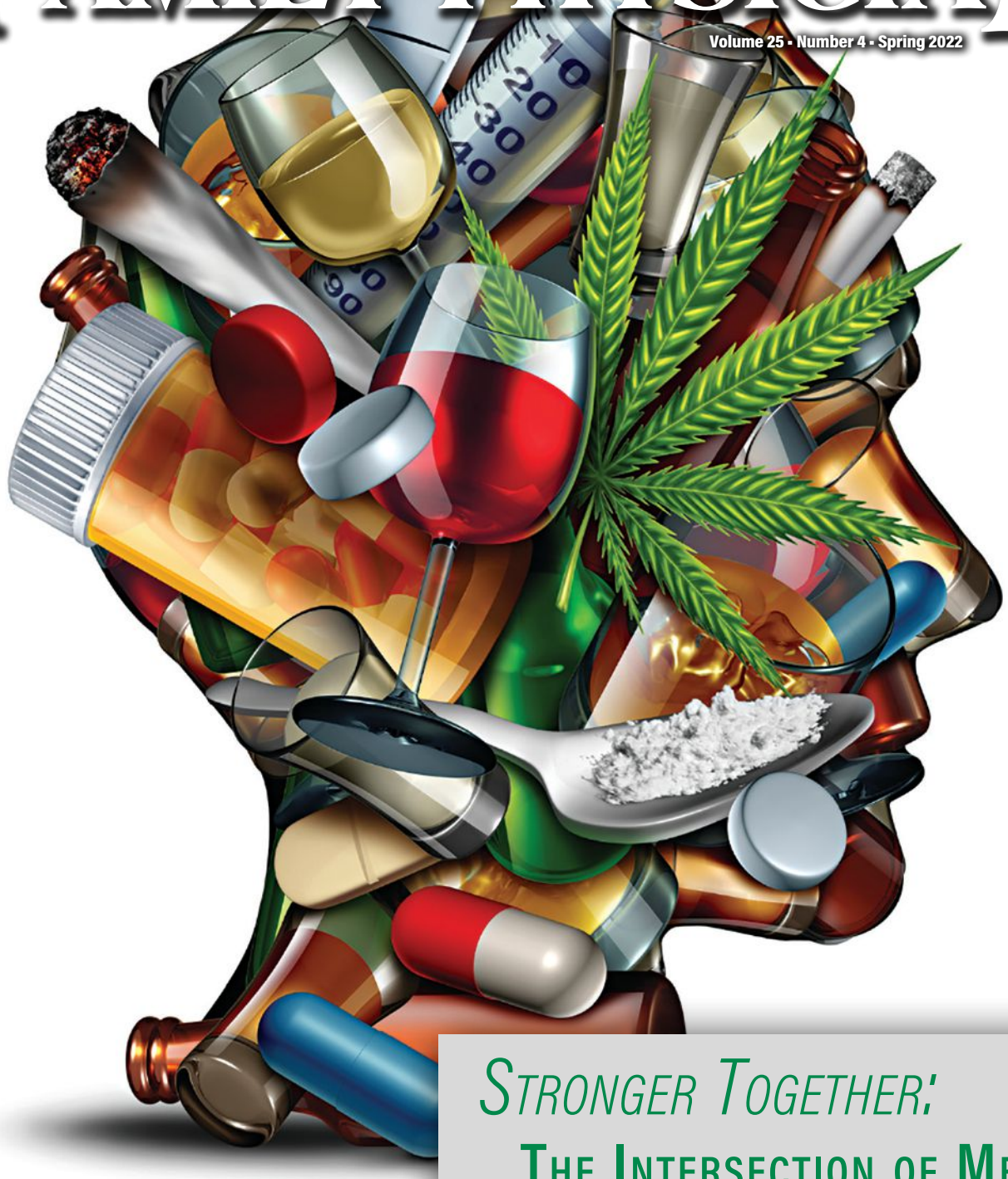

Stronger Together:
The Intersection of Medicine and Peer Recovery

Arkansas Academy of Family Physicians

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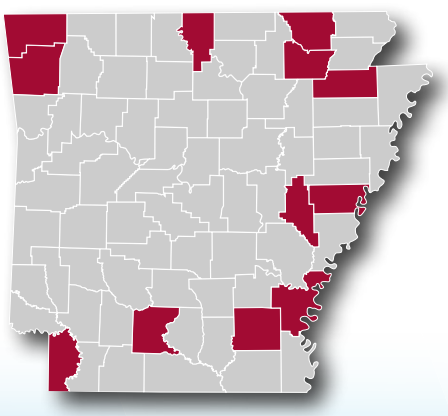

Family physicians in 12 counties have committed to promoting breastfeeding. Join the Breastfeeding Initiative and you'll earn free CME at the UAMS Family Medicine Spring Review April 26 – 29, 2022. Email wmitchell@uams.edu for details.

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Watch this short video on billing with UAMS' **Dr. Misty Virmani.**

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ARKANSAS ACADEMY OF FAMILY PHYSICIANS

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Dr. Eddy Hord
President

Here I sit, biding my time, begrudgingly tolerating the last few weeks of Winter, waiting on the novelty that is the Spring. I love Spring. It is the introduction of new beginnings. It is the source of longer days and the foundation of new blooms. It's the kickoff of farming season, softball season (shoutout to my Ricebird senior third basewoman), and my infatuation with all things turkey season. I think most everyone looks forward to Springtime at least a little bit. It rejuvenates me. My energy is boosted. I am more curious and eager to take on new challenges. The challenge in front of me is to crank out another message to our members. I wouldn't describe my mood about it as "eager," but I at least have a plan. It has served me well thus far, so I'm going to run with it again. Here's a quote, a tweet, an article and a podcast (sort of) that has caught my attention recently.

My quote this time is from Albert Einstein. It describes the classic learning paradox. "The more I learn, the more I realize how much I don't know." That's powerful from a man of his prowess. It is also painfully true for us as physicians. It can be equal parts frustrating and rewarding. That paradox is what pushes us to be lifelong learners. As physicians, regardless of our current knowledge base there will always be more to know. Sometimes this simple truth defeats me and sometimes it empowers me. To complicate it further, family medicine forces us to learn from a myriad of different inputs. Sure, the maintenance of certification agenda and the required CME commitments seem to monopolize the learning curve at times…but our profession is a veritable classroom in perpetuity. We learn every day from peers and patients. We learn every day from mentors and media. We learn from our successes as well as our failures. I'm not always a fan of what I learn. Nonetheless, that ongoing learning is what separates us as professionals and makes us good at what we do. At its core, Einstein's work was based on searching for a deeper understanding of why. When you think about it, we're pressed daily for the same information. Whether from a medical, social, psychological, educational or even a political determinant of health, standpoint our patients require us to keep learning more.

Twitter, when I started, was more for sports and humor than anything. I used it as a quick getaway for an easy laugh or to catch up on any new rumors in the sports world. I later figured out how educational it can be. There is a whole world of "medtwitter" content that is highly educational and easily consumable. It just so happened recently, that I had a patient in the office right out of a twitter post from the day before. The Twitter account is hosted by @EMBoardBombs. They routinely tweet EM board educational material that is evidenced based and uber-succinct. This particular tweet involved pediatric pneumonia, the most common pathogen by age, and the appropriate treatment based on the organism. Though it was not necessarily groundbreaking information, it was a precise review with an almost immediate return on my investment. Much of their content is geared for Emergency Medicine and particularly information directly applicable to their board exams. For better or worse, with most of our practices, there is still significant crossover with emergency medicine. I find their information is relevant and applicable to my daily routine. They also have an entertaining, no-nonsense podcast packed with useful tips and tricks. Oh, and the kid did great!

My article this time is from The Physician Philosopher. He's a writer, blogger, podcaster and physician lifecoach. He wrote a blog article titled, "The Difference Between Simple and Easy." It can be found as both a podcast version and as a digital print version at thephysicianphilosopher.com. We all can relate to things that are simple to understand but hard to practice. We see this played out daily in our patients that struggle implementing a healthier lifestyle. It seems "simple"…eat better, exercise more, live longer; when in reality, the application is anything but "easy". The connection parallels so many areas of our lives from weight loss, to personal finance and even religion. The article attempts to teach us why our lives don't always allow the simple to be easy. He suggests ways to demystify the process, solidify good habits, and reframe mistakes all in an effort to move simple closer to easy. The article discusses habits, particularly those of physicians, and how we're wired to avoid failure. He suggests that we examine our goals from a different perspective in an effort to lose the fear of failure. His advice is to consider obstacles as opportunities, to work on stringing good choices together, to realize there will be set backs along the way and to relish the process more than the result. It's easy to lose focus on those things in our own lives…even when we know better. Think how difficult it must be for our patients that don't have the opportunities, the skill set or the education we're lucky enough to have. This article reminded me to make adjustments in my life to try to make simple "easier." Additionally, it opened my eyes to the difficulty our patients have seeing the "easy" and being defeated, repeatedly, by the simple.

