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The Arkansas Family Physician

Volume 24 • Number 3 • Winter 2021

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The Arkansas Family Physician

The Arkansas Family Physician is the official magazine of the Arkansas Academy of Family Physicians

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Executive Director

Michelle Hegwood

Correspondence, articles or inquiries should be directed to:
ArAFP
P. O. Box 242404,
Little Rock, Ar
72223-9998
Phone: 501-223-2272
Fax: 501-223-2280
Email: arafp@sbcglobal.net

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PCI Publishing Concepts, Inc.

Created by Publishing Concepts, Inc.

Virginia Robertson, Publisher
vrobertson@pcipublishing.com

David Brown, President
dbrown@pcipublishing.com

Appathurai Balamurugan, MD, DrPH, DipABOM, FAAFP

President's Message

Appathurai Balamurugan, MD, DrPH, DipABOM, FAAFP (aka, Dr. Bala), President

We are the Champions, my friends!

As the Queen song goes, "We are the Champions, my friends, and we'll keep on fighting 'til the end…" More than any time in the past, we owe our service to our patients at this time. Our patients and their families are dealing with several uncertainties like we are. With the COVID-19 pandemic still looming, and with no clear end at sight, we have a moral imperative as leaders to deliver our duty to our patients and their families. We swore on a Hippocratic oath to uphold the values, "faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time". Humans have faced pandemics throughout centuries, and physicians have emerged as champions to protect and promote the health of mankind. "The Plague", a Nobel Prize-winning novel describes the life of Dr. Bernard Rieux, a general practitioner, a well-known physician during the time of plague visited homes to ascertain if individuals have been affected by the bubonic plague. Once he confirmed, he would move them to a quarantine hospital and those who had been in contact with the affected individual could not leave the home and had to quarantine at their home. It is the courage and commitment to the patients that helped Dr. Rieux and his fellow physicians to triumph over the plague during those challenging times.

The Spanish flu pandemic of 1918 presented a similar dire challenge to our patients and to us. Dr. Thomas Tuttle, then Washington's health commissioner, advocated fiercely for face masks and social distancing to slow the spread of the pandemic to the point that he was fired from his job, though his actions contributed to slowing the spread. During the tuberculosis epidemic of 1940's, an estimated 10% or more of physicians and trainees would go on to develop tuberculosis. These individuals did not shrug away their duty to treat those afflicted with the deadly disease.

During the HIV epidemic, while there were a few physicians who refused to treat HIV patients based on invidious bias, most forged ahead in treating patients and took their call for the duty to the heart, as healers. The American Medical Association's code of 1847 calls for physicians to be duty-bound to provide care during epidemics even at the jeopardy of their own lives. During the Spanish flu of 1918, there were no vaccines or antiviral drugs. The risk to physicians own lives was much higher. Advances in medicine with personal protective equipment, antiseptic precautions, and therapeutics have decreased the risk substantially. The SARS death rate for physicians was substantially lower than the Spanish flu. Physicians have always put their lives on the line, not just being duty-bound, but rising to the occasion to champion for patients, families, and their community.

Over the years, we have faced similar epidemics or outbreaks such as Ebola, H1N1, e-cigarette and vaping associated lung injury (EVALI), though may be on a smaller scale. However, history repeats itself, fast forward to 2020, our country and the world is being plagued with a pandemic. The Centers for Disease Control and Prevention estimates that health care workers accounted for 11% to 16% of Covid-19 infections during the early months of the pandemic. While therapeutics and vaccine development news offers some optimism, it is important to realize that we are in a marathon, not a sprint. It is time as physicians of this generation to rise up, renew our Hippocratic Oath, and champion our fight against COVID-19 for our patients and our families!!

Mary Beth Rogers, ArAFP Executive Director

Executive Director's Letter

Mary Beth Rogers

2020 is not even over yet and the year has already become synonymous with bad luck and unpredictable calamity. So far there have been wildfires, protests, riots, murder hornets, double hurricanes and the pandemic triggered a toilet paper shortage and stock market crash. History may remember all these bizarre experiences but what kept the world going was you.

We are here to support you and hope that you will continue to be a vital part of the Arkansas Academy of Family Physicians. We are here to assist you with any membership questions, CME reporting and resources you may need. We have the first version of the new website to update and we are working to make that an indispensable tool for our members.

Innovation is the name of the game and the method we will have to use to communicate and engage will include a virtual component for some time. We have created a free avenue for you to receive CME credit by attending our First Friday CME event held the first Friday of every month at noon. The presentations will be focused on topics relevant to Arkansas Family Physicians. We are honored to have received some chapter engagement grant money from the AAFP Foundation to support this effort. Watch your email and social media for more resources and collaborations coming soon!

While virtual is not going away, neither are our legislative issues. I've said it before and I'll say it again, the real work begins far before the legislative session convenes. The good news is that it's easier than ever to make a connection with our legislators. Don't leave this up to someone else to do because we need everyone's voice to be heard. These issues will affect the future of family medicine and we have an obligation to answer this call. See page 26 for your homework!

With another wave of COVID-19 hitting our state just in time for the holidays, we may have to get creative and host virtual holiday gatherings with our extended family and friends. There's one thing I know you can do and that is improvise. Take this chance to make new traditions and memories with your family. I hope that when you look back on this year you will see how you faced a pandemic head-on, adapted to telemedicine, re-invented your practice, continued working to eliminate health disparities all the while you had to scour the market for PPE's. You pitched in and worked in ER's, long-term care facilities, community health centers and COVID-19 testing stations, proving just how versatile, adaptable and indispensable Family Physicians are to all of us.

You, the Family Physician, the foundation of the healthcare system, took charge and made it happen. You are the reason all Family Physicians are recognized as Family Physician of the Year. As our new AAFP President Ada Stewart, M.D. told virtual FMX attendees that is was time for family medicine to take "it's rightful place as the foundation of a high-quality health care system." We have no doubt that you will because you will make 2020 remember you as the ones who made a difference. 2020 is the year that hero's wore stethoscopes and healed the world as you turned adversity into healing. 2020 still has a few months to go and we hope it doesn't have a grand finale but if does, we know who our hero's will be.

Best wishes for Happy Holidays & New Memories!
Mary Beth Rogers
Executive Director

NEW FROM CDC

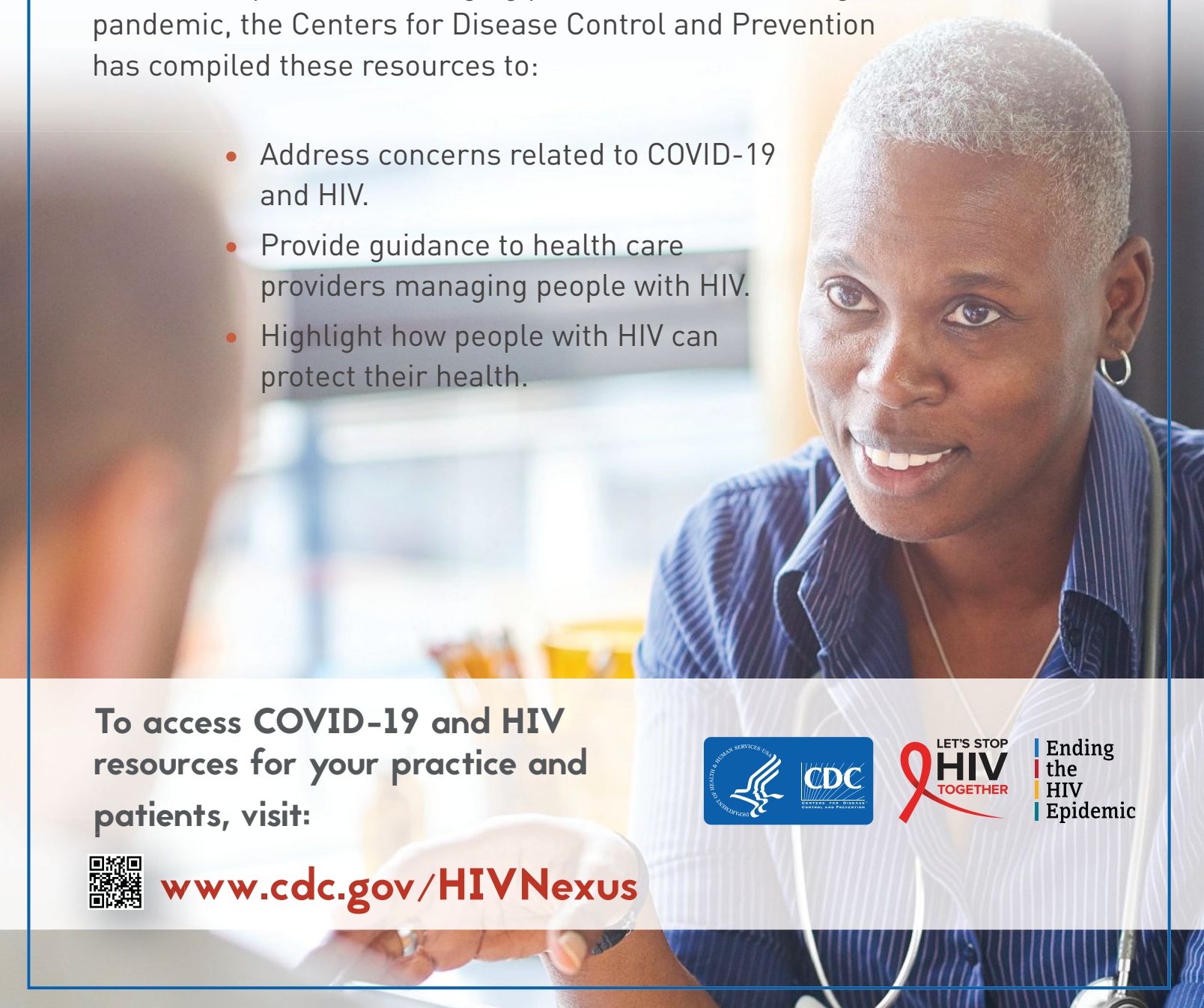
HIV NEXUS

CDC RESOURCES FOR CLINICIANS

HIV Nexus offers a comprehensive collection of key federal resources on COVID-19 and HIV.

