Annual Scientific Assembly August 4-7, 2021

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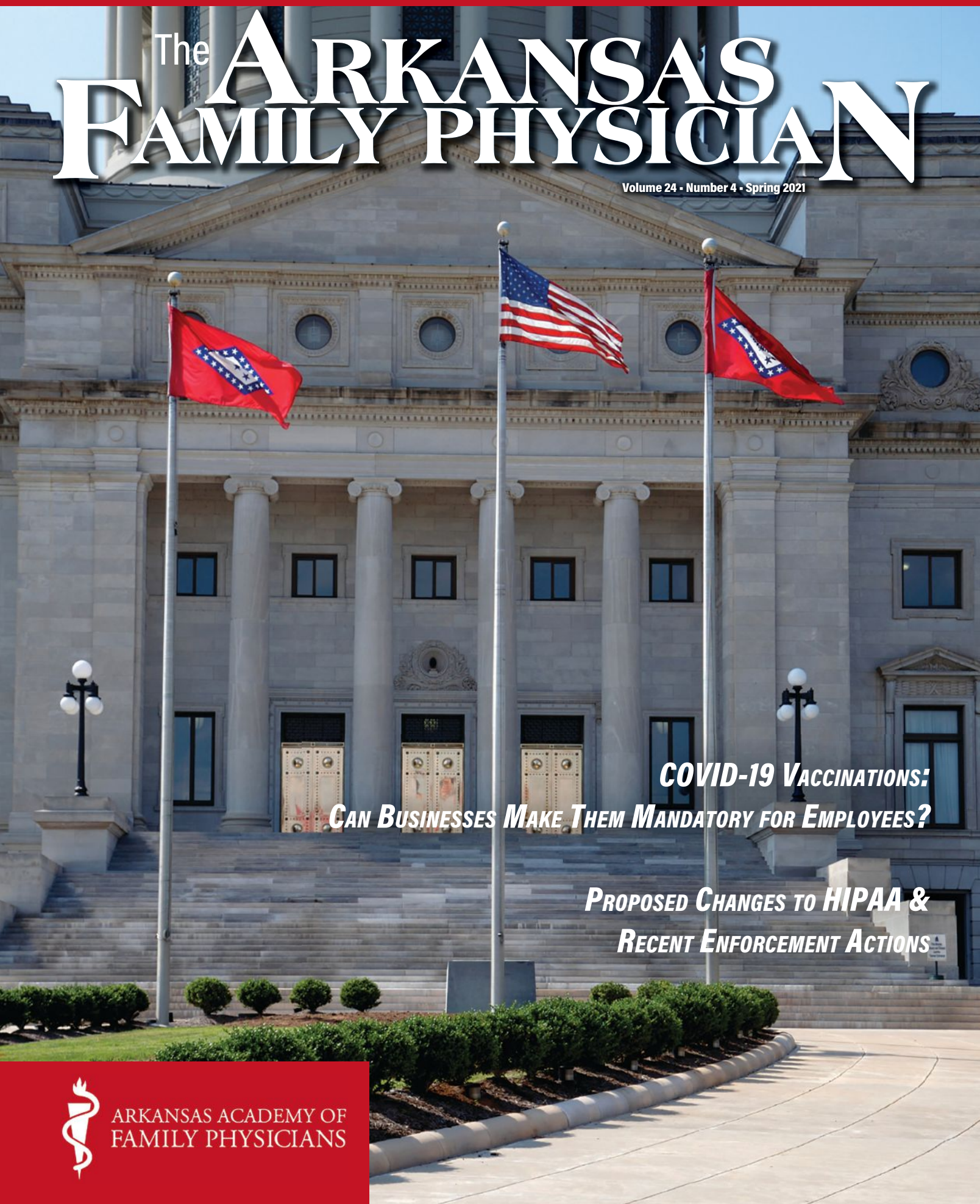


COVID-19 Vaccinations: Can Businesses Make Them Mandatory for Employees?

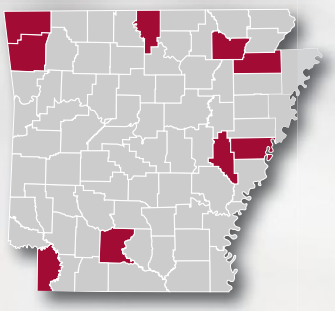
Proposed Changes to HIPAA & Recent Enforcement Actions

ARKANSAS ACADEMY OF FAMILY PHYSICIANS

Baby's best medicine doesn't come from a bottle.

Breastfeeding babies for 6 months or more helps prevent illnesses. Talk to your expectant and new moms about the benefits of breastfeeding over formula. **Breastfeeding is best.**

Family physicians in nine counties have committed to promoting breastfeeding. To learn more about the breastfeeding initiative, email wmitchell@uams.edu. Those who join will earn free CME at the UAMS Family Medicine Spring Review April 27-30, 2021.



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ARKANSAS ACADEMY OF FAMILY PHYSICIANS

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

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EDITION 95

On the cover: Arkansas State Capital

Mary Beth Rogers,
ArAFP Executive Director

EXECUTIVE DIRECTOR'S LETTER

The Consequences Have Arrived

Being the mother of two teenage boys I feel like I have preached about considering consequences until I am blue in the face. Teenagers see the instant gratification of a car, but they rarely think of the costs and responsibilities associated with it. Cars are dangerous if not driven with care and they require maintenance and upkeep to run properly. If these rules are not followed then, severe consequences may happen to the car or to the driver and those around them. We all know people that must learn the hard way and sometimes our healthcare system is just as short-sighted as a teenage boy with a fast car. That makes it even more frustrating when it is universally agreed that a strong primary care infrastructure is necessary to lower costs and stabilize the foundation of healthcare. The problem with dealing with systems is that for one investment to be made, someone else must give a little and that has not happened. So now, here we are in the midst of a pandemic and we have primary care on the front lines working on a cracked foundation.

To illustrate the harm done from neglecting the upkeep of our health system consider that according to a December survey of 1,485 clinician participants around the country by the Larry A. Green Center (https://www.green-center.org/), 91% of practices have some form of personnel shortage, 61% have severe/near severe practice stress, and 41% have staff positions they cannot fill. Sadly, 44% of clinicians had salary cuts while 25% report fee-for-service volume is down over 30%, yet 20% have still waived copays and reduced fees. Support for substance abuse (22%) and mental health services (65%) have increased.