Sticking with my theme of education, I'm going to drop a knowledge bomb for my podcast suggestion this time. If you haven't yet, go listen to any…seriously…ANY of the Curbsider's Internal Medicine Podcasts. Just do it. If you like audio education, and probably even if you don't, it will be worth your time. The series boasts highly professional production with witty and informative hosts interviewing renowned and respected guests from several different fields of medicine. The podcast is amazingly informative, knuckleheaded practical and provides actionable items that you can use every day in your practice. Other than the lack of peds content, there is really nothing not to like. If you listen to the American Family Physician Podcast, don't assume you know all medical podcasts. The Curbsider's show, in my opinion, is light years ahead on multiple levels. I won't focus on one episode, but instead will suggest you pick a topic or two from their episode list and give it a listen. A good starting point would be the most recent episode (at the time of this writing) on outpatient hypertension. I was able to change a few things in my practice immediately based on that podcast. Both my patients and my practice are already seeing the improvements.

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Family Medicine Opportunities

OFFICIAL CALL FOR MEETING

ANNUAL MEETING & SCIENTIFIC ASSEMBLY

August 3-6, 2022

Little Rock Embassy Suites

- **CME designed especially for Arkansas Family Physicians**
- **Pre-Assembly focused on Sports Medicine**
- **Saturday Job Fair, CME and events designed for students, residents and new physicians**
- **Special events to celebrate our 75th Anniversary!**

In accordance with the bylaws of the Arkansas Academy of Family Physicians all members are hereby notified and invited to attend the annual business meeting to conduct the business of the organization, elect officers, directors and transact other business that may be presented to the membership. The business meeting will be held at noon on Thursday, August 4, 2022.

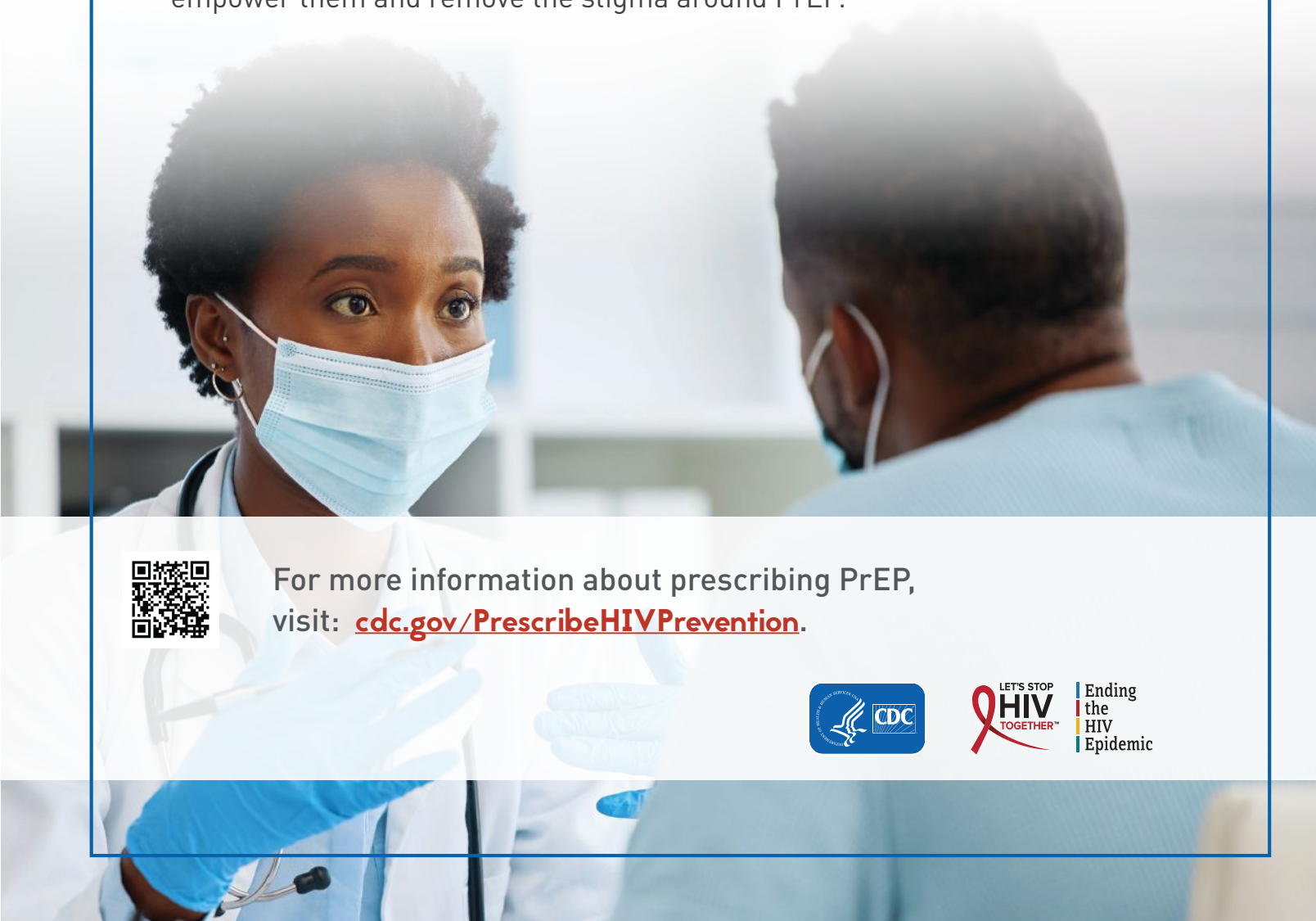
PRESCRIBE PREP

Prescribe PrEP to Help End the HIV Epidemic in the South.

Not enough people in the southern United States have access to pre-exposure prophylaxis (PrEP)—a powerful tool for preventing HIV. The South accounts for approximately 50% of new HIV infections but only 33% of PrEP prescriptions.

As a health care provider, you can help close the gap between PrEP need and use in the South by:

- Talking to all your patients at risk for HIV about whether PrEP is right for them.
- Informing your patients that PrEP is for anyone at risk for HIV through sex or injection drug use.
- Framing PrEP as part of your patient's comprehensive HIV prevention plan to empower them and remove the stigma around PrEP.



For more information about prescribing PrEP, visit: cdc.gov/PrescribeHIVPrevention.

CDC

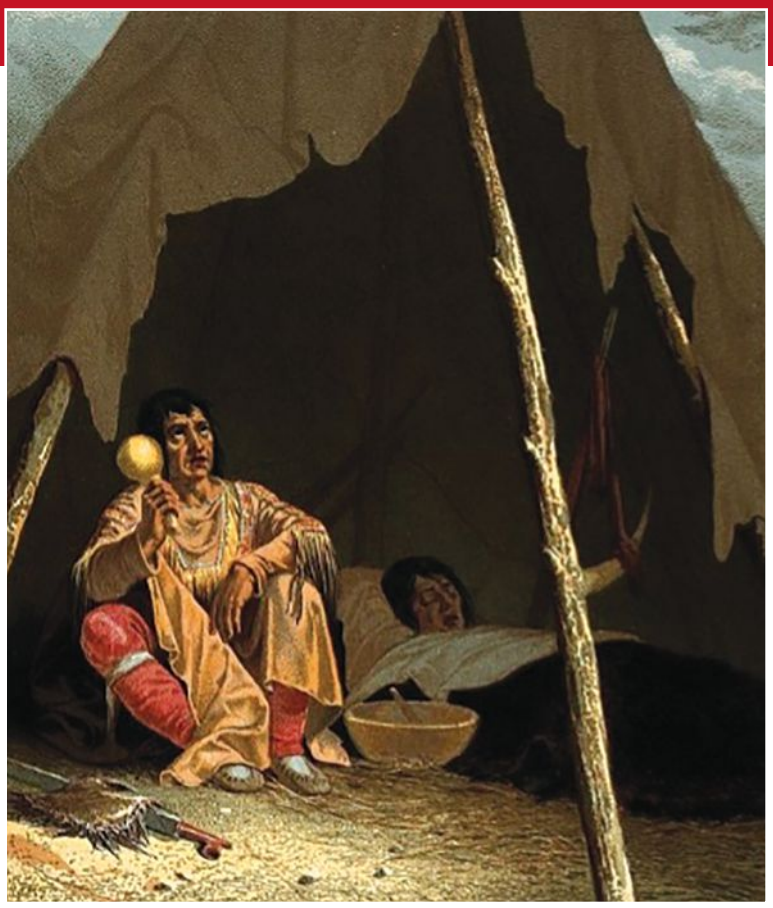
LET'S STOP HIV TOGETHER™

Ending the HIV Epidemic

By: Sam Taggart, M.D.
Family Physician and Author

For Every Family, A Family Doctor

Part one



The phrase, *For Every Family, a Family Doctor,* appears to have been penned by Dr. Fount Richardson of Fayetteville as he edited the newsletter for the Arkansas Academy of General Practice in Issue 12, February 15th, 1951. The national movement to formalize the General Practice/Family medicine movement had begun in 1947. In April of 1948, as a part of the Arkansas Medical Society meeting, a small group of Arkansas general practitioners met, created an organization, and applied for a charter with the American Academy of General Practice; that organization eventually morph into the Arkansas Academy of Family Physicians.

Over the next several issues of the Journal, we will discuss the Arkansas Family Medicine Movement and its history. In doing so, we will put the movement in the context of world and national history. In this first article we will explore the history of medicine and general practice.