More than half of HIV clinicians are primary care providers. To support health care providers managing patients with HIV during the COVID-19 pandemic, the Centers for Disease Control and Prevention has compiled these resources to:

- Address concerns related to COVID-19 and HIV.
- Provide guidance to health care providers managing people with HIV.
- Highlight how people with HIV can protect their health.



To access COVID-19 and HIV resources for your practice and patients, visit:

www.cdc.gov/HIVNexus

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Medication-Assisted Treatment in Arkansas

Arkansas Act 964 of 2019 allows for access to medications for Arkansas Medicaid eligible beneficiaries diagnosed with opioid use disorder (OUD). The act requires all health insurers and Arkansas Medicaid to remove prior authorizations to FDA-approved medications that support recovery. The act states there shall be no other requirement other than a valid prescription and compliance with the medication-assisted treatment (MAT) guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA).

SAMHSA defines MAT as the use of medications, in combination with counseling and behavioral therapies, for the treatment of substance use disorders. Not only is this combination of therapies effective in the treatment, they can help sustain recovery. Primarily, MAT is used to treat opioid addiction which includes pain medications containing opiates. The Centers for Disease Control and Prevention defines opioid addiction, or OUD, when an attempt to control the use is unsuccessful or when use results in social problems and failure to fulfill obligations at work, school and home. This disorder usually occurs after the person has developed opioid tolerance and dependence. According to SAMHSA, these medications (buprenorphine, methadone and naltrexone) normalize the body without the negative effects of the substance. They operate to normalize brain chemistry and block the euphoric effects of opioids while relieving the physiological cravings.

The latest data from the National Institue on Drug Abuse shows that in 2018, Arkansas deaths related to opioids grew to over 46,000, which is nearly 70% of all overdose deaths, and those deaths involving synthetic opioids (other than methadone) continued to rise with more than 28,000 overdose deaths. The Arkansas Department of Human Services and the Division of Medicaid Services adopted the state plan amendment to meet the requirements of Act 964 and to help in the fight of opioid addiction.

Effective September 1, 2020, many of the barriers that once prevented beneficiaries from seeking treatment and providers providing treatment have been removed. Arkansas Medicaid began supporting beneficiaries with OUD when provided by an X-DEA waivered provider. Physicians, nurse practitioners and physician assistants are eligible to receive an X-DEA identification number as long as they have a current Arkansas medical license and a current DEA identification number. To bill for these services with Medicaid, they must also be an Arkansas Medicaid provider and update their MAT designation with Medicaid Provider Enrollment. These designated MAT providers can prescribe medications required for the treatment of OUD for Arkansas Medicaid beneficiaries.

MAT training courses for providers to receive the X-DEA identification number are provided through the Providers Clinical Support System website - www.pcssnow.org. The one-time course is free of charge and will provide the necessary MAT waiver training, as well as explain how to submit the notification of intent and certificates upon completion to SAMHSA.

The Arkansas Medicaid MAT program will assist those with OUD by eliminating barriers and treating the "whole person." The updates to the Medicaid program ensure comprehensive services are being offered. Some of the updates when providing MAT services include:

- Primary Care Physician referral is not required as long as the services are rendered by an X-DEA waivered provider
- The Medicaid service limit of 12 physician visits per year is waived
- The $500 lab/x-ray limit is waived
- Related medications will not be subject to a co-pay and will not count towards the beneficiaries' prescription limit

The FDA approved prescriptions are now listed on the preferred drug list. This program applies only to prescribers of FDA-approved drugs for the treatment of OUD and will not be reimbursed for the practice of pain management. Please refer to the Medicaid physician manual for more details regarding the billing of services.

The overall goal of MAT is recovery. Providers who are interested in becoming a MAT provider or need additional information about integrating services into their offices, please contact your AFMC Provider Relations outreach specialist by visiting www.afmc.org/providerrelations or emailing providerrelations@afmc.org.

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STEMI and Stroke Care Amid COVID-19 Pandemic:
Implications for Primary Care in Arkansas

By David Vrudny, MPH, CPHQ, Ashamsa Aryal, PhD, Sharada Sarah Adolph, MD, DrPH, Appathurai Balamurugan, MD, DrPH

Introduction

While COVID-19 continues to pervade the lives of Arkansans, our state's ST-Elevation Myocardial Infarction (STEMI) and stroke systems of care have been ongoing to help reduce the impact of these time critical diagnoses on affected patients. This article describes the importance of hospital performance for improving and sustaining acute STEMI and stroke standards of care, implications of key performance indicators for primary care, and the role of primary care in STEMI and stroke systems of care, particularly in the age of COVID-19.

Burden of STEMI and Stroke

STEMI and stroke are serious conditions that compromise circulation in varying degrees to the cardiovascular system and central nervous system, respectively. Data show that heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause of death.[1] Arkansas ranks in the top ten among states with the highest rates of death from STEMI and stroke. Arkansas has the highest rate of death per capita from acute myocardial infarction (AMI) in the United States based on the *International Classification of Diseases, Tenth Revision* (ICD-10) codes: I21.0 – I21.9.[2] The latest available data from 2018 shows 2,844 AMI deaths in Arkansas (a rate of 75.6 per 100,000 population compared to 27.0 per 100,000 nationally).[2] With respect to stroke, in 2018 Arkansas experienced 1,551 deaths (ICD-10 codes: I60-I69).[2] This represents a rate of 41.5 deaths per 100,000 population in Arkansas compared to the national rate of 37.1 per 100,000.[2] These mortality data suggest Arkansas needs to focus preventive efforts at multiple levels, primarily in community, emergency care, hospital, and rehabilitation settings to mitigate this particular end-point for STEMI and stroke.

The Influence of COVID-19 on STEMI and Stroke

SARS-CoV-2 induced cytokine storm with destabilization of pre-existing plaques and viral-induced direct myocardial injury are two mechanisms postulated for acute coronary events based on evidence for influenza and human coronavirus-like infections.[3] Hypercoagulability states secondary to severe inflammatory response leading to both arterial and venous thrombosis have been most frequently reported for acute stroke patients presenting during the pandemic.[4,5,6,7] Both STEMI and stroke patients are by virtue of their disease states are at a higher mortality risk due to SAR-CoV-2 infection. More recent studies show that the COVID-19 pandemic has resulted in decreased volumes of patients with STEMI and stroke presenting to acute care settings.[8,9] We observed declining hospitalizations in Arkansas for STEMI and stroke during the months of March-September 2020, and have only now begun to witness a slow uptick in hospitalizations for these conditions. Reasons for this phenomenon have been attributed to stay-at-home and shelter-in-place practices or orders, the adoption of online platforms, and patients' personal fears of presenting to hospitals during the pandemic.[8] However, this does raise concerns about how many people with STEMI or acute stroke may have died at home for fear of venturing out during the pandemic. Due to reporting delay, data on community-level mortality from STEMI and stroke will only be available in 2022, when the true impact of this pandemic will be known. Both STEMI and stroke are medical emergencies and the onus needs to be on immediate recognition and timely intervention with appropriate aftercare.