It has taken a crisis to highlight the fault lines in our healthcare structure and we hope that our primary care system will tolerate the consequences as our nation begins to emerge from the pandemic. So much like our teenagers' cars, as physicians we need to ensure that the maintenance of our health system is taken care of. One way we can do that is by making sure that events occurring in the legislature that can affect our practices and the system are positive for both.

The gavel dropped in January to start the 2021 Legislative session. The session got off to a slow start while lawmakers passed and adopted new rules on how to do business as safely as possible. Public comments can still be made in person; however, we will not be congregating at the Capitol like we have in the past. That is why is absolutely imperative for you to respond to our Call-to-Action requests. Volume is the word of the day and I cannot stress enough how important it is for you to make those calls and send emails.

You can leave a message for your Representative by calling (501) 628-6211 and your Senator at (501) 682-2902. When you leave a message a "pink slip" is left on their desk. A stack of pink slips sends a powerful message so please take a minute to call when we send you a notice.

We will continue to fight for you by monitoring bills, communicating with legislators, and providing testimony on your behalf. We urge you to help us protect the foundation of healthcare by participating in this session because we know the consequences of inaction will be harmful. We are here to help keep you, the foundation of our healthcare system engaged with each other by influencing the government with our collective voice to reinforce our foundation for the greater good.

Mary Beth Rogers
Executive Director

Appathurai Balamurugan, MD, DrPH, DipABOM, FAAFP

Let It Be!

Friends, certainly these are troubling times like anytime in the history of our nation – a raging pandemic, a race to vaccinate the masses, civil and political unrest, and on. We the People have the power to reset those in our control through our thoughtful response. At the same time, we need to take solace in things we don't have the power to reset! Life can be extremely stressful at times with everything happening around us. Many philosophers attribute this to holding on to illusions of control. We tend to overthink, ruminate, and hold on to things beyond our control. This can cause a lot of physical and mental strain. On the flip side, letting go of things beyond our control is difficult and sometimes impractical for humans. We put ourselves under added stress and pressure to let go of things. Scholars are coming to a realization that allowing oneself to feel whatever comes up and accept that it is present, and moving forward is good for mental and physical health. One thing constant in our lives is change, so letting it be and practicing self-care lets us move forward safely. Beatles' Sir Paul McCartney articulated these thoughts a long time ago in the famous song about his mother, Mary McCartney, 'Let it be'. The lyrics from the song are worth contemplating during these troubling times.

"When I Find Myself In Times Of Trouble, Mother Mary Comes To Me
Speaking Words Of Wisdom, Let It Be
And In My Hour Of Darkness She Is Standing Right In Front Of Me
Speaking Words Of Wisdom, Let It Be
Let It Be, Let It Be, Let It Be, Let It Be
Whisper Words Of Wisdom, Let It Be
And When The Broken Hearted People Living In The World Agree
There Will Be An Answer, Let It Be
For Though They May Be Parted, There Is Still A Chance That They Will See
There Will Be An Answer, Let It Be
Let It Be, Let It Be, Let It Be, Let It Be
There Will Be An Answer, Let It Be
Let It Be, Let It Be, Let It Be, Let It Be
Whisper Words Of Wisdom, Let It Be
Let It Be, Let It Be, Let It Be, Let It Be
Whisper Words Of Wisdom, Let It Be, Be
And When The Night Is Cloudy There Is Still A Light That Shines On Me
Shinin' Until Tomorrow, Let It Be
I Wake Up To The Sound Of Music, Mother Mary Comes To Me
Speaking Words Of Wisdom, Let It Be
And Let It Be, Let It Be, Let It Be, Let It Be
Whisper Words Of Wisdom, Let It Be
And Let It Be, Let It Be, Let It Be, Let It Be
Whisper Words Of Wisdom, Let It Be"

Having lost my mother to cancer and going through a divorce this past year amidst a pandemic, I contemplate on these words and find solace. Lastly, an attitude of gratitude takes us further in the journey of life. I am thankful for life, my kids, family, neighbors, community, state, and this nation we call home. When we count our blessings, we would realize that we are actually better off than we thought we were. Whether you are a believer or not, the serenity prayer conveys similar messages for us during these troubling times. "*God grant me the serenity to accept the things I cannot change; courage to change the things I can; and the wisdom to know the difference*". We the People have the power to make a difference through our thoughtful response no matter how things seem; with gratitude, and taking solace when we are powerless to make a difference, while continuing our personal and professional duties for the good of us, our family, our patients, our community, our nation, and the world at large!

Colorectal cancer screening in Arkansas isn't working well.

56% of colorectal cancer in the state is diagnosed at Stage 3 or 4* because too many patients aren't screened soon enough or well enough. We're out to change that. Together with 1st Choice Healthcare in Northeast Arkansas, we are mapping out practices that are evidence-based, funneling patients into colorectal screening BEFORE it's too late. We call it **Partnerships in Colorectal Cancer Screening for Arkansas** or **PiCS AR**.