The beginnings of medicine

It isn't entirely clear when the idea of a priest/healer evolved but it did occur, and it occurred all around the world, well before the peopling of the Americas. In a society where life was short and not especially sweet, injury and disease were common, death was common especially among children. The priest was called on to use his or her powers to curry the favor of one or more deities to come to the aid of the injured soul. Stony effigies were incorporated into the various rituals. The Venus of Laussal in southern France dated from 20-22,000 years BCE and the Venus of Willendorf in Austria from 20000 BCE are excellent example. The development of ritualistic burials suggests an impulse toward other spheres of human function, an early sense of spiritually. World historian, Peter N. Stearns, PHD, George Mason University, says that the first religious impulses appear to have been poly-theistic residing in animals, the sun, moon, and the stars. As human society evolved, specialization caused the priest/healer to emerge; it seems that for several millennia, these two, were essentially the same. The first well documented instance of a priest / healer is of a female priestess 12,000 years ago (10,000 BC) in the Levant (Israel.) The tool kit of the priest/healer evolved over thousands of years to contain a variety of instruments but early on these were probably composed of amulets, stones, and a variety of readily available herbal compounds. Food and medicine have gone hand and hand throughout history. By the time of the Columbian Exchange in the 16th century C.E. and the Indian removals of the North American Continent in the early 19th century C.E. the indigenous peoples of the Western Hemisphere had developed a complex pharmacopeia based on native plants, clays, and therapeutic waters that were available in the environment. Most of these products were used not just as medicines but as adjuncts to the diets.

So, when did these adventurous migrating souls descend into the middle Mississippi valley?

As this point there is no firm record of the first human to put his foot on this soil but if we expand out in a series of geographic concentric circles, we will see that there were humans close to Arkansas for several millennia before humans can be documented in this place we call Arkansas

The people of Kimmswick in Missouri (Just south of St. Louis), Domebo in Western Oklahoma, and the Johnson Site in Tennessee hunted mega-fauna such as mastodons and wooly mammoths. By 8000 BCE, these large animals had gone extinct, and the climate was warming.

The next stages in the peopling of Arkansas were the Dalton Point Cultures. There are over 750 of these sites in northeast Arkansas alone. The Sloan Site Cemetery is an important site for our consideration. In 1974, Frank and Mary Sloan, notified the Arkansas Archeological Survey Unit at Arkansas State University that they had come upon an important artifact site; the site would soon be known as the Sloan Site. They had uncovered an organized cemetery

on a sandy bluff above the Cache River that eventually carbon-dated to 10,500 years ago. It appears to be more than a hunter's camp and suggests permanent residence. If this was a permanent camp, then they most certainly had those who acted as healers; **this represents the first country doctor/family doctor/general practice doctor in Arkansas.**

The Archaic Era (8000 BCE—1000 BCE) was the beginnings of Mound Building. Watson Brake, in extreme Northeast Louisiana was developed at approximately 3500 BCE. This presaged the Mound Building phenomena that dominated the Woodland and Mississippian cultures that followed. Mound Building suggests several cultural changes that were important to the health and welfare of the peoples of Arkansas/Louisiana. The building of large mounds indicates the ability to organize labor. Some mound building activities indicate a more complex burial pattern suggesting hierarchy within the community and burial patterns with more elaborate burial gifts and a religious structure.

This complexity of social organization, with at least modest hierarchical recognition of chiefs and priests/healers began the process of concentrating knowledge and power. Specialized knowledge and power were generally accumulated and passed on to protégés. Clearly, this happened with medicine men/women and shaman across societies around the world. There is every reason to believe that as agriculture proceeded, surpluses occurred, trade advanced and increasing specialization occurred.

It is speculation, but the probability is that at least in some style zones of the Middle Mississippi Valley the tradition of specialized priest/healer/shamans developed during the Late Archaic Period. (3000-600 BCE). In his book, *Archeology of the Middle Mississippi*, Dan Morse comments when discussing the production of beads, banner stones and effigies: "*it is possible that only certain persons were best suited by temperament and skill to manufacture beads and banner stones and that some of these may have been the shaman or "big-men."* He goes on to describe blocked-end tubular pipes that may have functioned as shaman blowers or sucking tubes. He also describes recovering a "shaman sucking tube" made from a human femur.

When the first Europeans arrived in the Trans-Mississippi in the 16th century, they found a mature culture of Chiefdoms that defies any concept we have of them as filthy savages. They had a complex pharmacopeia of herbal drugs, regular use of therapeutic waters and clays, intricate surgical techniques and an innate knowledge of public health and cleanliness. Over the next two centuries, as with the rest of North America, the Columbian exchange of epidemic disease decimated the native American populations and with that much of their social structure.

The history of medicine in western culture is that of the generalist. Part of the root word for civilization is the word

continued on page 10

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city. Anthropologists use the number of 5,000 population as the real beginning of what can be called cities and civilization. Despite, the emergence of cities, 90+ percent of the people in this world have lived in a rural setting. As for health care, clearly, Egyptian texts speaks of specialists who ministered to the royalty for each organ and each disease but for the vast majority of the population throughout history, the doctor is a generalist.

The very first time that the phrase ***general practice*** was used in Western Medicine was with the formation of the Society of Apothecaries in England in 1617. The members of this organization generally referred to themselves as General Practitioners. These men learned their trade as apprentices. Another type of practitioner in England during this timeframe was the Barber Surgeon. They also referred to themselves as General Practitioners. In 1815, England adopted the Apothecaries Act that gave the Society of Apothecaries the right to examine and license apothecaries. By 1840, one third of all apothecaries and barber surgeons were licensed to practice as General Practitioners. Physicians, then as now, were a quarrelsome group and in 1844, the barber surgeons and the Apothecaries created the National Association of General Practice in Medicine, Surgery and Midwifery.

We are now in a position to begin to compare and contrast the European-trained physicians and the Medicine men and women of the Native American populations.

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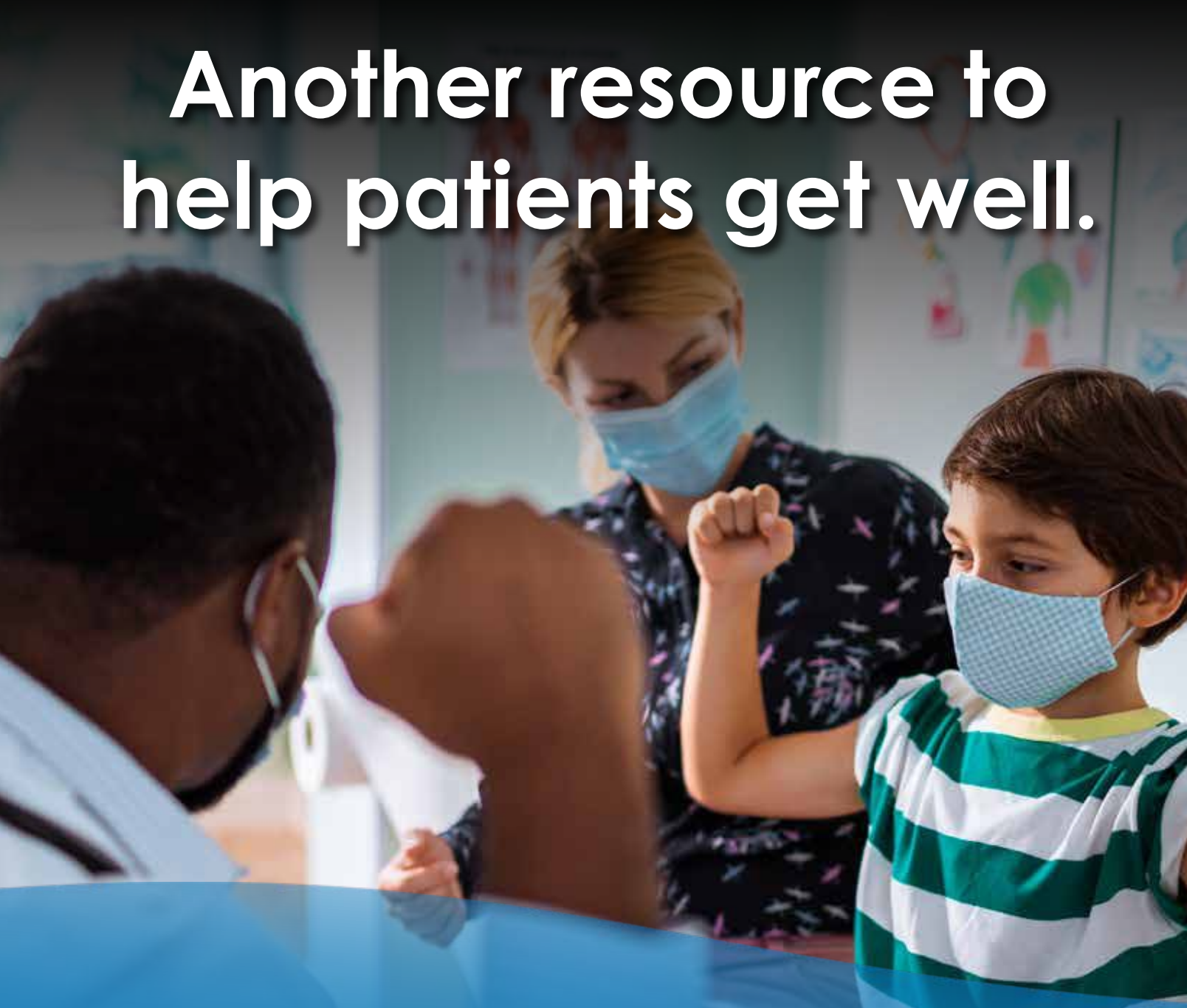
Another resource to help patients get well.