Arkansas STEMI and Stroke Systems of Care and Hospital Performance for Key STEMI and Stroke Quality Measures

The Arkansas Department of Health (ADH) in conjunction with acute care hospitals, Emergency Medical Services (EMS), American Heart Association/American Stroke Association (AHA/ASA), American College of Cardiology (ACC), University of Arkansas for Medical Services (UAMS), Arkansas Hospital Association (AHA), and several other stakeholders is committed to developing a robust STEMI and stroke systems of care in Arkansas. The first step towards understanding where Arkansas stands for STEMI and stroke care is to critically examine data and evaluate for gaps in care. The ADH stewards the statewide heart attack and stroke registries to track, measure and improve patient care. The Arkansas Heart Attack Registry (AHAR) is ACC's National Cardiovascular Data Registry, which collaborates with and collects data from 27 Percutaneous Coronary Intervention (PCI) hospitals. The Arkansas Stroke Registry (ASR), an American Heart Association Get With The Guidelines®-Stroke program, collaborates with and collects data from 75 acute stroke care-capable hospitals (eight of which are Joint Commission-designated stroke centers). Through registry participation, hospitals gain the ability to benchmark performance on the latest evidence-based clinical performance measures to help ensure best standards of care for patients and to achieve good clinical outcomes. Utilizing registry data, the ADH identifies gaps in performance that are likely to impact patient care delivered by participating hospitals and provides technical assistance for quality improvement to hospitals. Both STEMI and stroke systems of care comprehensively include prehospital care where EMS is critically involved, followed by in-hospital care for acute management and discharge recommendations. Transitions of care for both these disease modalities is where primary care physicians and specialists can efficiently collaborate. This is an area that needs significant development for the continuum of patient care in ambulatory care settings.

Tables 1 and 2 display select key STEMI and stroke performance measure data collected from all AHAR and ASR participating hospitals for the time period from July 2019 through June 2020, that are relevant to primary and transitional care. Pre-hospital measure data for STEMI reveal a striking difference between Arkansas and

the US for patient arrivals to hospitals by emergency medical services (EMS) as indicated by *STEMI arrived by EMS*. *Patients with first-medical-contact to pre-hospital ECG ≤10 minutes* is the percentage of patients who received electrocardiograms within 10 minutes of EMS first medical contact and is comparably lower for Arkansas compared to the national average (Table 1). *First medical contact – device time* is the percentage of patients with acute STEMI, or its equivalent, who received primary percutaneous coronary intervention (PCI) during the hospital stay with a time from first medical contact (FMC)-to-device ≤90 minutes. Arkansas seems to be doing reasonably well for this in-hospital measure at 86.2%. This level of performance is also reflected at 95.9% for *Door to Reperfusion therapy ≤90 min*, which is the percentage of patients with acute STEMI, or its equivalent, who received fibrinolytic therapy or primary PCI within 90 minutes of hospital arrival. STEMI discharge measures *Evaluation of left ventricular (LV) systolic function*; *angiotensin converting enzyme inhibitor (ACE-I) -I or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction at discharge*; *Cardiac rehabilitation referral from an inpatient setting*; *Beta-blocker prescribed at discharge*; *Aspirin at discharge*; *High intensity statin at discharge*; *P2Y12 Inhibitor at discharge*; and *Aldosterone antagonist at discharge* are self-explanatory. Performance for these measures is uniformly optimal except for the last measure for the percentage of eligible patients hospitalized with AMI, who were prescribed an aldosterone antagonist at discharge at 21.0% in Arkansas compared to 52.6% nationally (Table 1).

Table 1. ST-Elevation Myocardial Infarction (STEMI) Performance Measures Relevant to Primary and Transitional Care, July 2019-June 2020[10]

Measures	Arkansas	US
Pre-Hospital		
STEMI arrived by EMS	49.7%	79.8%
STEMI arrived by self/family	50.3%	62.6%
Patients with first-medical-contact to pre-hospital ECG ≤10 minutes	68.4%	91.4%
In-Hospital: Acute Care		
First medical contact – device time	86.2%	100.0%
Door to reperfusion therapy ≤90 min	95.9%	100.0%
In-Hospital: Discharge		
Evaluation of LV systolic function	97.1%	100.0%
ACE-I or ARB for LVSD at discharge	78.2%	100.0%
Cardiac rehabilitation referral from an inpatient setting	82.6%	99.6%
Beta-blocker prescribed at discharge	94.0%	100.0%
Aspirin at discharge	98.1%	100.0%
High intensity statin at discharge	86.9%	99.2%
P2Y12 Inhibitor at discharge	91.6%	99.4%
Aldosterone antagonist at discharge	21.0%	52.6%

Table 2 shows low percentages of hospital arrivals by EMS for acute stroke with *Stroke arrival by EMS* at 38.8% and 45.1% for Arkansas and the US, respectively. This not so desirable performance is also seen for *% Door-To-CT ≤25 min*, which is the percentage of patients who receive brain imaging within 25 minutes of arrival. *IV Alteplase arrive by 3.5 Hours, treat by 4.5 hours* is the percentage of acute ischemic stroke patients who arrive at the hospital within 210 minutes (3.5 hours) of time last known well and for whom IV Alteplase was initiated at this hospital within 270 minutes (4.5 hours) of time last known well. Performance for this measure is comparably good for both Arkansas and the US. Stroke discharge measures *Antithrombotics*; *Anticoagulation for atrial fibrillation/atrial flutter*; *Smoking cessation*; *Statin prescribed at discharge*; *Stroke education*; and *Rehabilitation considered* show excellent and uniform performance across the board for both Arkansas and the US.

Table 2. Acute Stroke Performance Measures Relevant to Primary and Transitional Care, July 2019-June 2020[11]

Measures	Arkansas	US
Pre-Hospital		
Stroke arrival by EMS	38.8%	45.1%
Stroke arrival by private vehicle	39.2%	33.9%
% Door-To-CT ≤25 min	50.0%	48.8%
In-Hospital: Acute Care		
IV Alteplase arrive by 3.5 Hours, treat by 4.5 hours	81.5%	88.6%
Time To intravenous thrombolytic therapy ≤60 minutes	61.7%	84.8%
In-Hospital: Discharge		
Antithrombotics	97.4%	98.7%
Anticoagulation for atrial fibrillation/atrial flutter	91.8%	96.7%
Smoking cessation	95.9%	97.3%
Statin prescribed at discharge	93.6%	97.2%
Stroke education	95.2%	94.6%
Rehabilitation considered	98.0%	98.9%

Implications for Primary Care

Effectively improving clinical performance and closing gaps in STEMI and stroke care requires affecting the continuum of care across the prehospital, in-hospital, post-discharge, rehabilitation, and ambulatory management settings. We know EMS and hospital emergency departments play a critical role in ensuring rapid assessment and treatment for STEMI and stroke patients. Any delay in receiving appropriate therapy at the hospital reduce the effectiveness of treatment and increases

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loss of heart muscle or brain tissue. The Global Use of Strategies to Open Occluded arteries study showed a strong inverse relationship between time to angioplasty and mortality for AMI patients: mortality was 1% when time to angioplasty was less than or equal to 60 minutes and increased to 6.4% when angioplasty occurred at 90 minutes or greater.[12] With respect to stroke, data show patients who arrive at the emergency room within 3 hours of their first signs of stroke often have less disability 3 months after a stroke than those who received delayed care.[13] While many physicians recognize the importance of educating patients at risk of STEMI and stroke signs and symptoms, they may not find the time to do it. Primary care physicians are frontline medical providers and are often gatekeepers who can prevent patients in their care from unforeseen STEMI- and stroke-related hospitalizations and emergency room visits. A message delivered by the primary care physician has significance for a patient because of the strong feeling of physician trust built over time. In addition, it is important for primary care physicians to engage at-risk patients and their family members or caregivers in STEMI and stroke recognition and preventive care education. The reason for this is because in many cases it is almost always a bystander or relative who recognizes pertinent signs and act in a timely manner by calling 911 when STEMI or stroke is suspected. ADH offers both STEMI education materials such as bookmarks and Early Heart Attack Care (EHAC) brochures, and stroke materials to providers at no cost to them. The University of Arkansas for Medical Sciences (UAMS) Stroke Program also offers stroke educational materials available at no cost to health professionals and lay community members.

For many STEMI and stroke patients, the transition from the acute care environment to another health care setting or home can be a significant challenge. For example, about 70% of stroke patients discharged each year from U.S. hospitals return back to their homes.[14] Stroke patients often have unmet educational needs, poor medication adherence, and limited access to medical and resources post-care.[14] There is a significant opportunity to help ensure STEMI and stroke patients have appropriate follow-up with their primary care and specialty care physicians as needed in order to ensure patient continuity of care for medication adherence and lifestyle changes as prescribed at hospital discharge.

As the work for the STEMI and stroke system of care continues, the ADH is also involved in improving upstream factors such as hypertension and diabetes control by working with health systems; and reducing tobacco use, improving healthy eating and physical activity by working with Arkansas communities. Primary care practices have an opportunity to educate patients on the "ABCS" of heart disease and stroke prevention: take aspirin as appropriate, control blood pressure, manage cholesterol, and quit smoking.[15] ADH's Be Well Arkansas tobacco cessation quitline can assist patients through free counseling offered by certified tobacco treatment specialists and nicotine replacement therapy if indicated, as well as linking people to diabetes and hypertension management resources.