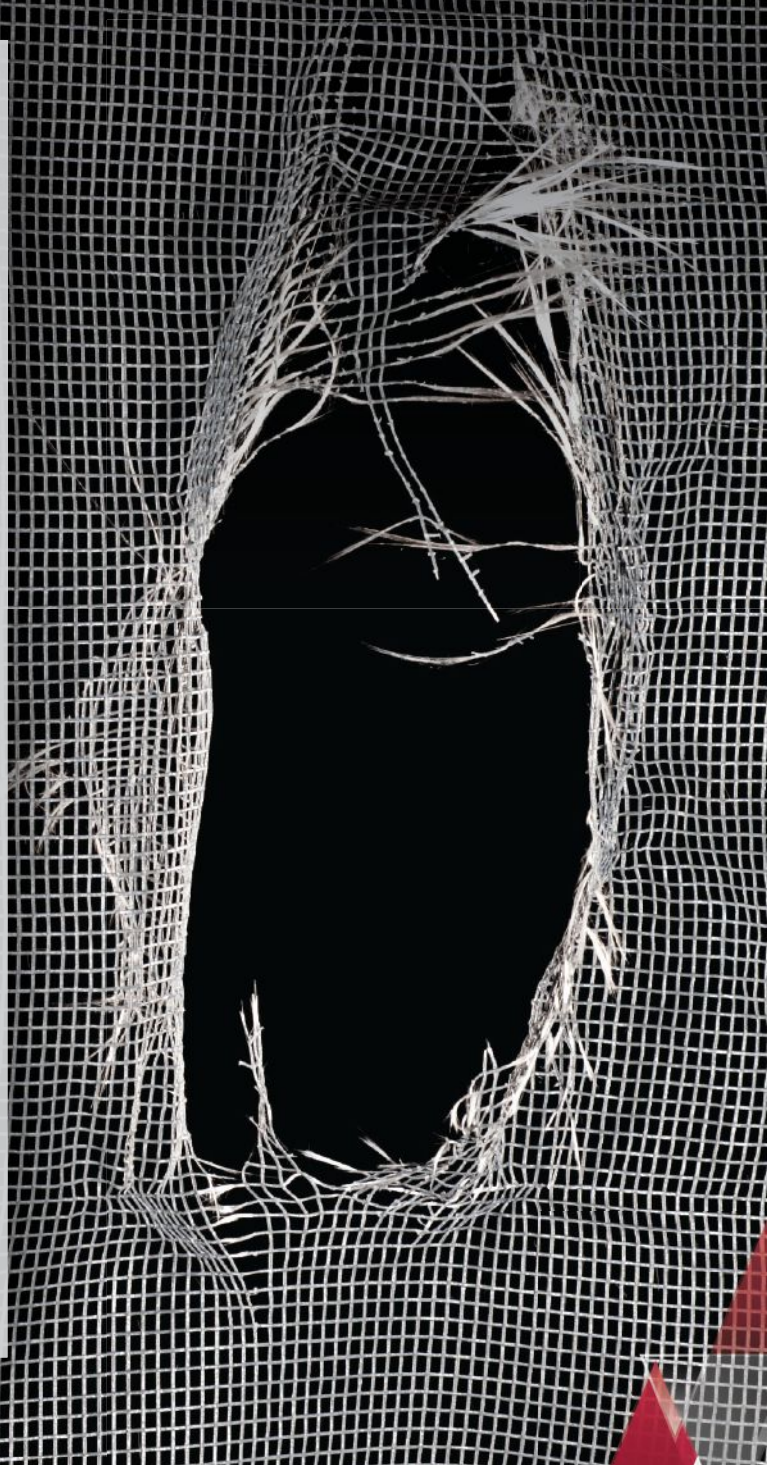
Learn more about colorectal cancer and other family medicine topics at the virtual UAMS Family Medicine Spring Review April 27 - 30, 2021. Email Marybeth Curtis at mcurtis@UAMS.edu for more information.

PiCS AR!
Partnerships in Colorectal Cancer Screening For Arkansas

UAMS College of Medicine

1ST CHOICE HEALTHCARE
Revolving around you

National Cancer Institute's State Cancer Profiles



Dr. T.E. Rhine

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

In the first half of the 20th century, there were eight to ten family physicians who could be identified as the poster boy for Family Practice in Arkansas. Two years ago we detailed the life of John William Morris of McCrory. In this article we will discuss the life of Dr. T.E. Rhine of Thornton, Arkansas. Like many of his contemporaries, he often was the narrator for his community, the father confessor, the soul who was there for families from birth to death; he was the person who they called on in time of need. One of his principal traits was trust, trust to do the right thing, trust to be there when he is needed. Wisdom is another of those traits that set him apart; his patients and those he mentored thought him to be the best diagnostician ever.

In 1985, his daughter, Pat Rhine of Pine Bluff wrote a wonderful book on the life of her father, *T.E. Rhine, M.D. Recollections of an Arkansas Country Doctor 1876-1964.*

Dr. T.E. Rhine was born in Lexington, Mississippi in 1876. At age five, his family moved to Rison, Arkansas in Cleveland County. His early education was in what he referred to as a "*Seed-Tick*" school. At an early age, he made it known that he wanted to be a doctor. The family moved to Fordyce when Ed was in the 9th grade. He finished his high school education and was a member of the first graduating class of Fordyce High School. After graduation he attended a private school in Fordyce called the Clarey Training School. This is where he began his preparation for teaching. He followed this with training at the Normal School for Teachers in Princeton. Arkansas. After a brief tenure at the Normal School for Teachers in Princeton, Arkansas. he obtained a job teaching.

In the fall of 1896, he began his medical training at the Memphis Hospital Medical College in Memphis, Tennessee. His education in Memphis consisted in a series of six-month courses of lectures.

After completing the second set of lectures, he went to Locust Grove in Calhoun County where he precepted with **Dr. E.L. Beck**. It was during this time that he was examined by a panel of three physicians: Dr. Beck, **Dr. W.D. Sadler** of Thornton and **Dr. W.B. Jones** of Summerville. He was examined in April and licensed to practice in September. When he began his rugged six-month internship in the Calhoun County, he weighed in at 165 pounds and at the end of this ordeal he had dropped to 135 pounds. Most of his time was spent on horseback with his pill bags across his saddle. In October, he began a third round of lectures in Memphis and graduated 2nd in his class in April of 1899. On May 17th, 1899, he rode into Thornton, Arkansas on a gray horse, with $40.00 of borrowed money with which to start his practice.

The town of Thornton was established in 1890 because of the newly completed Cotton Belt Railroad and the timber industry. In 1899, when Ed arrived, the town had a population of approximately 500 people. The Stout Lumber Company owned 70,000 acres of pine forest and was the principal employer.

In the early years of his practice there were few roads and the ones that did exist were impassible except in the summer and early fall. In the early years of his practice he spent the majority of his time on horseback. Generally, he wore a large gum coat, a gum hat and high leather boots to protect him from the weather. His daughter wrote in a biography of her father: "*Many times in freezing weather, he would pull off the coat, covered in ice, stand it on the porch of the house while seeing a patient, and return to find it still standing upright just as he had left it.*"

In addition to the inhospitable conditions, he weathered a number of epidemics such as smallpox, menigitis, typhoid and diphtheria and pneumonia. As the surgeon for the lumber company, he was called on to deal with a great deal of trauma and amputations; kitchen table surgery was common. He eventually delivered over 4800 babies. Most of his years in practice there was little he could do medically about many of the problems he faced. **Dr. Henry Hearnsberger,** a Little Rock psychiatrist, once said of his friend and benefactor, "*The doctor's personality was a lot of the treatment, and this was what Dr. Rhine's personality did, dealing with those people. It cured a lot of them. It was almost a faith healing.*"

continued on page 8

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continued from page 6

In the early years of his practice there were few hospitals. St. Vincent's in Little Rock was up and going strong but because of the road conditions it was quicker and easier to get critically ill patients to a Memphis hospital.

As time progressed, he moved from horseback to buggies, the occasional use of a bicycle and, in 1913, he purchased a Model-T Ford. As the company doctor, he had access to riding the trains along the main line and then spur lines going out to the logging camps to deal with illness and trauma.