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be well

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Most of the European-trained physicians of the 18th century who had an opportunity to ply their trade in the Middle Mississippi Valley were military physicians accompanying either the French or the Spanish Armies. These physicians were trained in a style of medicine based on Galen's Balance of the Humors. Their approach to illness was called heroic medicine and almost always involved emetic (inducing vomiting), cathartic (inducing diarrhea), bleeding, cupping and sucking. This theory of medicine believed that all illness was simply an imbalance in one of the four humors. No attempt was made to differentiate between various illnesses from a therapy standpoint. Each of the forms of therapy was used to mimic the symptoms induced by the illness. Their medical bag tended to be packed with many small bottles of basics which they compounded on site. They tended to use significant amounts of mercury and dramatic bleeding often to the detriment of the patient.

Morris Arnold, in his book, Colonial Arkansas, 1686-1804 described these physicians as being of two types: the university-educated doctor, whose job it was to diagnose and prescribe cures. Surgeons were considered craftsman, equivalent to tailors and barbers, whose primary training was apprenticeship. There were seldom many if any physicians in the territory during the first half of the 18th century. A physician by the name of Jean Michel accompanied Robert Cavelier De La Salle when he claimed Louisiana and the Mississippi river for France in 1682. A Surgeon and apothecary (pharmacist) reached the John Law Concession in 1721. There is record of a surgeon named Lefevre deserting his duties at Arkansas Post in 1748. At Arkansas Post, a small hospital was built in 1751. Most of the military hospitals were nothing more than a charnel house or a quarantine unit.

In 1769, when the Spanish took control of Louisiana, **Dr. François Menard** is listed as the Post Physician and Surgeon. For the time that he practiced **he was probably the first European physician to consider Arkansas his home.** He served in this position for short period of time and then retired to his business activities. Interestingly, the records reflect that he had twenty-seven medicines in his chest including a variety of ointments, salts and balms, mercury, diaphoretic antimony, absinthe, verdigres, aloe, gum drops and elderberry cough syrup. Some of the more exotic medicines were Spanish fly, snake powder, crawfish eyes and quinine.

In the 19th century, self-help texts would be an important source of health information. In 1796, a small tract was published in Madrid to be used in the territory called *Medicines and a Digest of Method.* The subtitle states that it is intended, "*for use of families deprived of physicians and particularly for the inhabitants of colonies exposed to the malign influences of the climates they inhabit.*" This was probably the first self-help text in the wilderness of Arkansas.

A generation later, Missionary Timothy Flint gave a vivid testimony to the conditions of misery that beset those who lived in this part of the Mississippi Valley, "*the valley of Arkansas, with very little exception is sickly. Remittent and intermittent (fevers) are so common, that when a person has no more than the simple fever and argue (malaria), he is hardly allowed to claim the immunities of sickness, and it is remarked that he only has the ague. The Autumn that I was there, it appeared to me that more than half of the inhabitants, not excepting the creoles, had the ague.*"

The Native American physicians/Medicine men/ Healers had been contending with this challenging environment for several millennia. Virgil Vogel in his book *American Indian Medicine* details in great depth a complex compendium of herbal drugs, therapeutic waters and clays, along with technical approaches to common surgical, orthopedic and obstetric problems. They also had a subtle and sophisticated understanding of the role of psychology, placebo and trust.

In an act of ethnocentric snobbery, the Europeans tended to downplay the Native American contributions while at the same time borrowing heavily from them. To quote Vogel: *"Our civilization is in fact a compendium of such borrowings, and it is a demonstrable error to believe that contacts of "higher" and "lower" show benefit flowing exclusively in one direction. Indeed, a good case can be made that in the long run, it is the "higher culture" that benefits more through being enriched, while the "lower" culture not uncommonly disappears entirely as a result of contact."*

When Louisiana was purchased from the French in 1804, the place we call Arkansas had almost no doctors. Estimates are that there were two to four thousand Native Americans, three hundred to four hundred European hunters and trappers, and sixty-five African American Slaves.

In the next fifty-six years the population would change dramatically as would the number of doctors.

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Arkansas Children's

HOSPITALS · RESEARCH · FOUNDATION

by Kyle Brewer, BS, PRPS

Stronger Together:
The Intersection of Medicine and Peer Recovery

If you would've asked me five years ago what I would be doing today, I guarantee you the answer would not have been anything remotely close to writing this article and being employed by both the University of Arkansas for Medical Sciences (UAMS) and NAADAC, the Association for Addiction Professionals. In February of 2017 I returned to using heroin and prescription opioids after a brief period of abstinence. This period of abstinence was a result of my second attempt at residential treatment for a substance use disorder (SUD). My first attempt and exposure to treatment was at the age of 17. Alcoholism and drug addiction are a common denominator in my family. Watching family members drink, use drugs, fight, or get arrested was a normal part of life. I was desensitized to substance abuse and the lifestyle that came along with it. **The abnormal was normal.** At the age of 13, following the death of my grandmother, I slowly began my own personal journey down the road of substance use. What began as occasionally drinking alcohol quickly progressed to abusing over the counter cough medicines, like Robitussin, to eventually smoke Marijuana daily. This soon led to multiple arrests and a bad reputation. However, I maintained my attendance in school and continued making decent grades. By the time I graduated from Benton High School in 2008 I had been arrested multiple times, completed a residential SUD treatment program, and experimented with just about every drug I could get my hands on.

I was accepted to the University of Central Arkansas (UCA) and enrolled to begin my freshman year in Fall 2008. I fell in love with the college life and quickly found my place on campus. Throughout my time at UCA I excelled academically and socially. I made 3.5 and 4.0 GPAs. I was elected to President and Vice-President positions in my fraternity and other campus organizations. On the surface it appeared that I was doing everything I should be doing and doing it at a very high level. Underneath the surface there was a darker narrative unfolding. During my freshman year, I had my wisdom teeth removed. As is commonplace, I received a prescription of opioids after the procedure. Early on, I began taking the Oxycodone as prescribed to dull the pain from the surgery. This quickly escalated to calling-in refills and within two months, I developed a tolerance for the drug needing more and more of the medication to achieve the desired effect. By the time I was out of refills, I was trapped in the vicious cycle of opioid addiction. **I had no idea at the time but that one Oxycodone prescription would eventually lead me to homelessness and a life controlled by a needle full of heroin and/or prescription opioids.** When I began my senior year of college, I was spending $100 or more a day on prescription opioids. It was no longer about the euphoria, rush of energy or overall high. **It was simply about not being sick**. I needed the medication to avoid the withdrawal symptoms and maintain the image that I was doing good. I limped through my senior year and graduated from UCA in 2013. The irony of it all is that I graduated with a Bachelor of Science in Addiction Studies. **I thought I was fooling the world but in reality, I was only fooling myself.**

I would end up spending the next four years living with a timer in my head. The timer told me when I needed to use to keep the withdrawal symptoms away. I would do things I never thought I would do. Go places I never thought I would go. And hang out with people I never thought I would be around. I graduated from taking opioids orally to snorting them to eventually intravenously using heroin. It destroyed every aspect of my life. My relationships with friends and family were broken and strained. I was arrested multiple times for a variety of reasons such as driving while intoxicated and theft of property. I totaled two vehicles and burned every bridge to the point that I would eventually become homeless. This brings me back to 2017.

Mugshots

On July 10, 2017, after several days of methamphetamine and heroin use, I found myself in a state of fear and psychosis. I was dropped off at the Nehemiah House, a Little Rock homeless shelter, and the staff quickly determined that a hospital was more appropriate for my needs and called an ambulance to pick me up. I was taken to Baptist Health to detox and upon discharge I returned to the Nehemiah house. I entered their 9-month faith-based recovery program and began learning about faith and recovery. I surrendered my life to Jesus and began channeling all my energy and attention towards recovery. I took that same type of mentality and dedication that was required in my active addiction and applied it to my faith and recovery. I completed the recovery program and stayed at the Nehemiah House for about


Nehemiah House Intake Picture

12 months. I learned that recovery does not have a finish line because recovery is not just a thought or an action. Recovery is not about a particular program, pathway, or amount of time. Recovery is a lifestyle for a lifetime. **By the grace of God, I've been in long-term recovery since July 10, 2017. Today I have hope, purpose, and freedom**.

Unfortunately, my story and struggle with opioid addiction is very common. The opioid epidemic has sadly claimed the lives of thousands of Americans. **Provisional data from CDC's National Center for Health Statistics indicate that there were an estimated 100,306 drug overdose deaths in the United States during a 12-month period ending in April 2021.** This is an increase of 28.5% from the 78,056 deaths during the same period the year before. Drug overdose is the leading cause of accidental death in the United States and opioid use is driving this epidemic.

In Arkansas, there were 411 drug overdose deaths in 2017, which increased to over 550 in 2020. From 1999 to 2019, nearly 247,000 people died in the United States from overdoses involving prescription opioids. Overdose deaths involving prescription opioids more than quadrupled from 1999 to 2019. **These numbers are more than statistics, they are our friends, neighbors, and family members.** Every person has left behind a family who deeply misses and grieves their passing every day. The problem is complex, and, as a nation and a state, we didn't arrive here overnight. Overprescribing and misinformation about addiction, stigma and the explosion of illicit Fentanyl use are just a few of the contributing factors. In Arkansas, 2.49 million opioid prescriptions were filled in 2020. Although the number of opioids prescribed in Arkansas has decreased, Arkansas remains one of the leading states in the nation for opioid prescribing. According to the Centers for Disease Control and Prevention in 2019, Arkansas' rate of 80.9 prescriptions per 100 people is still well above the national average of 46.7.