While the tide on the COVID-19 pandemic may soon turn, improving the health of Arkansans especially for STEMI and stroke acute- and after-care involves a continued, integrated approach between ambulatory care, hospitals, and EMS, along with community engagement. The ACC and American College of Emergency Physicians (ACEP) in their most recent position statement underscore the importance of calling EMS for AMI symptoms, targeting the use of PCI or fibrinolysis for STEMI patients, and maximizing the safety of medical personnel through the use of recommended precautions during COVID-19.[16] Similarly, the AHA/ASA Stroke Council Leadership has issued emergency guidance to Stroke Centers that emphasizes continued treatment of stroke patients as appropriate, continued use of telestroke, and following COVID-19 protocols.[9] Unified approaches to STEMI and stroke care are necessary now more than ever, and it behooves primary care physicians to understand why they will play a greater role in systems of care for these patients along with their hospital, EMS, and public health counterparts.

References

1. Lange SJ, Ritchey MD, Goodman AB, et al. Potential Indirect Effects of the COVID-19 Pandemic on Use of Emergency Departments for Acute Life-Threatening Conditions — United States, January–May 2020. MMWR Morb Mortal Wkly Rep 2020;69:795–800. DOI: http://dx.doi.org/10.15585/mmwr.mm6925e2
2. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html on Oct 19, 2020 8:37:06 PM
3. Sheth AR, Grewal US, Patel HP, Thakkar S, Garikipati S, Gaddam J, and Bawa D. (2020). Possible mechanisms responsible for acute coronary events in COVID-19. Med Hypotheses. 2020 Oct;143:110125. doi:10.1016/j.mehy.2020.110125
4. Klein DE, Libman R, Kirsch C, and Arora R. (2020). Cerebral venous thrombosis: Atypical presentation of COVID-19 in the young. J Stroke Cerebrovasc Dis. 2020 Aug;29(8):104989. doi:10.1016/j.jstrokecerebrovasdis.2020.104989
5. Abou-Ismail MY, Diamond

A, Kapoor S, Arafah Y, and Nayak L. The hypercoagulable state in COVID-19: Incidence, pathophysiology, and management. Thromb Res. 2020 Jun;194:101-115. doi:10.1016/j.thromres.2020.06.029
6. Hess DC, Eldahshan W, and Rutkowski E. (2020). COVID-19-Related Stroke. Transl Stroke Res. 2020 Jun;11(3):322-325. doi:10.1007/s12975-020-00818-9
7. Avula A, Nalleballe K, Narula N, Sapozhnikov S, Dandu V, Toom S, Glaser A, and Elsayegh D. COVID-19 presenting as stroke. Brain Behav Immun. 2020 Jul;87:115-119. doi:10.1016/j.bbi.2020.04.077
8. Zitelny E, Newman N, amd Zhao D. (2020). STEMI during the COVID-19 Pandemic - An Evaluation of Incidence. Cardiovasc Pathol. 2020 Sep-Oct;48:107232. doi:10.1016/j.carpath.2020.107232
9. Temporary Emergency Guidance to US Stroke Centers During the Coronavirus Disease 2019 (COVID-19) Pandemic. (2020). On Behalf of the American Heart Association/American Stroke Association Stroke Council Leadership. Stroke. 2020;51:1910-1912. doi:10.1161/STROKEAHA.120.030023
10. Arkansas Department of Health. Retrieved October 21, 2020, from Arkansas Heart Attack Registry.
11. Arkansas Department of Health. Retrieved October 21, 2020, from Arkansas Stroke Registry.
12. Russo J and Le May MR. Time to Treatment. Interventional Cardiology Clinics. 2016;5(4):427-437.
13. Stroke Facts. (2020, September 08). Retrieved October 23, 2020, from https://www.cdc.gov/stroke/facts.htm
14. Reeves MJ, Hughes AK, Woodward AT, et al. Improving transitions in acute stroke patients discharged to home: the Michigan stroke transitions trial (MISTT) protocol. BMC Neurol. 2017;17:115 . https://doi.org/10.1186/s12883-017-0895-1
15. Wright JS, Wall HK, and Ritchey MD. Million Hearts 2022: Small Steps Are Needed for Cardiovascular Disease Prevention. JAMA. 2018;320(18):1857–1858. doi:10.1001/jama.2018.13326
16. Mahmud E, Dauerman HL, Welt FG, Messenger JC, Rao SV, Grines C, Mattu A, Kirtane AJ, Jauhar R, Meraj P, Rokos IC, Rumsfeld JS, and Henry TD. (2020). Management of Acute Myocardial Infarction During the COVID-19 Pandemic. A Position Statement From the Society for Cardiovascular Angiography and Interventions (SCAI), the American College of Cardiology (ACC), and the American College of Emergency Physicians (ACEP). 2020 Sep;76(11):1375-1384. doi:10.1016/j.jacc.2020.04.039

Charles Daniel, M.D.
and Marshall

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

Most country physicians are originally from small towns and made the conscious decision to return. Each little town has its own story with diverse characters and dramas. The physician is often the narrator, father confessor, the soul who is there for families from birth to death; the person who is called in time of need. One of his principal traits is trust, trust to do the right thing, trust to be there when he is needed. Wisdom is another of those traits that sets them apart. Each little town thinks of their doctor as the best diagnostician ever. When poetry and fiction is written about the country doctor, it is usually written with an admiring eye. Often, the physician's role extends well beyond traditional medicine to include involvement in church, schools, business, politics, and local government. These observations are certainly true for Dr. Charles Daniel of Marshall, Arkansas.

Dr. Charles Daniel was born July 1, 1940. Despite living in Marshall, he was born in St. Vincent Hospital in Little Rock. The hospital and OB services were limited in Marshall, so his grandmother insisted that the children go to Little Rock for delivery. Both sides of his family had migrated in the late 1800's from the Eastern United States to Arkansas in search of free land. Dr. Daniel's grandfather opened a medical practice in Marshall around 1900. In that day, the town of Leslie was a larger community than Marshall because of a cooperage factory taking advantage of the large stands of white oak trees in the region.

Unlike his father before him, Dr. Daniel's father was a merchant most of his life. He had a meat market at one time but eventually opened Daniel Hardware which is still in existence and run by Charles's brother.

Charles had three brothers and one sister. His brother, **Dr. Sam Daniel,** was a family physician in Conway. On the Ferguson side of the family, his uncle, **Dr. Vance Ferguson** practiced in El Dorado.

Education was an important element in both sides of his family, and it was a given that they would move up the education ladder.

Charles excelled in school and especially in the sciences. He knew as early as the 10th grade what he was going to do with his life; be a doctor and come back to Marshall.

Throughout his teenage years he had been expected to work primarily in his father's hardware store.

He graduated from high school in 1958 and enrolled in the University of Arkansas in the fall of that year.

In addition to being a physician, his paternal grandfather was the county judge, and this set the pattern for the young Dr. Daniel to be active in politics. He points proudly to the fact that he is a Democrat in a county that is and always has been 90 % Republican. He has been active in the organization of the Searcy County Democratic party since his return in 1965.

Dr. Daniel's college years at Fayetteville were uneventful and he did well in his studies ending up with a degree in Natural Science.

He found the first two years of academics at UAMS difficult especially pathology, microbiology, and embryology. He discovered early on that he was competing with some very smart people, but he made it through. His third and fourth years were a different story all together. He has fond memories of Dr. George Ackerman and Dr. Hara in the medicine department.

During his clinical rotations, he fell in love with each discipline but from the get-go he knew he was coming back to Marshall to practice. He completed a rotating internship at St. Vincent and then returned to Marshall in 1968 to set up a practice.

Medicare and Medicaid had been in force for three years. When he started his practice, he charged $5.00 dollars for an office visit. His office staff included his aunt who ran the front office and a nurse who worked for him and the small hospital in Leslie. Despite his training in OB, he found the facilities in Marshall to be limited so he quickly began limiting that part of his practice. Because there were few physicians and limited facilities in the area, he found himself working day and night seven days a week. *"One day I was coming back from a delivery in Leslie just as daylight was breaking over the horizon. I was on top of Brushy Mountain. It was just a beautiful scene. I pulled over and was just sitting there. I thought to myself, "Man, if I ain't got time to watch this, I just might as well leave." So anyway, I didn't deliver that many children after that."*

Not only was OB a challenge so was dealing with acute medical problems such as heart attacks. In the early days there was little that could be done but deal with the pain and give them oxygen and maybe nitroglycerin. Specialists were an uncommon commodity in the mountains. The closest specialty services were 30-50 miles away in Harrison or Mountain Home over bad roads. As with other small towns in Arkansas, there were no ambulances only hearses provided by the local funeral home.

Marshall is only about fifteen miles south of the Buffalo River and National Park but many of those who live in Searcy county feel that the National Park hurt the county and city because it had a negative impact on the ability to raise funds since it took 70 thousand acers out of the counties coffers.

Dr. Daniel is quick to say that he was well compensated for what he did in the practice of medicine. He goes on to add: *"Well, the living I made was really good for here and I loved what I did. The most gratifying part of medicine was being able to know the people that I was treating, treating them, and knowing that just nearly all of them really appreciated what you did."*

"Medicare and Medicaid had a major positive impact on the people of our county. Many simply could not afford care and would not seek it. Unlike many of my medical friends I am all for universal health care and I hope that we will figure out how to do it somehow."