The mid-1920s provided the good doctor with several setbacks. In March of 1924, he awoke on a Sunday morning to find that his right side was paralyzed. The next several months were spent in Little Rock and Hot Springs rehabbing from the stroke. He was advised by this physicians, that he would probably not be able to return to work or to his loved pastime of fox hunting. In September, he was six-months into his forced rest period when a fire broke out in the barn next to his house. He jumped into action and soon was working as hard as anyone else in putting out the fire. The next day he announced that if he could work that hard at putting out the fire with no harm, he could go back to work. Despite the warnings of this doctors and family, he went back to work.

Unkind fate was not through with the good doctor. In 1925, the sawmill burned to the ground and, in 1927, the Stout Lumber Company sold all of it interests. Dr. Rhine was offered good paying jobs that would require him to leave the community. He and his family decided not to leave the town of Thornton: *"Why, these folks raised me. When I go to see them, they look at me with confidence in my ability to relieve their suffering; there's a lot of satisfaction in that."*

Dr. Rhine's involvement in the Thornton did not end at the sick bed. He was thoroughly involved in community and especially the school system. He was a member of the school board for thirty-five years.

In 1948, he was named Physician of the Year in the State of Arkansas and was runner up for the American Medical Society's General Practitioner of the Year in 1950.

He practiced medicine in Thornton from 1899 to 1964 and died at age 86 in 1964.

Jack Gresham commented on Dr. Rhine: "*He was unacquainted with the nine to four working day, with weekends off. Had he operated under such a schedule, he would probably have lived to be one hundred, but then, he wouldn't have been Dr. Rhine. He was truly one of a kind."*

(Arkansas Country Doctor Museum, Wall of Honor, T.E. Rhine, 2005, last accessed 4-5-2018)

(Rhine, Pat, T.E. Rhine, M.D. Recollections of an Arkansas Country Doctor 1876-1964, August House, 1985

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COVID-19 & Be Well Arkansas

Joy Gray, TTS, Donald McCormick, MS, Bala Simon, MD, DrPH, FAAFP
Arkansas Department of Health

While COVID-19 continues to ravage our state and the nation; heart disease, cancer, chronic obstructive pulmonary disease, and diabetes remain the leading causes of death in the state and the nation. More than 86% of the nation's health care costs are associated with these chronic diseases, and for most part are preventable. Health behaviors such as tobacco use, poor diet, and physical activity contribute to these diseases that impact the health of our state and our nation. COVID-19 has placed limitations on our lifestyle due to quarantine and isolation needs, and travel restrictions to contain the pandemic.

Be Well Arkansas (BWA) is a public health program that comprises of a wellness assistance line and a health communications campaign, launched by Arkansas Department of Health on November 5th, 2018. This newly-formed wellness assistance line replaced the previous "Arkansas Tobacco Quitline." Callers to BWA can receive tobacco cessation counseling as well as resources on diabetes and hypertension management. Eligible callers may also receive nicotine replacement therapy. Arkansas is currently the only state in the nation that operates a wellness assistance line and call center from its Department of Health.

Background

In 2002, 26.3% of adults in Arkansas reported cigarette use in the past 30 days. The use of tobacco cessation services has quickly grown due to the high prevalence of smoking and the adverse health effects associated with its use. Tobacco quit line provides residents with the ability to receive evidence-based tobacco cessation treatments with the goal of reducing tobacco use prevalence and the associated health burdens. Current cigarette use among adult Arkansans dropped to 22.7% in 2018, but this decline has been associated with increased use of alternative tobacco products since 2002. In 2018, 29.3% of adults in Arkansas reported using at least one tobacco product in the past 30 days. By tobacco type, cigarettes were the most prevalently used product (with 22.7% of respondents reporting use in the last 30 days) followed by smokeless tobacco use (6.4%), and e-cigarette use (6.3%). While the tobacco control efforts resulted in a decline in traditional cigarette use, the addition of new tobacco products and adverse health complications associated with tobacco products use showed the need for ongoing tobacco cessation efforts.

The Arkansas Tobacco Quitline (ATQ) began operations in 2002 and continuously provided tobacco cessation services through an out-of-state vendor until November 2018. In November 2018, the ATQ was relocated to the Arkansas Department of Health (ADH) Tobacco Prevention and Cessation Program (TPCP) and was rebranded and operates as the Be Well Arkansas (BWA) wellness assistance line. The wellness assistance line provides free, telephonic tobacco cessation counseling provided by trained Tobacco Treatment Specialists (TTS) during regular business hours (i.e., Monday – Friday, 8:00 a.m. to 4:00 p.m.). Callers can access BWA services by calling 1-833-283-WELL (9355) or 1-800-QUIT-NOW (784-8669) or completing an online registration on the BWA Website. Individuals who are referred to the BWA Wellness assistance line are responded to within one business day. Healthcare providers can submit referrals via fax or the BWA website. Tobacco cessation services are provided by BWA counselors in English and Spanish, and a third-party vendor provides translation services for clients who converse using Marshallese, Chinese, German, Vietnamese, Korean, Cantonese, and Sign Language. In addition to tobacco cessation services, the Wellness assistance line provides diabetes and hypertension management referrals to local healthcare providers.

Context

BWA provides various levels of services to Arkansas residents who use tobacco products. Arkansas residents who call BWA begin their tobacco cessation journey by participating in an intake process and will be referred to as "**callers**." During intake, a BWA counselor will determine caller eligibility based on factors including: type of service requested; insurance, military, and employment status; and the caller's interest in participating in counseling.
The following list of guidelines detail the services offered to callers based on BWA internal protocols and national treatment recommendations:

Counseling Services:
- All callers **13 years and older** are eligible to receive counseling services.

Nicotine Replacement Therapy (NRT) Samples:
- Clients must be **at least 18 years old**, and **weigh more than 100 pounds** to receive samples.

NRT Prescriptions:
- Clients must be **at least 18 years old**, be **Medicaid beneficiaries**, and **weigh at least 100 lbs.** in order to receive prescriptions.

Individuals who would like to participate in counseling and pharmacotherapy offered by BWA are registered as "clients." All clients are eligible to participate in a four-session counseling protocol and receive a two-week, free nicotine replacement therapy (NRT) medication or NRT prescription. Special interest groups, such as women who are pregnant, are offered an additional six counseling sessions, but NRTs are not allowable by pharmaceutical regulation for this group of women. The Wellness assistance line also provides diabetes and hypertension management resources and referrals to local healthcare providers.