The stigma that surrounds the disease of addiction prevents people from being honest and asking for help. Stigma is one of our biggest and oftentimes most subtle obstacle. As with COVID-19, we have seen that no one is exempt from this issue. However, stigma keeps us from normalizing the conversation about addiction and recovery. **Addiction impacts every socioeconomic background, race, religion, gender, and geographic location.** Every level of society has been and will continue to be affected by the opioid epidemic. But, working together, we can and will find hope.

What comes to mind when you hear the word recovery? Maybe you think of a previous medical procedure and the time it takes to bounce back. It could be one of those irritating moments that require your email address to recover your password. Or you could have an image of a group of people drinking coffee in a mutual support recovery meeting. Chances are that you think of one particular memory, definition, or aspect of life that you connect to the word recovery.

The journey of recovery usually starts with words that lead to action. Sometimes that includes medication, emotional support, or residential treatment. For addiction it may look like detoxification from the substances(s) of choice and the removal of the substance(s) that is causing problems. For mental health there may be medication, medication adjustments or the need for a higher level of care. And recovery does not stop there. In fact, that is just the beginning.

When a doctor performs a surgery, they often prescribe medications, physical therapy and recommend adjustments to your diet, exercise, and daily routines. If you have the surgery and don't follow any of the post-surgery guidance, it's reasonable to think that your chances of a full and successful recovery significantly decrease. Addiction and mental health challenges have a significant impact on every aspect of life. It is no surprise that recovery can and will have an equal or greater impact on a person's life. Recovery from addiction and mental health requires significant changes to a person's life and the way in which they live it. Recovery directly impacts an individual's physical, emotional, psychological, and spiritual health. Each one of these areas require attention to detail on how it is lived out in daily practice with possible adjustments, and a lot of hard work. **You don't typically get to decide which days you're in recovery and which days you're not. It's a 24/7 full-time lifestyle commitment.**

Recovery can be overwhelming to an individual that is in the beginning of the process. It can be frustrating and confusing for the family members of those individuals beginning recovery. It's important to remember that recovery is a lifestyle, but it's just as important to remember that recovery is also a process. It takes time, energy, finding new ways to express your life and times when the individual is just not sure on which step to take next. However, a person on the path of recovery can only get to the top of a mountain by taking one step at a time.

Recovery is complex and there is no cookie cutter answer for everyone. It requires collaboration from the family, community, and the individual seeking recovery. Some days life is very positive, and some days life is not so positive. Recovery is very similar to life. You have good days, and you have bad days. I've always heard when life puts pressure on you that's when you find out what you're made of. "Adversity does not build character, it reveals it" James Lane Allen, novelist. When you squeeze a lemon; you get lemon juice. When the tough or the hard days of life put pressure on someone in recovery the lifestyle that they've developed and implemented will be what comes to the surface – that is recovery!

Recovery may seem like a simple word but for someone with a substance use and/or mental health disorder the word "recovery" is much greater than any other word in their vocabulary. When faced with the task of changing everything about your life it's easy to feel alone, scared, and uncertain. That is why people typically don't find and sustain recovery in isolation. It requires a supportive community working together to accomplish a common goal. The doctor, pastor, judge, and other members of the community must collaborate and work together to positively impact the community and reduce the number of overdose deaths. Communities do not have to do this alone. **Across the state, communities are being armed with a vital resource – Peer Recovery Specialist(s).** A Peer Recovery Specialist (PRS) is someone who has personal direct lived experience with drug addiction and/or mental health challenges. The unique-lived experience is combined with training, education, supervision, and a code of ethics.

Relationships are a very important part of life and recovery. Trust and mutual respect are often fundamental to the foundation

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of a successful relationship. Peer support is rooted in relationships that are founded on the principles of equality, mutuality, and shared experience. It is this foundation that enables a PRS to walk alongside someone, empower them to make their own choices, and model a life of recovery.

The State of Arkansas is blazing a trail by equipping and empowering the recovery community to take their past and give it purpose through peer support. A PRS is a powerful weapon against the opioid epidemic. They are also a vital and important resource for physicians and medical professionals across the state.

The Arkansas Peer Specialist Program (APSP) is a collaborative effort between NAADAC, the Association for Addiction Professionals, and the State of Arkansas that streamlines each step of the peer credentialing process, producing highly trained and knowledgeable peer specialists, and creating a one-stop shop for all peer credentialing needs.

APSP is an innovative three-tiered credentialing process developed with involvement of peer specialists at every level of the application, certification and ethics process that provides an individual the opportunity to progress through the core, advanced, and supervisory levels of the Arkansas Model. Through this model, peers can climb the career ladder, to hold the Arkansas Core Peer Recovery Specialist (PR) credential, the Arkansas Advanced Peer Recovery Specialist (APR) credential, and the Arkansas Peer Recovery Peer Supervisor (PRPS) credential. **By the time an individual has reached eligibility to take their Core PR exam they have completed a minimum of 500 hours of direct work experience, 25 hours of direct supervision, and an additional 46 hours of continuing education.** Each level of this career ladder has its own code of ethics, training, education, experience, and supervisory requirements designed to produce highly trained and knowledgeable Peer Recovery Specialists.

Peer Recovery Specialists are currently being utilized by communities across the state in a variety of settings and capacities. Hospitals, emergency departments, jails, treatment centers, primary care clinics, re-entry programs, youth services and police departments are a few places that peer specialists are positively impacting the community and helping others find and sustain a life of recovery.

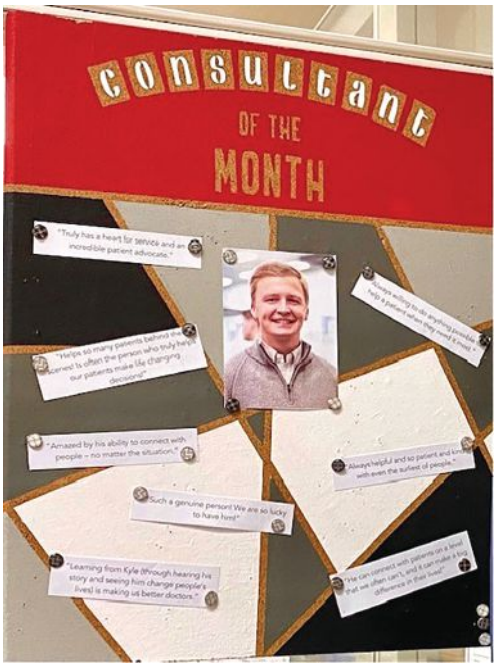
In 2019, I was hired by the University of Arkansas for Medical Sciences (UAMS) as the first PRS to be employed and stationed in an emergency department. This new program would demonstrate the power and effectiveness of a physician and PRS collaboratively working together to accomplish a common goal – saving lives. When an individual would present to the emergency department or hospital for an overdose, withdrawal symptoms, or any other medical condition associated with alcohol or drug use they would be directly connected with a PRS who could relate to what they were going through and also provide treatment and recovery resources right there from the hospital bedside. While the physicians and other medical professionals worked to medically stabilize and treat the person, the PRS would meet the person right where they were and begin providing person-centered peer support services. The services vary based upon the individual's needs. It could be as simple as an encouraging conversation and the exchanging of contact information. Or facilitating the intake and referral process to a detox or inpatient treatment program. Since a PRS is in recovery themselves, they are naturally well connected to the treatment and recovery community. These relationships, coupled with their experience of personally navigating the system, enables the PRS to expedite the process of getting connected to appropriate resources.

In the first year of the program, a team of two peer specialists worked with over 500 people. Directly linking 105 to treatment, referring another 112 to treatment, and distributing over 380 doses of Naloxone, the life-saving medication that reverses the effects of opioids. This program directly impacted the patients, hospital staff, and the community. UAMS is a teaching hospital, so I was given the opportunity to build relationships with many amazing residents, attendings, social workers, and registered nurses. By working alongside a person in recovery, hearing my story, and witnessing firsthand the spark of hope that is ignited through peer support, perceptions were shifted, and the system of care was strengthened. **One resident shared this message with me before they completed their residency –** ***"I have to say (mainly because I don't want to forget before I finish residency) knowing you and seeing the incredible things you have done with your life taught me an incredible amount and will change the way I practice for the rest of my career. I can honestly say I was a little closed minded about addiction and didn't put much thought into what I might be able to do for someone that might change their situation. Hearing your story and knowing you has given me a completely different outlook! And all that might sound a bit cheesy, but I am extremely grateful!"***

Consultant of the Month Award

The PRS position made such an impact in the UAMS emergency department that I was awarded the "Consultant of the Month". This is an award that is nominated and voted on by the emergency department residency program**.** A doctor and a PRS on the same team are a dynamic duo that can really make a difference in the lives of the people they serve. The UAMS program led to the birth and development of peer programs in several hospitals across the state, including Bradley County Medical Center, Jefferson Regional Medical Center, Unity Health – Harris Medical Center, and Saline Memorial Hospital.