"Technology really changed everything in life not just medicine." For the last fourteen years of his practice he affiliated with a large hospital out of Harrison but for him it just wasn't the same and on January 1st, 2011 he retired. For the last few years he has been engaged in raising cattle and now is just raising hay.

When asked what he would like to say to his great, great grandchildren, Dr. Daniel replied: *"I think if you're interested in what you're doing, you can make it meaningful and enjoy what you do. Work and do a good job. Help others; if you don't help others your life will be less meaningful. If you believe in what you're doing and do something that does have some type of meaning for yourself and for others, your life will be fulfilled.*

Dr. Charles Daniel died on the September 11th of 2019.

Photography by J.P. Bell

Arkansas Behavioral Health Integration Network – Building Bridges

By Patty Gibson, M.D. Chief Medical Officer for ABHIN

True story: the names and details have been changed....

Mr. Smith is a 67-year-old man who is retired and living alone after his wife of 47 years died earlier this year from complications of COVID-19. His children living in Texas recently called his family physician because they were concerned that their father was not eating, quit leaving his house and recently told his daughter on the phone, "I just don't know what's the use anymore." His physician knew him well from the community, but Mr. Smith did not usually go to the doctor since his wife used to keep track of refills for his medications.

When Mr. Smith's daughter came to town, he agreed to go see his family doctor to "get his BP checked." Although the patient denied any emotional problems to his doctor, he was given a PHQ9 Depression screen. The clinic had recently started giving the PHQ9 to all their patients as part of a CPC (Comprehensive Primary Care) program. Mr. Smith scored an 18 which correlated with "moderately severe depression," and he answered question number 9 positively saying that "nearly every day" he "had thoughts that he would be better off dead."

After encouragement from his doctor, Mr. Smith agreed to meet that same day with the clinic's therapist. The therapist worked in the clinic to provide behavioral health integration support as part of the practice's primary care extended team. After a brief collaboration with the therapist, the doctor was able to move on to his next patient.

In the 20-minute visit with the therapist, Mr. Smith admitted that he felt sad and lonely and that he didn't feel like doing his woodworking because his back pain had gotten worse. He said he started drinking a "couple" of beers every night to try to sleep since his wife died and said that he didn't care about eating anymore since he wasn't used to cooking.

Mr. Smith admitted he had been thinking he could shoot himself with his hunting rifle, but he denied any previous attempts. He also said that he believed it would be a sin to kill himself. He knew his children would be upset, but he had started thinking that they would be better off without him. Mr. Smith refused to start any medication or go to the emergency room, but he agreed to meet with the therapist again the next day for a longer visit.

The therapist was able to let the doctor know a little more about the context of the patient's situation and their plan to meet again the next day. The therapist also met with the patient and daughter together to get more information about the family and to discuss a crisis response plan. The therapist and physician also had a consulting psychiatrist available as needed.

Mr. Smith returned the next day. He met with the therapist at the clinic a couple more times over the next three weeks, and then he checked back a month later. He continued to refuse to take antidepressant medication, but he started walking in his neighborhood and reconnected with his Sunday school class. He cut back on drinking beer and was surprised he began to sleep better. He didn't think he needed any "therapy" but liked to check in with the therapist by telephone every few weeks.

This story was a success for everyone involved, including the doctor, the daughter, the therapist, and the patient. The patient's depression and suicidal ideation were assessed quickly and efficiently. The patient was able to get the urgent care he needed in his primary care doctor's office without having to go to an emergency room or wait for an appointment at a mental health clinic.

With a few brief visits, the therapist was able to help the patient develop skills to cope with this devastating but "normal" life event of the death of his spouse. Since the therapist worked in the primary care clinic, the patient was willing to continue to "check in" with her periodically; and she was able to keep the doctor informed and keep required documentation in the clinic EMR.

Unfortunately, this story describing the potential of integrated care is not usual care in most Arkansas clinics. Primary Care Physicians (PCPs) know better than anyone that patients are not able to get the mental healthcare they need. PCP's are expected to take care of more patients with more complicated problems and to limit referrals to specialists. Talking to patients who

Managing Suicidal Patients In Primary Care

This two-hour training course and Q&A session with Kent A. Corso, Psy.D., BCBA , was initially offered to primary care clinicians and teams on October 23, 2020. A recording is accessible on the ABHIN website with CMEs and CEUs available. www.ABHINetwork.org patty.gibson@abhinetwork.org

The goal of the training is to increase attendees' competence, confidence and comfort managing suicidal patients in primary care. Attendees will learn to assist patients with suicidal symptoms in a collaborative way, anchored in their values and priorities, assess suicide risk in 10 minutes or less, discuss with patient's ambivalence and reasons for living, and collaboratively devise a crisis response plan that may reduce suicide attempts by 76%.

Webinar Instructor

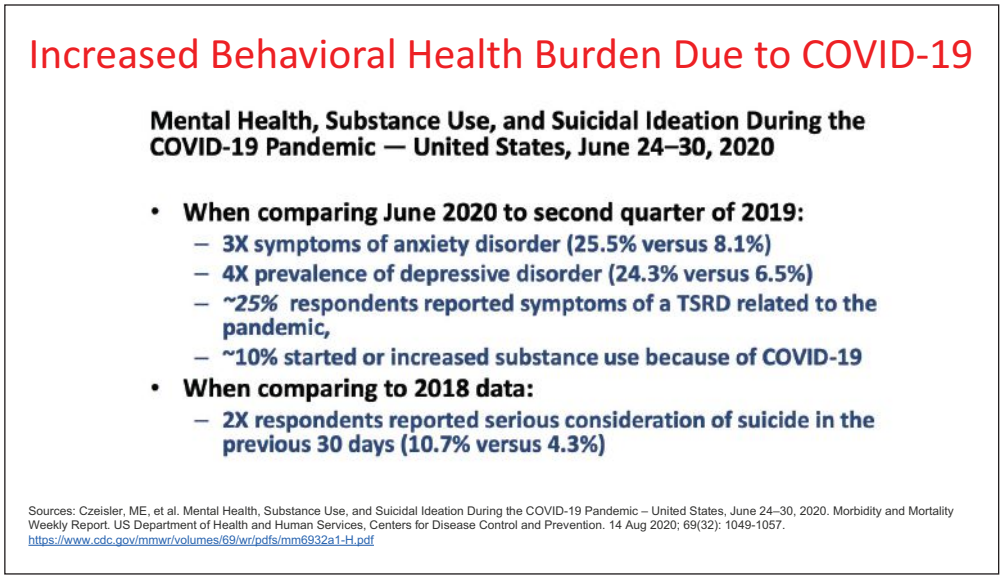
Dr. Kent A. Corso is a licensed clinical psychologist and board- certified behavior analyst. His experience in suicide prevention began almost two decades ago, while serving as an officer in the U.S. Air Force. Since then, Dr. Corso has researched, developed and trained others to implement evidence-based methods of suicide prevention and intervention nationally and internationally. He has published numerous peer-reviewed research papers and with his expertise in behavior analysis, is a leading expert in novel scientific methods and digital technologies for analyzing variables and patterns associated with suicide.

This training is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $750,000.00 with 100% percentage funded by HRSA/HHS and $0 amount and 0% percentage funded by nongovernment source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the U.S. Government.

Arkansas Behavioral Health Integration Network

experience stress and depression takes time that does not fit the primary care clinic workflow. All these factors and more can make treating patients in crisis stressful and frustrating for the physician.

Even if PCP's have time to administer depression or anxiety screens, there are not enough psychiatrists or therapists available to see patients in a timely fashion.[1,2] Stigma, lack of insurance coverage, and long wait times lead to high no-show rates which further decreases patients' access to the few mental health specialists that are available. PCPs end up being the "de facto" mental health providers, prescribing 65% of all psychotropic medications.[3,4]



Pandemic Increasing Mental Health Issues

Unfortunately, this burden on family practice physicians will increase due to the shortage of mental health providers and dramatic increase in reported behavioral health symptoms over the past year. A CDC survey in June 2020 reported that over 40% of all U.S. adults have experienced at least one adverse mental health symptom. Depressive disorder prevalence is nearly 3.5 times higher than it was in 2018 with over **10% of all adults seriously considering suicide in the last 30 days**. Perhaps more concerning is that **25% of those age 18-24 years and 16% of those 25-44 years old reported suicidal ideation**.[5]

There are and will be many more patients like Mr. Smith who would benefit from mental health assessment, triage to appropriate level of care, and brief, evidence-based focused interventions in primary care.[6] There are also significant economic reasons for behavioral health integration which add to the urgency of this healthcare transformation.[7,8] However, even though the evidence for integrative behavioral health has been increasing and various models are being developed across the country, Arkansas practices are finding it very challenging to implement.[9,10,]

AR Behavioral Health Integration Network (ABHIN) is a nonprofit grassroots organization that was created to be part of the solution. ABHIN grew out of a CPC Stakeholders behavioral health integration (BHI) workgroup. ABHINs purpose is to develop a professional learning *collaborative* that supports and encourages the integration of behavioral health services into medical settings throughout Arkansas.