Results and Discussion

During the year 2020, BWA wellness assistance line received 11,127 intake calls from Arkansans across the state; 6,295 individuals were enrolled for BWA counseling for tobacco cessation and 1,729 were referred to programs offered by private insurance providers. Additionally, 1,973 individuals were offered hypertension resources and referrals, and 898 individuals were offered diabetes resources and referrals. Over 4,150 NRT packets were sent to patients to assist with tobacco cessation, and 2,131 NRT prescriptions were mailed to patients.

All tobacco cessation clients can access free text support though Smokefree Text Messaging. Individuals can sign up for text messaging support through the smokefree.gov website. In order to provide continuity

of services, all clients are requested to participate in 4-, 7-, and 13-month follow-up interviews to determine the effectiveness of counseling through the BWA tobacco cessation wellness assistance line. Individuals are contacted up to four times after counseling to participate in a follow-up interview where they discuss their current tobacco use status, any problems or relapses experienced, and any external resources they may have used to help them quit tobacco. Beginning Spring 2021, pregnant women will have the option to enroll in Be Well Baby, which is targeted towards pregnant smokers exclusively.

The ADH is excited to link our services together to provide enhanced wellness resources for our fellow Arkansans through Be Well Arkansas program while addressing COVID-19 pandemic!

Student Happenings

Reid A. Counce, Student Representative Arkansas AFP Board of Directors
UAMS College of Medicine '21

The Family Medicine Interest Group at UAMS has had a great academic year so far. Although our meetings have been on Zoom, we have been fortunate to have experienced residents, attendings, and faculty speak to our students. We have also created webpages with recordings of these lectures for our students to watch at a later time if needed. Now more than ever, we realize how important it is to reach out to people via social media, whether that be Instagram, Facebook, or other outlets. We gave residents at each program in the state the keys to our Instagram account and let them "takeover" for a day. It allowed our students to really see what a "day in the life" is like for residents at each respective program, and I believe it was a big hit. One project we are currently working on is a mentoring program between Family Medicine residents and medical students. We aim to reach the students earlier during their time at UAMS and match them with not only a strong voice for Family Medicine, but someone that has experienced the ups and downs of medical school and can be there for them during those challenging times. We are always open to new ideas and having physicians as guests in our FMIG Meetings, so if you are interested, please let us know!

Stuart Jackson
Partner on WLJ's Labor & Employment Team

COVID-19 Vaccinations: Can Businesses Make Them Mandatory for Employees?

With a myriad of potential COVID-19 vaccinations on the horizon, the business community is collectively breathing a sigh of relief. While distribution and timing are still up in the air, everyone hopes that by the start of the third quarter of 2021, most Americans will have access to a vaccination. This gives businesses the opportunity to think through how they want to approach their employees about COVID-19 vaccinations — should they be mandatory or at the discretion of the employees? Many businesses, especially in the health care field, will push for mandatory COVID-19 vaccination policies.

If your business decides to go the "mandatory" route, which in the case of a worldwide pandemic is allowable, be ready to field requests to forego the vaccination once you roll out your policy. Some (maybe most) requests can be turned down, like those people who just don't like the idea of vaccines in general or those who have some latent distrust of the COVID-19 vaccines (perhaps socially or politically driven). Full disclosure: I plan to get the vaccination when it's my turn.

However, you need to listen to those requests to not take the vaccine that involve some type of health-related or religious reason. Ignoring them potentially violates the Americans with Disabilities Act or Title VII of the Civil Rights Act, both of which apply to businesses with at least 15 employees, and the Arkansas Civil Rights Act, which applies to businesses with nine or more employees. Here's the specific EEOC guidance on what a covered business should do in response to a request to not take the vaccination due to health or religious reasons:

If an employer requires vaccinations when they are available, how should it respond to an employee who indicates that he or she is unable to receive a COVID-19 vaccination because of a disability? *(12/16/20)*

The ADA allows an employer to have a qualification standard that includes "a requirement that an individual shall not pose a direct threat to the health or safety of individuals in the workplace." However, if a safety-based qualification standard, such as a vaccination requirement, screens out or tends to screen out an individual with a disability, the employer must show that an unvaccinated employee would pose a direct threat due to a "significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation." 29 C.F.R. 1630.2(r). . . . If an employer determines that an individual who cannot be vaccinated due to disability poses a direct threat at the worksite, the employer cannot exclude the employee from the

workplace—or take any other action—unless there is no way to provide a reasonable accommodation (absent undue hardship) that would eliminate or reduce this risk so the unvaccinated employee does not pose a direct threat.

If there is a direct threat that cannot be reduced to an acceptable level, the employer can exclude the employee from physically entering the workplace, but this does not mean the employer may automatically terminate the worker. Employers will need to determine if any other rights apply under the EEO laws or other federal, state, and local authorities. For example, if an employer excludes an employee based on an inability to accommodate a request to be exempt from a vaccination requirement, the employee may be entitled to accommodations such as performing the current position remotely. This is the same step that employers take when physically excluding employees from a worksite due to a current COVID-19 diagnosis or symptoms; some workers may be entitled to telework or, if not, may be eligible to take leave under the Families First Coronavirus Response Act, under the FMLA, or under the employer's policies.

If an employer requires vaccinations when they are available, how should it respond to an employee who indicates that he or she is unable to receive a COVID-19 vaccination because of a sincerely held religious practice or belief? *(12/16/20)*

Once an employer is on notice that an employee's sincerely held religious belief, practice, or observance prevents the employee from receiving the vaccination, the employer must provide a reasonable accommodation for the religious belief, practice, or observance unless it would pose an undue hardship under Title VII of the Civil Rights Act. Courts have defined "undue hardship" under Title VII as having more than a de minimis cost or burden on the employer. EEOC guidance explains that because the definition of religion is broad and protects beliefs, practices, and observances with which the employer may be unfamiliar, the employer should ordinarily assume that an employee's request for religious accommodation is based on a sincerely held religious belief. If, however, an employee requests a religious accommodation, and an employer has an objective basis for questioning either the religious nature or the sincerity of a particular belief, practice, or observance, the employer would be justified in requesting additional supporting information.

You can find the full text of the EEOC's vaccination guidance at *www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws*.

Now, just because one of your employees asks for an exemption from a mandatory vaccination policy due to health or religious reasons does not mean he or she is automatically entitled to it. But, you should listen, get the facts and fully understand the law before you make a decision (one you might have to explain in court) on whether to grant an exception. In my view, working with an employee to see if there is a reasonable option – like a remote working arrangement, some type of extended leave or even a transfer to another job – is never a bad idea.