Where there's a doctor and a medical practice, there will be patients, which means there will inevitably be someone who is either directly struggling with addiction or has a family member who is struggling with addiction. Therefore, there should also be a PRS who is either paired with the physician or available for them to refer out to in the community. If you are a medication-assisted treatment (MAT) waivered provider who is currently or plans to prescribe



Buprenorphine for opioid use disorder it is so important that you connect your patient with recovery services. **The medication is very important but it's only one piece of the equation and will only address one aspect of the problem. Recovery will address the remaining pieces of the equation and equip your patients with the tools and skills needed to live a self-directed life of recovery.** Even if you are not a MAT waivered provider or ever plan to become one you will certainly provide care to someone who can benefit from recovery support services. Providing access to this support will enhance your practice, strengthen the continuum of care, and provide positive outcomes for your patients.

Since 2018, the State of Arkansas has provided core peer recovery training to over 430 people. We currently have over 170 people who are either registered as a Peer in Training (PIT) or certified at one of the three levels of the program (PR, APR, PRPS). There is an army of peers that have been formally trained, certified, and refined by the fire of their personal experience, who are ready and willing to provide vital recovery support to your patients. To find a PRS in your community visit the Arkansas Opioid Response Dashboard at www.artakeback.org. The interactive map under the peer recovery tab will display who has been trained and certified in your community as well as provide contact information for the individuals who are currently registered and/or certified in the Arkansas Peer Specialist Program. If you know someone with two years of recovery from a substance use and/or a mental health disorder, who would like to learn more about the Arkansas Peer Specialist Program, including eligibility requirements and details about the application process, please visit www.naadac.org/arkansas-peer-specialist-program or contact me at kbrewer@naadac.org.

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Faihza M. Hill MD, MPH, MS
Arkansas AFP Resident Director

A Call to Combat Maternal Mortality Rates

Inarguably, the maternal morbidity and mortality rates amongst pregnant women, especially minority women in the United States (US) are too high. According to the Center for Disease Control (CDC), 60% of pregnancy related deaths are preventable and 33% occur between one week and one year after delivery.

Three common methods for measuring maternal death [xii]:

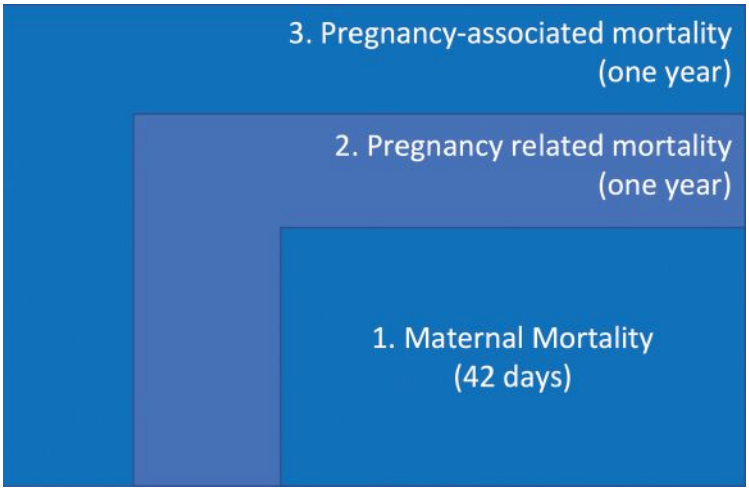

Image 1: Types of Maternal Mortality
Adopted from Commonwealth Fund, Dec. 2020xii

1. Maternal mortality: death during or related to pregnancy up to 42 days postpartum
2. Pregnancy-related mortality: death during or related to pregnancy up to one year postpartum (based on pregnancy complication)
3. Pregnancy-associated mortality: death during pregnancy or up to one year postpartum regardless of underlying cause

Clinical practitioners, epidemiologists, and public health experts alike have been brainstorming on different ways to translate these data into actionable items by creating multilevel interventions. Following private and Medicaid expansion, two safety bundle initiatives (National Network of Perinatal Quality Collaboratives and the Alliance for Innovation on Maternal Health) were established to heighten federal, state, and hospital level accountability.[xiii] As a result, policies for clinical decision trees aimed to standardize care. Targeting hemorrhage management, a leading cause of pregnancy related death, is one example. Since its implementation, there has been a significant decrease in deaths related to hemorrhage in highly populated urban areas. Unfortunately, there is not sufficient data to show a documented change in maternal mortality rates in smaller urban or rural US areas from 2000-2018, which suggests these places require closer surveillance and additional methods of intervention. Generalized policies, though necessary, alone are not always effective in all environments. Region specific guidelines are crucial.

Beyond geographical differences, there are also disparities identified between races. The CDC attributes health inequities to poverty, unequal access, lack of education, stigma, and racism. This implies removing any one of the beforementioned variables should result in better overall outcomes. Therefore, increased education is expected to parallel with a decrease in pregnancy related mortality ratios. In a study by Petersen EE et al, data controlled for education and stratified across different ethnicities showed only a significant improvement in outcomes for non-Hispanic white women making education a protective factor for this group alone. This alludes to the idea that the issue is multifactorial, complex, and needs attack from different angles.

Within the last six months, the American Academy of Family Physicians (AAFP) has published two press releases highlighting the instrumental role primary care providers play in combatting this crisis:

(a) Together with the American College of Obstetrics and Gynecology (ACOG), a joint statement calling family physicians to have a more collaborative relationship with obstetricians and midwives was made to ensure the availability of higher quality services for all women regardless of geographical region or ethnicity.

(b) The AAFP stands in solidarity with ACOG and the Federal Administration's call to permanently extend postpartum Medicaid coverage from 60 days to 12 months in the Build Back Better (BBB) Act. The BBB act will remove the need for each state to apply for a waiver to prevent pregnancy-associated mortality.

Until final decisions are made on the BBB Act, the American Rescue Plan Act is effective April 1, 2022. This law is a state plan amendment which allows each state to apply for a waiver. The waiver allows comprehensive coverage for women 12 months postpartum. This removes some barriers to care and can potentially reduce the number of preventable deaths. Because of cumbersome requirements, only five states (New Jersey, Virginia, Georgia, Illinois, Missouri) have legislative waivers approved and two (Florida, Massachusetts) have waivers pending. Not every state can financially afford to allocate these funds in their budgets, hence the need for federal assistance.

Though these funds allow national monitoring up to one year postpartum, they are not intended to overshadow the need for surveillance across the continuum of a woman's reproductive years. Family-oriented and patient centered relationships are at the core of Family medicine training; are often established in childhood. Such relationships can make it easier to begin conversations with girls as they transition into their reproductive years. Family physicians (FP), therefore, have a unique opportunity to help improve outcomes in the smaller urban and rural areas by creating another layer of protection. FPs can act as safety nets within the community, especially amongst a cluster of rural states in the south (Alabama, Arkansas, Kentucky, and Oklahoma) where a woman's chance of pregnancy associated mortality is twice as high as other states.

Increased provider access and streamlined information can improve women's health overall. When likeminded providers within AAFP and ACOG collectively develop actionable policies, advocacy efforts, and educational material, sustainable change is on the horizon.

Increased provider access and streamlined information can improve women's health overall. When likeminded providers within AAFP and ACOG collectively develop actionable policies, advocacy efforts, and educational material, sustainable change is on the horizon. Obstetrics does not have to be at the epicenter of a family medicine provider's practice to bridge the gaps and have an impact. All providers are called to use a more collaborative approach to women's health. This will enhance education, prevention, family planning, pregnancy, and postpartum care to ultimately decrease mortality.

By Chad T. Rodgers, MD, FAAP,
Chief Medical Officer, AFMC; Partner and
Pediatrician, Little Rock Pediatric Clinic

Painkillers and Children

Children many times have accidents or conditions that require surgery. Sometimes it is a broken bone that needs repair, but sadly, other times, they need, more in-depth procedures to heal. Those procedures can be painful during and after surgery, and doctors are working to make sure that pain is addressed safely and effectively.

The Opioid crisis has had a tremendous impact on the lives of children and their families. As a nation, we have witnessed the powerful impact of addiction. The story is all too familiar. A friend going in for a simple procedure prescribed a "pain killer" and then become dependent on that medication. In some cases that person turns to other drugs like heroin when they are no longer able to get pain medication prescriptions. This happens to teens and adults alike. When it comes to your child, balancing that fear with not wanting your child to be in pain is challenging.

For more than two decades, the American Academy of Pediatrics has recommended against routine use of opioids in children, except for very painful procedures such as a tonsillectomy, bad fractures, or severe injuries. Even then, pain medications should be prescribed in very limited amounts. In the last few years the Food and Drug Administration (FDA) formally recommend against opioid use in children. Some of the commonly used opioids include Tylenol with Codeine for pain control after surgery, Oxycontin for pain crisis related to Sickle Cell Disease, and Phenergan with Codeine for cough. Over the last few years, we have seen efforts to reduce the use of these and other opioids while increasing the use of alternative pain-relieving medications and treatments (i.e., over-the-counter medications, physical therapy, etc.).

Pain is a very real thing. We all have varying degrees of pain we can tolerate. There may be times that a short course of opioids is needed for

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Arkansas Good Medicine℠

Announcing the Arkansas Good Medicine Fellowship

A 12-week study program with a nine-month program development to make an impact on your community through an health care transformation project.

Program goals:

- Enhance leadership skills
- Improve understanding of how social factors affect health
- Disseminate strategies to implement trauma-informed care
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- Improve quality

Curriculum includes learning modules, case studies, assigned readings and discussions. The training will identify best practices for trauma-informed care for adverse childhood experiences (ACEs), opioid abuse, mental health care and childhood obesity. This online program welcomes health care providers from all fifty states to apply.