ABHIN does not have all the answers, but they intend to work with others to bring knowledge and skills in behavioral health integration from around the country to providers in Arkansas. The goal is to build relationships and connections in Arkansas and to be a bridge between medical providers and specialty mental health providers so that providers can administer whole person, team-based care. There is a pressing need to develop connections and to break down barriers, and there are many great services and committed people in Arkansas who are ready to do it.

With two HRSA grants awarded September 1, 2020, ABHIN will be working to reduce suicides and opiate use disorder in Arkansas by providing training for primary care clinics in suicide assessment and crisis response. The first training was recorded on October 23, 2020 and will be available with CME's on the website www.ABHINetwork.org.

Another promising idea is creating an Arkansas Psychiatric Access Program. Psychiatric access programs usually consist of a hotline for PCP's to get assistance with referral to mental health and social service resources as well as same day telephone psychiatric consultation.[11] Psychiatric access programs have been successful in 38 other states and would greatly improve access to urgently needed care in Arkansas.

Because behavioral health integration that involves primary care providers working closely with mental health clinicians is a very different type of practice than current traditional specialty mental healthcare, focused education, training, and support is needed for both mental health providers and medical providers.

ABHIN – Arkansas Behavioral Health Integration Network plans to be part of the solution in improving patient care and outcomes, increasing patient and provider satisfaction, and in providing support for family physicians. If you have ideas, suggestions, or want to get involved, contact Patty Gibson, MD at patty.gibson@abhinetwork.org or Kim Shuler, LCSW at kim.shuler@abhinetwork.org.

References:

1. Merritt Hawkins 2018 White Paper, "The Silent Shortage."
2. https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Thought_Leadership/mhawhitepaperpsychiatry2018.pdf

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3. National Council for Behavioral Health. "The Psychiatric Shortage: Causes and Solutions." March 28, 2017. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf?daf=375ateTbd56
4. Mark TL, Levit KR, Buck JA. Datapoints: psychotropic drug prescriptions by medical specialty. Psychiatr Serv. 2009;60:1167.
5. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62:629-640. [PubMed] [Google Scholar] https://pubmed.ncbi.nlm.nih.gov/15939840/
6. Czeisler, ME, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24–30, 2020. Morbidity and Mortality Weekly Report. US Department of Health and Human Services, Centers for Disease Control and Prevention. 14 Aug 2020; 69(32): 1049-1057. https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf
7. Robeznieks, "Why collaboration's key to help patients access mental health care,"
8. https://www.ama-assn.org/delivering-care/public-health/why-collaboration-s-key-help-patients-access-mental-health-care
9. Milliman Research Report. January 2018. "Potential economic impact of integrated-medical behavioral healthcare" https://www.milliman.com/en/insight/potential-economic-impact-of-integrated-medical-behavioral-healthcare-updated-projections
10. Milliman Research Report. Aug 13, 2020. "How do individuals with behavioral health conditions contribute to physical and total healthcare spending?" https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx
11. Kathol et al. "Clinical Integration: Population Health and Accountable Care," 3rd ed (2015), Chapter 11 Non-Traditional Mental Health and Substance Use Disorder Services as a Core Part of Health in CINs and ACOs. https://www.cartesiansolutions.com/wp-content/uploads/2019/10/Kathol-et-al-Chapter-11-Pop-Health-Acct-Care-2015.pdf
12. Business Case for Integrated Medical and Behavioral Health Care.
13. https://www.cartesiansolutions.com/resources/
14. Massachusetts Child Psychiatry Access Program https://www.mcpap.com/
15. Oregon Psychiatric Access Line (OPAL-K for kids, OPAL-A for adults) https://www.ohsu.edu/school-of-medicine/child-and-adolescent-psychiatry/oregon-psychiatric-access-line
16. Florida Behavioral Health Collaborative http://floridabhcenter.org/index.html

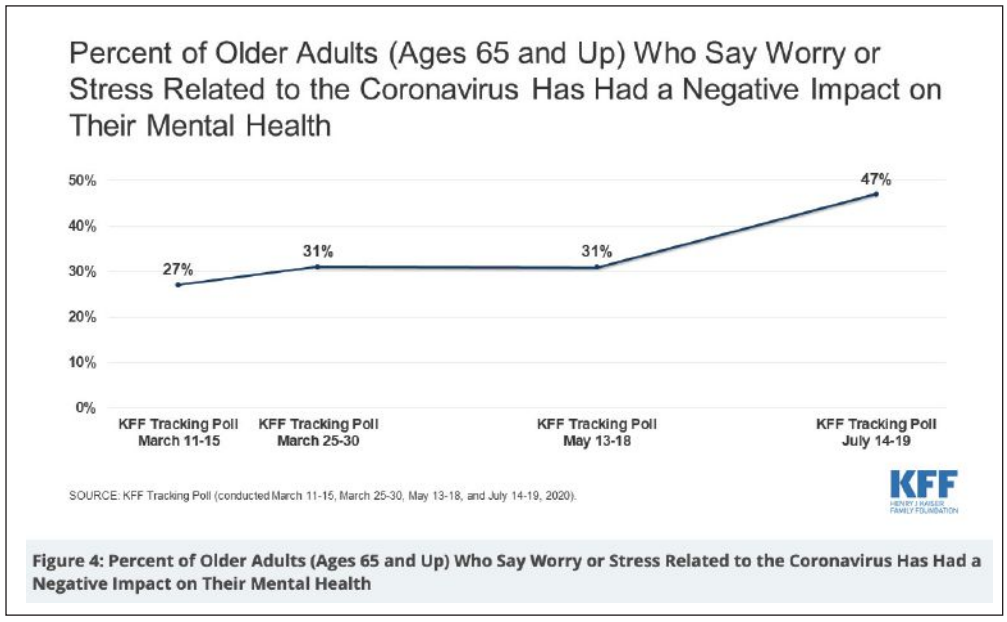
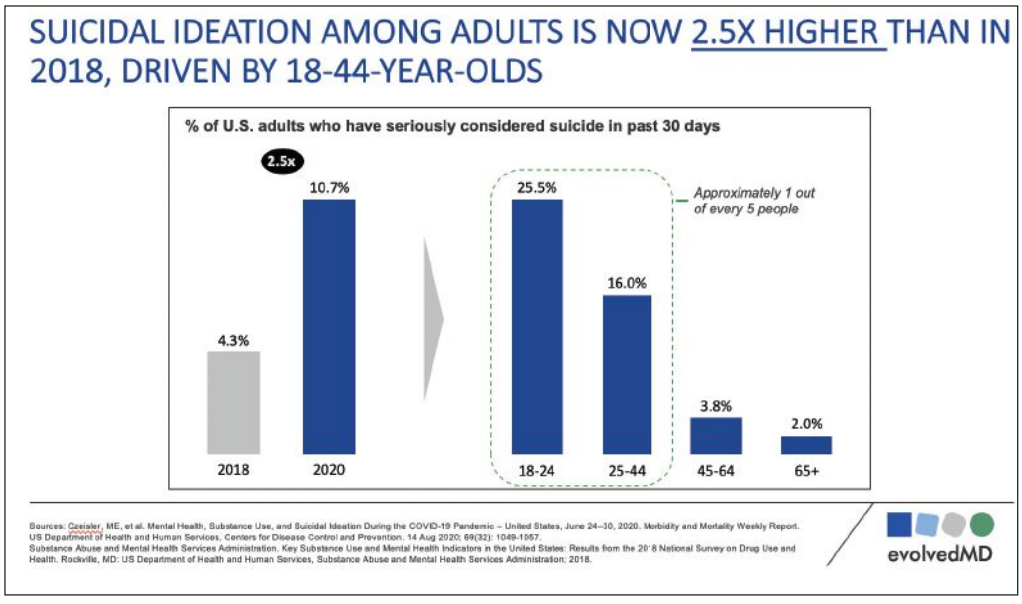


Figure 4: Percent of Older Adults (Ages 65 and Up) Who Say Worry or Stress Related to the Coronavirus Has Had a Negative Impact on Their Mental Health



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2020 Congress of Delegates a Virtual Success!


Dennis Yelvington, M.D.


Lonnie Robinson, M.D.


Jeff Mayfield, M.D.


Daniel Knight, M.D.

The 2020 Congress of Delegates (COD) is in the books. The COD met virtually for the first time in history on October 11-13 just prior to the 73rd virtual Family Medicine Experience. The COD elects directors and officers and serves as the AAFP's policy-making body which addresses a wide range of issues that affect family physicians and their patients. Arkansas delegates were Dennis Yelvington, M.D. and Lonnie Robinson, M.D. Jeff Mayfield, M.D. and Daniel Knight, M.D. served as alternate delegates.