Jennifer Smith, Attorney
Wright, Lindsey & Jennings, LLP

Proposed Changes to HIPAA & Recent Enforcement Actions

On December 10, 2020, the Department of Health and Human Services Office for Civil Rights ("OCR"), which enforces HIPAA, released a proposed rule that would make several changes to the HIPAA Privacy Rule. One purpose of the proposed rule is to strengthen the rights of individuals to access their medical records.

With limited exceptions, the right of an individual to access his or her medical record includes both the right to inspect the records and the right to receive copies of the records. A recent audit report released by the OCR showed that 89% of covered entities audited were not correctly implementing the right to access. In 2019, the OCR began prioritizing enforcement of violations of the right to access. Since beginning this initiative, fourteen access-related investigations have been settled with health care providers. More than half of these settlements were with physicians or physician groups. Penalties were imposed for failure or refusal to provide timely access, failure to provide copies in the requested format, and failure to cooperate with the OCR's investigation. The average penalty imposed against a physician group was around $36,000.

The current HIPAA regulations provide that a covered entity must respond to an individual's request to access his or her records within thirty days of receipt, or, if the records are maintained off-site, within sixty days of receipt. If a covered entity cannot respond to the request within this time frame, a thirty-day extension is allowed if the covered entity provides the individual with a written statement that explains the reason for the delay and provides a date for when the request will be fulfilled.

If copies are requested, they must be produced in the format requested by the individual, or if the requested format is not readily producible, in a format agreed to by the individual. The current HIPAA regulations also allow covered entities to charge a reasonable fee for providing copies, but the fee is limited to the cost of labor associated with copying the records and related supplies and postage. This fee limitation applies when individuals request copies of their own records. It does not apply when an individual requests his or her records to be transmitted to a third party.

The proposed rule would change the right to access in several ways. The time frame for responding would be reduced from thirty days to fifteen days. If an extension were needed, the covered entity would be allowed only one fifteen-day extension, and the covered entity would still be required to provide the individual with a written statement of the reason for the delay and a date when the request will be fulfilled. Covered entities may also be required to establish a process to prioritize urgent or high priority requests for access, such as for requests that are related to a health or safety issue.

In addition to allowing individuals to inspect their records, the proposed rule would provide individuals with the right to take notes and photograph or otherwise capture information contained within their medical records as long as the individual used a personal device that did not require connecting to the covered entity's information system.

With respect to fees, covered entities would continue to be limited to charging fees for labor involved with making copies of records, including electronic copies, related supplies, and postage when the record would be mailed. If a summary of the record were requested or agreed to by the individual, a reasonable charge could be imposed to prepare the summary. Covered entities would be prohibited from charging an individual for inspecting records or accessing records through an internet-based method, such as a personal health application. In addition, any fees would need to be disclosed in advance. Covered entities would also continue to be prohibited from refusing to provide access to records if a patient had an outstanding medical bill. Finally, the OCR would encourage, but would not require, covered entities to waive fees for individuals with limited financial means, such as individuals who have Medicaid or those who qualify for a financial assistance program.

Individuals would continue to have the right to direct a covered entity to send a copy of their medical record to a third party, but this right would be limited to electronic health records and would not include records maintained on paper or other media, such as microfiche. Fees for directing electronic copies to third parties would also be limited to labor for making the copies and/or preparing a summary or explanation if agreed to by the individual.

The proposed rule would also grant current or prospective patients the right to request that a covered entity request copies of their medical records from other covered entities. Such requests would have to be made by the requesting covered entity within fifteen days. The disclosing covered entity would then have fifteen days to respond and would be allowed one fifteen-day extension if needed.

In addition to changes to the right to access, the proposed rule would also provide clarity for when protected health information ("PHI") could be disclosed without an authorization for case management and care coordination, including to community-based organizations, caregivers and family members, and when PHI could be disclosed in a patient's best interest. Finally, the proposed rule would eliminate the need to obtain a written acknowledgement that a patient received a copy of the covered entity's notice of privacy practices.

If finalized, the proposed rule will become effective sixty days after publication. Covered entities will then have 180 days to comply with the rule, which will require updating policies and procedures and the covered entity's current notice of privacy practices, as well as making sure staff are trained on these new requirements.

Jennifer Smith is an attorney at Wright, Lindsey & Jennings specializing in health law. She can be reached at 479-631-3290 or jsmith@wlj.com

Arkansas Fellowship Convocation

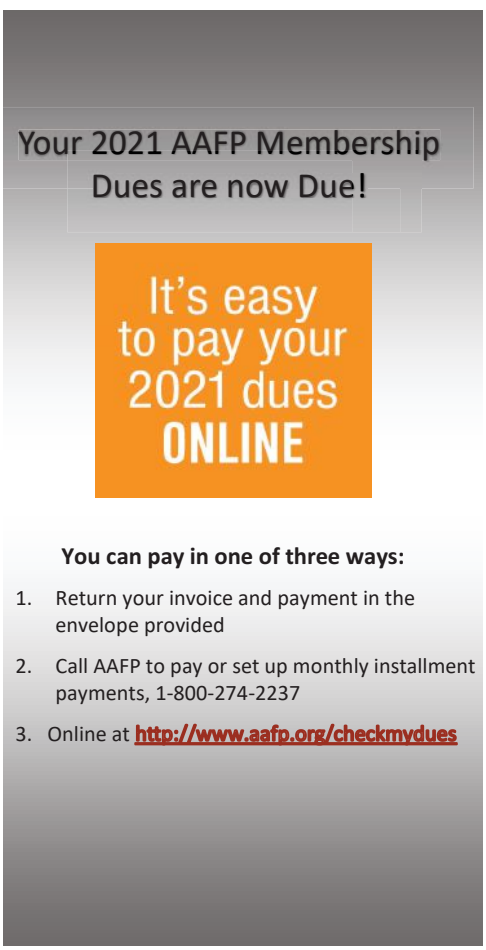
The American Academy of Family Physicians Degree of Fellow was established in 1971 is a special honor bestowed upon AAFP members who have distinguished themselves among their colleagues by their service to Family Medicine and their commitment to their professional development through medical education and research.

You may be eligible for this honor if you are an Active, Life or Inactive member of the AAFP and have been for at least six years or have held a combination of Resident and Active membership for at least six years.