Benefits:

- Receive a **$1,200/mo stipend** for the year-long program
- Gain knowledge through the program curriculum
- Make a positive impact on your community
- Providers continue to practice while incorporating time to participate in the fellowship program into their practice

Applicants must meet the following minimum requirements:

- Practicing two years as a MD, DO or PA
- Practice in the field of internal medicine, family medicine, general practice or pediatrics
- Medical license in good standing

Deadline to apply: **January 28, 2022** | Apply online: **info.afmc.org/agm**

Questions? **ARgoodmedicine@afmc.org**

ARKANSAS GOOD MEDICINE IS A COLLABORATIVE WORK OF THE ARKANSAS FOUNDATION OF MEDICAL CARE (AFMC), THE ARKANSAS COLLEGE OF OSTEOPATHIC MEDICINE (ARCOM) AND ARcare, A FEDERALLY QUALIFIED HEALTH CENTER. THE FELLOWSHIP IS GRANT FUNDED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' HEALTH RESOURCES AND SERVICES ADMINISTRATION.

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severe pain. We have shifted from a thought of "pain-free to what pain can you tolerate. Many times, common medications such as Acetaminophen (Tylenol) and Ibuprofen (Advil/ Motrin) may provide the relief needed to tolerate pain. Sometimes simple treatments like using ice and/or heat may be helpful in relieving pain.

Addiction is the biggest concern when using Opioids. There are other undesirable side-effects such as sedation and constipation. At higher doses, your ability to breathe can be impacted, even the potential of death. Naloxone is a commonly prescribed medication that reverses the side effects of opioids and has the potential to save lives. You should always ask your physician or pharmacist about its use if you are prescribed opioids.

When getting a prescription for anyone in your family, it is a good idea to ask two questions: What kind of medication was prescribed, and how will it interact with other prescriptions being taken? Never be afraid to ask if that medication is an opioid.

If you or your child are prescribed opioids, it is very important to store these medications appropriately. If someone in your household has a history of addiction, you may want to find a way to secure the medication that only you can access. You always want to make sure medications are out of reach to children by placing them in high locations or preferably, locked cabinets.

Other prescriptions commonly prescribed are benzodiazepines such as Valium, Xanax, or Clonazepam, etc. for anxiety. These prescriptions should be cautiously used with opioids. As other medications, they should be secured.

When getting a prescription for anyone in your family, it is a good idea to ask two questions: What kind of medication was prescribed, and how will it interact with other prescriptions being taken? Never be afraid to ask if that medication is an opioid. A discussion with a trusted health care provider about the medicine and its use is a beneficial way to prevent medical complications and future addiction.

Practice Opportunity:

Established family practice located in Benton, AR is looking to replace a retiring physician. The practice is privately owned by the current eight physicians. It is a clinic based practice with 1 in 7 call and no hospital call. Close working relationship with Saline Memorial Hospital.

Competitive salary with no buy in.

Please contact office manager, Courtney Salmon at (501)778-0934 or Dr. Evelyn Cathcart at cell number (501)944-1179 or email evelyn.cathcart @yahoo.com.

45 is the new FIT-ty!

The recommended age to begin colorectal cancer screening is now 45, and one of the easier ways to screen is with the stool-based, at-home FIT test. Order one for your patients turning 45 with an average risk for colorectal cancer and help reduce the late-stage diagnosis of colorectal cancer in Arkansas.

Learn more about colorectal cancer screening at the UAMS Virtual Family Medicine Spring Review April 26 – 29, 2022!
Go to cme.uams.edu for details.

UAMS.Info/PiCSAR!

UAMS College of Medicine

PiCS AR! Partnerships in Colorectal Cancer Screening For Arkansas

F.I.T. Just takes a BIT

A Medical Student's Perspective of Early COVID-19 Response at Homeless Shelters

Samuel Eric Byrd, Sharada Sarah Adolph, MD, DrPH, Bala Simon, MD, DrPH, FAAFP

My name is Samuel Eric Byrd. I am native to central Arkansas having grown up in Malvern, Arkansas. After attending Hendrix College in Conway, I was drawn to a career in medicine because I wanted to be able to heal those who needed healing. In my first year at UAMS College of Medicine I elected to do research in infectious disease but decided to pivot on COVID-19 when news of the pandemic struck. Having never experienced anything like this, I knew that most people would struggle with adapting to slow the spread. I reached out to the Arkansas Department of Health, who was at the helm of addressing the COVID-19 pandemic in Arkansas. With their guidance, we focused our project on shelters housing underrepresented homeless population to assess their response and needs during the early days of the pandemic.

Introduction

Late in 2019, the world observed a new virus, severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) make rapid inroads into every country including the United States (US), causing a highly invasive, human-to-human transmissible, ongoing pandemic.[1] Coronavirus disease 2019 (COVID-19), the resulting infection primarily invades the lungs and causes acute respiratory compromise and other multi-organ dysfunction.[2,3] At the time of this writing, the global magnitude of COVID-19 was evidenced at 115.4 million confirmed COVID-19 cases and 2.6 million related deaths.[4] US-attributable COVID-19 cases were 28.8 million (24.9%) and deaths were 518,758 (20.2%) of the global burden, respectively.[4] Arkansas saw its first case of COVID-19 on March 11, 2020, and saw 323,353 COVID-19 cases and 5,261 attributable deaths during the first wave of the pandemic.[5] COVID-19 has not spared any demographic or social sector, and disease transmission is noted to be highest in confined congregate settings with shared air spaces, such as nursing homes, correctional settings, and homeless shelters. The Arkansas Department of Health's (ADH) pandemic response guidance and technical assistance extended to all these settings where the risk of COVID-19 outbreaks is particularly high. Homeless shelters were among the first locations to be targeted by the ADH for dissemination of COVID-19 guidance and phased viral testing, since they house highly mobile populations who can contribute to community spread of disease.[6,7,8] Chronic diseases and mental illnesses among the homeless additionally increases the vulnerability of this group of people to SARS-Cov-2 infection and its complications, particularly hospitalization and death.[8,9,10] At the height of the pandemic in June 2020, as a first-year medical student at the University of Arkansas for Medical Sciences (UAMS) College of Medicine, I partnered with the ADH to study how homeless shelters responded to prevent and control infection during the first wave of COVID-19 as they provided essential services to most vulnerable homeless populations in Arkansas.

Our Approach

We contacted directors at 96 homeless shelters listed in Arkansas's Homeless Shelters Directory through telephone calls and emails. Most shelters did not respond to our outreach efforts either due to closure or partial operations because of the pandemic. We gained consent for telephone interviews from directors at four shelters who continued to provide services during this time and conducted in-depth, semi-structured interviews with these informants to capture pandemic-related experiences at their respective shelters. Two of these shelters were independent facilities, one of which was long-term (Shelter A) and the other intermediate (Shelter B) located in the central and northeastern regions of the state, respectively. The other two shelters (Shelters C and D) were organizationally managed, transitional facilities located in the northwest region of the state. At the time of this report, the four shelters were at 64.8% occupancy and collectively housed a total of 92 homeless persons and served meals to an additional 80 non-resident homeless visitors. Most shelter residents (88.0%) were over 18 years of age and children less than age 18 years made up the remaining 12.0%. Male shelter residents at 57.6% exceeded female shelter residents at 42.4%. This population was predominantly White at 79.3%, followed by African Americans at 14.1%, Hispanics at 3.3%, and the remainder were other minorities.

Lessons Learned

We identified several facilitators and barriers for COVID-19 response through qualitative, thematic analysis of interviews. Verbatim observations are shown in Tables 1 and 2. Facilitators included: *Planning for prevention*. These shelter directors determined to keep their doors open during the pandemic and quickly planned to continue much needed services for homeless persons. *Timely communication*. Shelters received communication from different sources, either from headquarters for organization-based facilities, or from state agencies, community members, other shelters, and the Arkansas Homeless Shelter Coalition. *COVID-19 guidance-based reorganization*. Reorganization of shelter facilities included spacing, the use of barriers between beds, head-to-toe sleeping arrangements, and isolation or quarantine provisions where feasible. *Implementation of COVID-19 response procedures*. Shelter staff began assessing their residents for fever and other COVID-19 symptoms. Staff ensured the use of gloves and masks, and masks were offered to residents. Handwashing was strongly encouraged with the addition of handwashing stations. Hand sanitizers were widely available. These facilities were increasingly sanitized to prevent the spread of disease. *Availability of resources*. Most resources, such as cleaning supplies, gloves, and masks were made available to shelters through their headquarters, or community partners, and UAMS. *COVID-19 education for staff and residents*. Shelter directors educated their staff and residents about COVID-19 through the display of relevant print media, meetings, and one-on-one conversations to help them understand the importance of maintaining prevention guidance. *COVID-19 vaccine acceptance*. Responses to COVID-19 vaccine acceptance were mixed. Some shelter directors felt the COVID-19 vaccine would be accepted based on their experiences for flu vaccine uptake among shelter residents. Barriers included: *Scale of the pandemic*. One shelter director in particular expressed concern over the overwhelming nature of the pandemic and uncertainty about how to proceed. *Infrastructure and resource challenges*. The biggest concern was not having space to isolate or quarantine an individual who tests positive for COVID-19. One shelter