A "Meet the Candidates" virtual room was held on Sunday prior to the town hall meeting. Members were able to ask questions and make comments and hear about current AAFP information, events and issues. Reports from AAFP leaders and the candidate's forum were live while other reports were pre-recorded.

The virtual platform made for an abbreviated special session but was also a unique opportunity for many members to participate since they didn't have to travel. The reference committees were held the weekend before COD. Only resolutions that were considered exigent issues were brought to the Congress. There was a total of 12 resolutions that qualified. Delegates rejected a resolution that would have limited the number and scope of resolutions brought before the Congress. A full list of the resolutions can be found on the AAFP webpage under the News tab.

New officers elected:
President-Elect: Sterling Ranson, Jr., M.D. (VA)
Speaker: Alan Schwartzstein, M.D. (WI)
Vice-Speaker: Russel Kohl, M.D. (KS)

New board members elected:
Jennifer Brull, M.D. (KS)
Mary Campagnolo, M.D. (NJ)
Todd Shaffer, M.D. (MO)
New Physician: Danielle Carter, M.D. (FL)
Resident: Anna Askari, M.D. (CA)
Student: Cynthia Ciccotelli (PA)

American Academy of Family Physicians 2020-2021 President, Dr. Ada Stewart!

Ada D. Stewart, MD, FAAFP, is a family physician with the Eau Claire Cooperative Health Centers, Columbia, South Carolina, where she has practiced since 2012. She currently serves as lead provider and HIV Specialist. In the aftermath of Sept. 11, 2001, Stewart enlisted in the U.S. Army Reserves and has achieved the rank of Colonel. She is a preceptor for nurse practitioners, medical residents and medical students, and has received numerous awards, including the Alpha Omega Alpha Honor Medical Society Volunteer Clinical Faculty Award for her precepting at the University of South Carolina School of Medicine.

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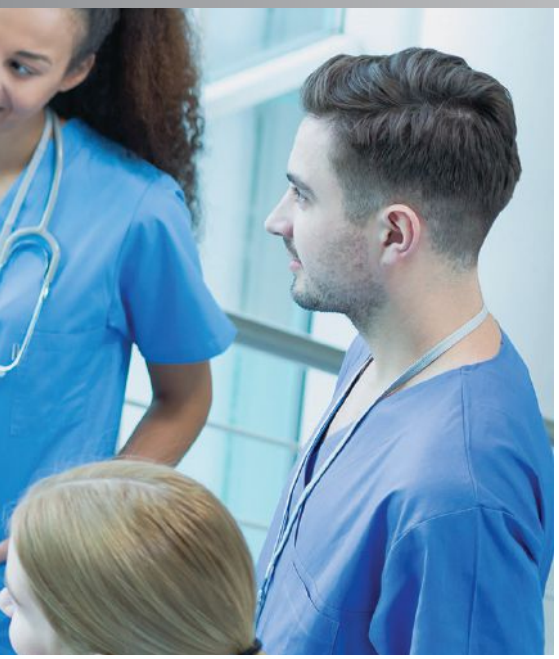
Resident Corner

By Upton Siddons, M.D.
UAMS West Family Medicine Residency
Fort Smith, AR

It's easy to forget these days that there's much else going on in the world besides a viral pandemic. As a medical resident, doubly so. Many of us spend long hours in the hospital facing a medical crisis that seemed unimaginable a few short years ago while sitting in lecture halls and studying for licensing exams. Protective equipment shortages, staff quarantines, carrying on through the long days while worrying in the back of your mind that the fatigue and muscle aches aren't just the usual toll of a medical residency but maybe something *prodromal*. Where are the opiate and obesity epidemics that I expected to be the defining health care issues of our generation of physicians?

Well, as I'm sure most of you can tell me, they're still there. Percolating in the background while we're distracted by the immediacy of the novel coronavirus, Arkansans continue to suffer from the same maladies that have come to dictate health care in our time. One in five Arkansans smoke. A good many more than that are clinically obese. Heart disease is the leading cause of death in our state and we're one of the front runners for rates of cardiac mortality in the nation. These are numbers that hold true throughout our region of the country; our neighbor, Mississippi, leads the nation in many of these statistical categories (though not football).

All this being said, I was intrigued when I was handed a copy of "A Declaration on Climate Change and Health" a few days ago. Briefly, it is a document signed in 2017 by the American Academy of Pediatrics, the American College of Physicians, and numerous other professional societies calling for swift action on federal, state, and local levels to mitigate adverse health outcomes due to climate



change. If you're anywhere near my age, the national climate change debate has been on the radar for most of your life. Also, like so many things, it's been thoroughly infiltrated with political rhetoric. Combine that with the fact that the most severe impacts of it have, for much of my time, been distant storm clouds on the horizon and it's not difficult to appreciate why climate change languishes on the to-do list while other issues take center stage. But that piece of paper reminded me that there is a world and medicine outside of COVID-19.

Much as the dazzling promise of decades of genetic research is starting to bear fruit and will be the greatest medical triumph of our generation, the long-brewing effects of climate change are *the* health challenge we will face. Arkansans specifically will be at increasing risk of arthropod-borne disease, water-related infections, temperature extremes, crop damage, air-quality deterioration, and extreme weather events. Malaria was endemic in Arkansas up until about a century ago when public health programs helped eradicate it. Read most any early description of Arkansas by the army surgeons stationed at what were then frontier forts and the adjectives used to describe it are such as *fetid*, *fever-ridden*, *miasmic*. Prior to flood control efforts by the Army Corps of Engineers and levee districting, routine flooding wrought havoc with Arkansas agriculture. NOAA data demonstrates that the adjusted cost of damage from extreme weather events in Arkansas is on a record-setting pace for the year 2020. Much of the quality of life most Arkansans enjoy is based on previous decades of public health, engineering, and civic works--climate change has the potential to unravel all of that.

What's my point in all this? Is it to add to the suffocating load of Big, unsolvable problems that we bear daily? Nonsense! Climate change is a

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massive problem that we can each do something about right now and we, as physicians, are uniquely positioned to be on the vanguard of presenting the 21st century's major health issue:

- The healthcare sector accounts for about 8% of total national CO2 emissions. Go to **mygreendoctor.org** to learn about practical, realistic, and effective changes that every clinical practice can make.
- A large portion of US greenhouse gas emissions are from the meat protein industry. I won't lie, I've never said no to a steak, but I also know that most all of us would benefit from a more plant-based diet. Encourage your patients to eat food produced locally by Arkansas' 45,000 family-owned farms and sold at the state's farmers markets.
- Advocate at the local and state level for common-sense programs to address this problem. Sensible, self-limited legislation has been introduced to Congress that would correct market inefficiencies and establish a path towards sustainable energy production nationally. The nominal prices of much of our current energy production doesn't take into account the hidden, back-end costs of healthcare and environmental degradation that are subsidized by the well-being of our patients. Read about the **Energy Innovation and Carbon Dividend Act, HR 763**, and decide for yourself.
- There are hundreds of organizations that advocate for change. I'd like to keep things simple for anyone even considering making a few small changes that will pay long-term dividends both personally and professionally:
  - **American College of Physicians Climate-Change Toolkit**
  - **Citizens' Climate Lobby**
  - **ArkansasGrown.org**

I find myself feeling helpless more often than I am comfortable with these days. Climate change is a big problem that we can each chip away at and, what's more, it's solutions also tend to address many of the long-term health problems that we run up against every day in our field.

This pandemic is grueling. Hang in there. Know that there are brighter days ahead of us and we, as family physicians, will help to get our state there if, as they say, the good Lord willing and the creek don't rise.

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Members joining in November and December will be billed for the upcoming year's dues and will receive the remainder of the year complimentary.

Visit www.abqaurp.org or call (800) 998-6030 to join as a Professional Member today!

Legislative Update

Be On the Look Out!

Legislative Call to Action Emails will be Arriving Soon

2021 is going to be an important year for many issues but especially so with scope of practice legislation. Our Legislative Committee is already at work with our partner organizations but we can't do this alone. Relationships and numbers are everything. The more our lawmakers hear from you, the better. Please be on the look out for the call to action alert icon in your mails so you can easily see when we need your help.

As you know, the Safe Surgery ballot item was thrown out on a technicality. This was a devastating blow because that would have set an important scope of practice precedent that would have benefited Family Physicians.

However, our work is just beginning. Our Legislative Committee has already met with our partner organizations to create a strategy. Representation is key, the more contacts we make the better and the earlier we do this, the better our voice will be heard. Please do your homework!

Homework

1. **Find your Representative & Senator** - Go to arkansashouse.org, search on your zip code and your Representative will show on the map. To find your Senator—Go to senate.arkansas.gov/senators/ click on the Find my Senator button and fill in your zip code.

2. **Send an email** to each to introduce yourself as a constituent and a Family Physician. Offer to be a resource for COVID-19 and vaccine information. Offer to be a resource for scope of practice issues or in any way you can.