The Arkansas Chapter will recognize Arkansas Family Physicians who have earned the Degree of Fellow by the American Academy of Family Physicians at the Annual Scientific Assembly in August 2021 at Embassy Suites. You must have completed the application and earned your Degree of Fellow by May 15, 2021 to be conferred at the August Assembly.

The requirements and application can be found at:
www.aafp.org/degreeoffellow

Please let us know if you wish to be conferred in August or need assistance in applying for the Degree of Fellow by calling 501-223-2272 or email michelle@arkansasafp.org.



Stay Connected to the AR AFP on Social Media

Did you know we can be found on Facebook, Twitter, and Instagram? Follow us on your preferred social media platforms for Arkansas AFP updates and happenings.

Facebook (@ARAcademyofFamilyPhysicians),
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Expansion of Antimicrobial Stewardship in the Outpatient Setting

Marsha Crader, PharmD, FASHP – Associate Professor of Pharmacy Practice, UAMS College of Pharmacy and Lead Antimicrobial Stewardship Pharmacist, St. Bernards Healthcare

Kodi Liddell, PharmD, BCPS – Clinical Assistant Professor of Pharmacy Practice, UAMS College of Pharmacy and Clinical Pharmacy Specialist, UAMS Northeast Family Medicine Clinic

Antimicrobial stewardship has become an essential component of patient care within acute and long-term care settings and is now expanding into outpatient clinics. Guidance for this expansion was introduced in 2016 with the launch of the Centers for Disease Control and Prevention's (CDC) Core Elements of Outpatient Antibiotic Stewardship. These core elements advise clinic antimicrobial stewardship programs to include: 1) commitment, 2) actions to improve, 3) tracking and reporting, and 4) education and expertise.[1] Although initial groundwork was provided to hospitals and nursing homes to advance antimicrobial stewardship practices through previous statewide collaboratives in Arkansas, outpatient clinics have not had those same opportunities to date. Physicians, quality improvement personnel, and other health care professionals in the clinic setting should educate themselves on the latest evidence-based information and regulations to ensure appropriate antibiotic prescribing.

Arkansas has consistently prescribed a high rate of antibiotics since reporting began in 2011 and was ranked 44th in 2018 compared with all other states. Arkansas prescribers wrote 1,011 antibiotic prescriptions per 1,000 persons compared to 451 prescriptions per 1,000 persons in top-ranked Alaska.[2] Unnecessary antibiotic use can stem from many reasons, including the treatment of viral infections with antibiotics, usage of more broad-spectrum antibiotics than necessary, and excessive length of therapy.

Regulatory and Insurance Requirements

To help drive improvements in antibiotic usage, now regulatory bodies and insurance companies are requiring evidence of stewardship programs and subsequent prescribing improvements. Both Arkansas BlueCross BlueShield (BCBS) and Arkansas Medicaid Patient-Centered Medical Home (PCMH) programs have quality metrics tied to reimbursement rooted in outpatient stewardship efforts.

Arkansas BCBS PCMH quality metrics include increasing the percentage of pediatric patients who receive appropriate treatment for upper respiratory tract infections (URIs) as well as reducing the percent of adult patients (18-64 years) with a diagnosis of acute bronchitis who receive a prescription for a respiratory antibiotic on or three days after the initial visit.[3]

Arkansas Medicaid PCMH evaluates similar quality metrics, including reducing the percentage of patients with a diagnosis of non-specified URI who received an antibiotic and the percent of pediatric patients who received prescriptions for oseltamivir (Tamiflu) and respiratory antibiotics on the same day. Additionally, the program tracks informational metrics regarding antibiotic usage and issues biannual antibiotic utilization reports for participants, targeting a 15% reduction of overall antibiotic use by 2022.[4]

Actions for Improvement

There are many approaches to incorporating antimicrobial stewardship within the outpatient setting. After providers and administrators commit to improvement, education is needed to help identify actions for improvement. Common opportunities revolve around determining if antibiotics are needed and, when they are, selecting optimal antibiotics and duration of therapy.

Empiric Therapy and Culture Collection

When antibiotics are indicated, consider if a local antibiogram is available to help guide empiric therapy. Outpatient-specific antibiograms may be available from hospitals that provide clinics with culture and susceptibility results. Reference labs may also be able to supply antibiograms for local clinics.

It is also important to review a patient's previous culture and susceptibility history. In recent years, communities have begun to identify more resistant organisms not only in the hospital setting but the outpatient setting as well. Extended-spectrum beta-lactamase-producing organisms such as *E. coli* are increasing among patients, particularly in urinary isolates.[5] In these cases, beta-lactams antibiotics, including penicillins and cephalosporins, are clinically ineffective. Even in less resistant urinary pathogens, commonly used antibiotics such as sulfamethoxazole/trimethoprim and fluoroquinolones are no longer effective in all patients. These examples demonstrate the need for collecting isolates to ensure appropriate empiric and post-culture therapy for patients.

Avoidance of Fluoroquinolones

Increasing resistance to fluoroquinolones among certain pathogens has necessitated limiting empiric treatment with levofloxacin and ciprofloxacin in recent years. Further, usage should also be limited despite organism susceptibility due to the risk of adverse effects such as hypoglycemia, tendon rupture, and potentially permanent nerve damage. The Food and Drug Administration states fluoroquinolones should be avoided when possible for patients with acute bacterial sinusitis, acute bacterial exacerbation of chronic bronchitis, and uncomplicated urinary tract infections.[6]

Penicillin Allergy Verification

Fluoroquinolones and other broad-spectrum antibiotics may be avoided by verifying penicillin allergies. Approximately 10% of the U.S. population reports having a penicillin allergy, but less than 1% has a true Type I IgE-mediated reaction to penicillin.[7] Thorough patient histories may help determine specific reactions to antibiotics if any beta-lactam antibiotics have been administered without reaction, and if patients are less likely to have an allergic response again (e.g., after 10 years). Additional resources should be

utilized for more information on this topic to determine when cephalosporins may be an option depending upon the specific antibiotic allergy and reaction.[8]

Length of Therapy

Evidence-based literature regarding the duration of therapy was limited until recent years. Literature now supports equal efficacy for shorter lengths of therapy for many common infections. Uncomplicated cystitis may be treated for 3-5 days depending upon the specific antibiotic prescribed.[9-10] Uncomplicated skin and soft tissue infections and community-acquired pneumonia can be treated for 5 days.[10]

Antibiotics During COVID-19

Many unknowns have presented with COVID-19, leading to numerous patients receiving antibiotics for a viral infection. A meta-analysis including 3,338 hospitalized patients published in July 2020 found that the overall proportion of COVID-19 patients with a bacterial co-infection was 6.9% based on a co-infection rate of 3.5% at presentation and 14.3% as a secondary bacterial infection. Bacterial co-infection was higher at 8.1% in critically ill patients, so providers should continue to re-assess the need for antibiotics when treating COVID-19 patients in the outpatient setting.[11] Although the COVID-19 pandemic has dealt the health care community many challenges, it is important to ensure antimicrobial stewardship best practices are employed for the care of all Arkansans.