Table 1. Facilitators for Coronavirus Disease 2019 (COVID-19) Response at Arkansas's Homeless Shelters During the First Wave of the Pandemic

Facilitators	Verbatim Observations
Planning for Prevention	"Our main concern at that time was to keep the residents that we have safe and healthy as well as our staff. That was our top priority." Shelter B "When we knew how bad it was, even before it had hit Arkansas, we knew that we needed to get ready because it was coming. We didn't panic, but we were being careful. We sat down and thought about what we need to change." Shelter A
Timely Communication	"We received information from different places, the Homeless Coalition, from the Department of Human Services we've been getting emails, from the CDC website, from the Department of Health website." Shelter B "We have a weekly call with Dr. B from the state health department, and he has been very beneficial in helping us understand. He speaks to a group of us every Thursday about the continuum of care." Shelter A "We got so much information from our headquarters, so we were given guidelines, like I said, hanging the sheets between the beds, cleaning techniques 2 or 3 times a day. Along with everything that they sent us, a lot of that information they said came strictly from the CDC, you know they were following those guidelines." Shelter D
COVID-19 Guidance-based Reorganization	"We had to really rearrange our whole way of doing things." Shelter B "We had some dividers that were kind of like wooden and on wheels. Kind of like what you would seeing a church gym. We had them setup so that we could divide some of them into family rooms." Shelter C "We have done the head-to-toe arrangement. We've always had hand sanitizer. Having an outdoor hand washing station like our mailman uses it every day when he comes. We have increased sanitizing the facility because of COVID. Obviously, we've always had some level of that." Shelter A
Implementation of COVID-19 Response Procedures	"We've got a COVID-19 screening questionnaire. Everyone who comes in has gotten in the habit of just automatically taking their temperature every day. Cleaning times 10 happened after COVID came around. We had a handwashing station installed on our property." Shelter D "Our big thing was the cleaning and sanitizing and getting new linens every single day. We made sure everyone (staff) was wearing gloves and masks and sprayed a lot of disinfectants and wiped down everything well." Shelter C "We are at the point that we are going to start making the warning of wearing the mask more official because the numbers in Arkansas have gone so high. You know, this is serious. All the residents are supposed to be down at 8:30 am to go through the list of questions and get their temperature checked." Shelter A
Availability of Resources	"We haven't even considered the idea of limiting our number of residents. If we have room for somebody, we're going to help them. Well, we were provided with, again from headquarters, masks to wear at all times, gloves, all the extra cleaning supplies." Shelter D "We didn't know what to expect but we were prepared. We've had tremendous outpouring of UAMS (University of Arkansas for Medical Sciences) and different places that have sent us sanitizer and masks and the things that we needed so that helped out a lot." Shelter B
COVID-19 Education for Staff and Residents	"Well, we posted a lot of material in our shelter and diner. Basically, just tried to engage people in conversation and lower the hysteria or the concern." Shelter C "We get a lot of new information sent to us. So, we post anything we are able to in our shelter, on the bulletin board, etc. We also have regular meetings to keep everyone updated on what's going on." Shelter D
COVID-19 Vaccine Acceptance	"Most of our guests take the flu vaccine. Now for the COVID vaccine I assume everyone would want one." Shelter D "Absolutely! I would not see any reason why we wouldn't." Shelter C

Table 2. Barriers to Coronavirus Disease 2019 (COVID-19) Response at Arkansas's Homeless Shelters During the First Wave of the Pandemic

Barriers	Verbatim Observations
Scale of the Pandemic	"In the winter, it's pretty bad with the cold and flu. With the coronavirus it would be a much, much bigger problem. Kind of uncertainty in how it would affect the people we serve. We really weren't sure because as it came along, and it got worse. We were like, "Oh boy! where do we go from now?"" Shelter C
Infrastructure and Resource Challenges	"I don't have the space for COVID if we did get an outbreak here, I don't have the space to quarantine everybody. I do the best I can when we have an outbreak of the flu. I try to quarantine them, and I try to take food to them, not let them come in the dining room and so forth." Shelter B "Having to quarantine is our main concern, if one of our guests tests positive, we'd have to close the entire shelter to quarantine for 14 days." Shelter D "Getting sanitizer was hard honestly. You still can't go out and buy Clorox wipes. It took longer to get the thermometer. I was pretty frustrated it took 3 or 4 weeks to get thermometers. I saw lots of people and businesses on my Facebook saying, "Where can I find a thermometer?" Our personal pharmacist is like, "We can't get them; they're out."" Shelter A
Shelter Residents' Non-Adherence to COVID-19 Safety Measures	"Basically, the two camps are, "Omg this is crazy, I'm going to get away from crowds," and then the other group thinks that it's something the government invented to try to control. We've had a hard time with that group, getting them to social distance, getting them to comply. We had masks available, with consensus we couldn't make them wear them. Like I said, the two homeless camps, the ideologies, and opinions, either people were asking us for them, they had their own, or they would not wear them." Shelter C "It's just hard in a shelter situation to follow those guidelines. They're out in the community in the morning, and of course they're being told to social distance but everywhere you go they're clumped together, not following those guidelines." Shelter D "We're not wearing masks unless..., so we're looking at us as a family here. We are not masked around each other, but when we are around other people we are." Shelter B "I think getting our residents to understand the importance of social distancing and masks. I think that's very hard for them." Shelter A
Reorganization Challenges	"Most often the social distancing, we really, really, really want it to be in place. We really want people to be further apart, but we're dealing with limited space." Shelter D "Like with our meal, people line up outside. We put cones out there and told everybody to stay six feet apart, but they bunched up over there while they were waiting. So, it was much like pulling teeth to get people to social distance." Shelter C
COVID-19 Vaccine Hesitancy	"It's probably 50/50. I don't know about when the COVID vaccination comes, I don't know if we will enforce that." Shelter A "Ooh! You're hitting on a controversial subject, now, aren't you?! Yeah, I would make it known to them of course, you know the pros and cons of it, and they could make their own decisions." Shelter B

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had difficulty obtaining sanitizers and thermometers. *Shelter residents' non-adherence to COVID-19 safety measures*. Shelter staff often found it difficult to convince shelter residents to follow recommended guidance for social distancing and wearing masks. *Reorganization challenges*. Shelters found social distancing the most difficult to maintain due to lack of space. One reorganization change was to move meal services outdoors, but those efforts were often impeded by a lack of social distancing. *COVID-19 vaccine hesitancy*. Two shelter directors were unsure about whether their residents would accept the vaccine.

Learning through experience. One shelter director aptly summarized their shelter's experience during the COVID-19 pandemic by stating, "Educational! There is no doubt about it. We've learned a lot about viruses and things, hopefully we've learned a lot, and we've put it into practice. It's been a wakeup call for sure!" *Sustaining recommended guidance procedures*. There is an understanding of the need to continue pandemic mitigation efforts at homeless shelters as noted by another shelter provider, "Well, I think the changes that we've made now as far as cleaning and hand sanitizers being a requirement. I think that's just going to become the norm, it already has here. Even with the vaccine, I don't see that changing." *Addressing barriers*. Another provider indicated the need to address barriers during the current crisis and in the event of similar, future public health crises by remarking, "After it's over, I think we need to step back and look at what we did that worked and what we could do better because we may have another one. It's always good to have a wrap up afterwards."

We gained reasonable insight into experiences at regionally varied local shelters for handling COVID-19 during the first wave of the pandemic. The rapidly evolving COVID-19 pandemic resulted in different levels of response at these homeless shelters. Shelter directors viewed COVID-19 as a major hurdle to the delivery of necessary services but relied on public health guidance and resourcefully adapted their settings to prepare for the disease out of safety concerns for their staff and service recipients. Mitigation measures at shelters included several components of recommended guidance for pandemic response while they continued to provide essential services. Limited facility space was a challenge for physical distancing, quarantine, and isolation and led to versatile spacing solutions. The reluctance to wear masks and maintain physical distance among the homeless is not unremarkably different from behaviors seen among the general population. Shelters engaged in education and reiteration of COVID-19 prevention messages, which are important modifying factors for disease transmission. Although increased emphasis is being placed on the critical roles of SARS-Cov-2 testing and immunization, infection control measures employed at homeless shelters are equally important components of multimodal approaches for containing the COVID-19 pandemic.[12,13]

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In Conclusion

As a medical student going through a pandemic with disruption in classes and learning about pandemic response to the most vulnerable homeless population was an eye-opening experience. During our work, we reiterated the importance of following recommended public health guidance for shelter service providers and encouraged SARS-Cov-2 testing and COVID-19 vaccination when available. The ADH began simultaneous, phased rollout of SARS-Cov-2 testing at homeless shelters across the state and opened a COVID-19 quarantine and isolation facility [14] specifically for homeless persons, testing and vaccination efforts through the 'Operation Compassion' program.[15, 16] The ADH communicates with homeless shelter service providers on a weekly basis to provide updates on the COVID-19 situation, screening efforts at shelters, utilization of the ADH COVID-19 quarantine and isolation facility to assist with quarantine and isolation needs of infected persons, and planning for immunization to achieve herd immunity. Creating access to universal immunization is viewed as a long-term solution to curb the catastrophic proportions of COVID-19, particularly for socially marginalized, vulnerable populations. The ADH is currently working with UAMS and several healthcare entities across Arkansas to increase access to COVID-19 vaccines for all populations including the homeless.

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