3. **BONUS POINTS!** - Take them on a coffee break! Facetime is so much better and establishes a relationship. Most people can find a few minutes before or after work so don't be shy. Remember, they work to represent you too!

Welcome New Members

The Arkansas Chapter welcomes the following new Active, Resident and Student members. We look forward to meeting you and please contact the Academy office if we can assist you in any way.

Congratulations and Welcome to Arkansas!

Active

Marielie Agesilas, M.D.
Karen Pickett, M.D.

Residents

Souvonik Adhya, M.D.
Julia Davis, M.D.
Saritha Katta, M.D.

Students

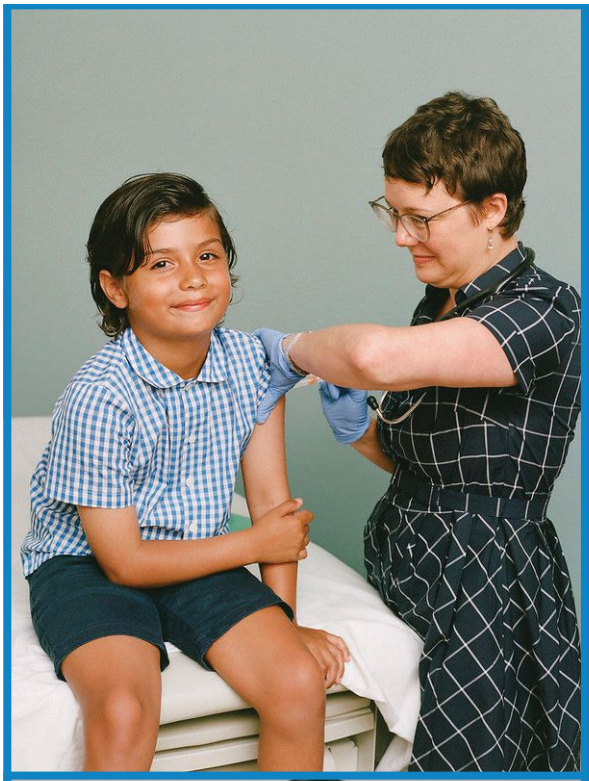
Sidhant Dalal
Nikita Deval
Christopher FludJ
Jonathan Gardner
Yea Eun Han
Eric Huynh
Lauren Kruse
Amanda McMellon
Heather Morgan
Jacob Parmley
Surbhi Patel
Hayden Scott
Theresa Vu
Hannah Yasin

AAFP TIPS Now Free to Members

The full library of AAFP TIPS is now free to members. AAFP TIPS provides members with tools, resources, and team training to assist in the implementation of practice improvement projects. Each AAFP TIPS topic offers short, interactive online training courses, ready-to-use tools, and slide decks with speaker notes for team training and discussion. All of the AAFP TIPS topics have been created with member input by AAFP subject-matter experts, based on the most recent evidence and best practices. TIPS save members time which they'd otherwise spend researching and planning implementation and training for their team. The topics currently available are:

- Agenda Setting
- Clinical Data Registries
- Continuity of Care
- Empanelment
- Quality Improvement
- Standing Orders
- Team Documentation

Most of the TIPS topics offer 1-2 AAFP Prescribed credits. Members can access this resource at www.aafp.org/aafptips.



Arkansas Cancer Coalition

ImmunizeAR

ARKANSAS IMMUNIZATION ACTION COALITION

Take action to increase HPV vaccination today!

Your recommendation is the #1 reason parents choose to vaccinate their children

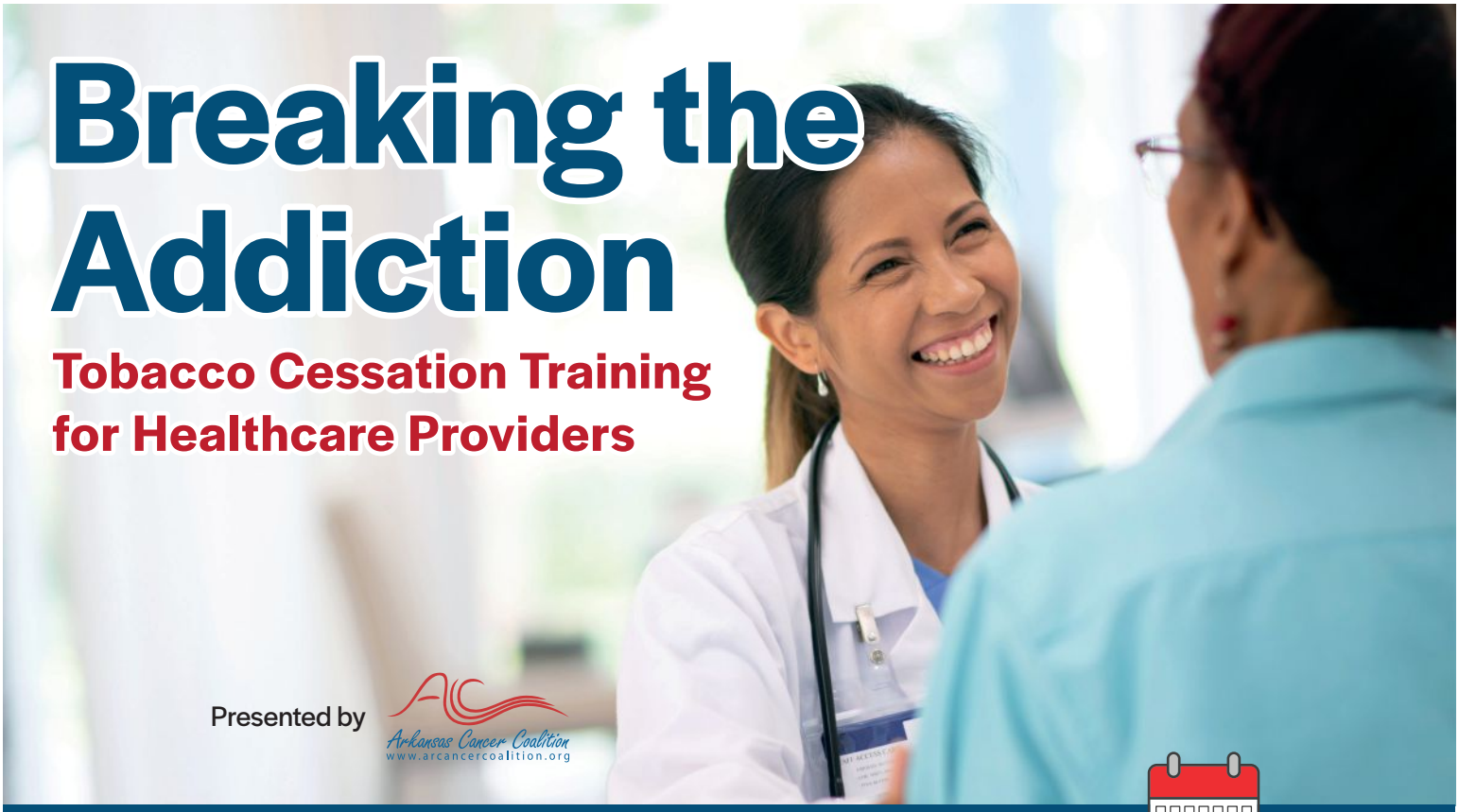
HPV vaccine is cancer prevention

Get more information at:

https://www.immunizear.org/hpv-information

Breaking the Addiction

Tobacco Cessation Training for Healthcare Providers



Presented by Arkansas Cancer Coalition
www.arcancercoalition.org

With the help of a clinician, the odds of quitting tobacco more than double.

While counseling and medication are both effective for tobacco cessation, combining these treatments can be even more effective.

This training will instruct participants with developing quit plans for tobacco users, prescribing medications and referring patients for lung cancer screenings.

Target Audience: Physicians, physician's assistants, nurses, pharmacists, wellness managers, nutritionists, respiratory therapists, dental professionals, social workers, community health professionals, cancer and tobacco control advocates.

Continued Education Information: See Page 2 for details.

2020 FALL SESSIONS*

November 4th
Julie Kissack, PharmD
Pharmacotherapy

November 5th
Patricia Franklin, APRN, CTTS
Low Dose CT Screening

November 6th
Sandra Brown, DNP
Motivational Interviewing

2021 SPRING SESSIONS*

February 2nd
Julie Kissack, PharmD.
Pharmacotherapy

February 3rd
Patricia Franklin, APRN, CTTS
Low Dose CT Screening

February 4th
Sandra Brown, DNP
Motivational Interviewing

**All Fall and Spring Sessiona are held virtually.*

REGISTER ONLINE AT https://www.surveymonkey.com/r/ACCBTI

Contact: info@arcancercoalition.org | 501.404.0028

BTI Brief Tobacco Intervention

Tobacco Cessation Training for Healthcare Providers

be well

Your Tobacco Settlement Dollars at Work

Arkansas Academy of Family Physicians
P. O. Box 242404
Little Rock, Arkansas 72223-9998

We have your back, so you can move forward.

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www.svmic.com

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