References:

1. Sanchez GV, et al. Core Elements of Outpatient Antibiotic Stewardship. MMWR Recomm Rep 2016;65(No. RR-6):1–12. DOI:http://dx.doi.org/10.15585/mmwr.rr6506a1
2. Centers for Disease Control and Prevention [Internet]. Outpatient antibiotic prescriptions — United States; 2018 [cited 2020 Dec 30]. Available from: https://www.cdc.gov/antibiotic-use/community/programs-measurement/state-local-activities/outpatient-antibiotic-prescriptions-US-2018.html
3. Arkansas BlueCross BlueShield [Internet]. Patient-Centered Medical Home Program Manual; 2020 [cited 2020 Dec 30]. Available from: https://www.arkansasbluecross.com/docs/librariesprovider9/default-document-library/2020-pcmh-program-manual_final-508.pdf?sfvrsn=a92860fd_0
4. Arkansas Department of Human Services [Internet]. PCMH Program Policy Addendum; 2020 [cited 2020 Dec 30]. Available from: https://humanservices.arkansas.gov/about-dhs/dms/info-for-providers/pcmh
5. Centers for Disease Control and Prevention. Antibiotic Resistance Threats in the United States, 2019. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2019. DOI:http://dx.doi.org/10.15620/cdc:82532
6. Center for Drug Evaluation and Research. FDA Drug Safety Communication: FDA warns about increased risk of ruptures or tears in the aorta blood vessel with fluoroquinolone antibiotics in certain patients. U.S. Food & Drug Administration; 2018.
7. Centers for Disease Control and Prevention [Internet]. Evaluation and Diagnosis of Penicillin Allergy for Healthcare Professionals; 2017 [cited 2020 Dec 30]. Available from: https://www.cdc.gov/antibiotic-use/community/for-hcp/Penicillin-Allergy.html
8. Blumenthal KG, et al. Antibiotic allergy. Lancet. 2019;393(10167):183-198. DOI:10.1016/S0140-6736(18)32218-9
9. Gupta K, et al. International Clinical Practice Guidelines for the Treatment of Acute Uncomplicated Cystitis and Pyelonephritis in Women: A 2010 Update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases. CID 2011;52(5): e103-20. DOI:https://doi.org/10.1093/cid/ciq257
10. Wald-Dickler N and Spellberg B. Short-course Antibiotic Therapy - Replacing Constantine Units With "Shorter Is Better." CID 2019;69(9): 1476-9. DOI:10.1093/cid/ciy1134
11. Langford BJ, et al. Bacterial co-infection and secondary infection in patients with COVID-19: a living rapid review and meta-analysis. Clin Microbiol Infect. 2020 Dec;26(12):1622-1629. DOI:10.1016/j.cmi.2020.07.016

Article provided by the Arkansas Foundation for Medical Care

Vision 2025 Project

AAFP to Develop Value-based Payment Model for Primary Care

News Staff — In many ways, family medicine has been ahead of the value-based care delivery curve for years. In a policy statement on value-based payment developed more than a decade ago, the AAFP went on record as recognizing the urgent need to "improve both efficiency and effectiveness in the delivery of medical care, in which 'efficiency' is understood to mean 'doing the thing right' and 'effectiveness' means 'doing the right thing.'"

For their part, family physicians are hard-wired to deliver high-value, evidence-based care, which they do in 90% of counties across the United States. Although FPs make up only 15% of all U.S. outpatient physicians, they provide nearly one-quarter of all outpatient visits and are more equitably distributed than any other physician specialists.

In other words, family physicians are foundational to the success of VBC in this country.

To best position family physicians for that role, the AAFP Board of Directors in April approved and funded a special project. Dubbed Vision 2025: Defining the Future of Value-based Payment, the three-year project is designed to empower AAFP members to successfully navigate a rapidly evolving VBP environment and prepare them to partner with payers to help improve quality and control total costs of care.

Vision 2025 encompasses two workstreams. The first focuses on member education and activation and the second centers on defining the future of primary care payment while continuing to play a critical role in shaping current advanced payment models to increase investment in primary care.

Vision 2025 took a major step forward last month, when the AAFP convened the Value-based Care Advisory Group for its inaugural meeting. Members of the group represent a diverse cross-section of movers and shakers in this space, including leading health plan officials, policy experts, community advocates, and research and academic authorities.

AAFP Senior Vice President of Advocacy, Practice Advancement and Policy Stephanie Quinn opened the meeting, delivering an overview of the project and its goals. Division of Practice Advancement Director Heidy Robertson-Cooper followed up by outlining the advisory group's anticipated role during the meeting and beyond.

Specifically, said Robertson-Cooper, the Academy is seeking the group's observations on VBP models currently deployed in primary care settings and how those lessons can be applied as the AAFP moves forward with developing and implementing its next-generation primary care VBC model.

The Academy is also looking for the group's suggestions for potential partners in that endeavor from the payer and primary care practice communities, she added, as well as their recommendations regarding the best ways to notify and educate AAFP members about opportunities to participate in VBP models.

Those introductory statements sparked a round of questions participants said should be considered when

envisioning a VBP model that appropriately elevates primary care, such as

- What is the proper alignment of payment mechanisms and incentives to promote adoption of value-based models, and how does that differ from practice to practice?
- What are the barriers to adoption of down-side risk models, especially among solo and small independent practices, and how they can be mitigated?
- What level of business acumen is needed for practices to adopt and sustain a robust VBC model?
- What data elements do practices need to facilitate decision-making in a value-based environment, and what education/training is needed to act on that data?
- How can the patient experience — especially patient satisfaction with their care — be reliably measured?

Also informing the discussion was an environmental landscape assessment by health policy consulting firm CapView Strategies that evaluated more than a dozen primary care-centric VBP models operated by public as well as private payers (i.e., CMS/Center for Medicare and Medicaid Innovation, Medicare Advantage, Medicaid, and commercial payers).

CapView's findings were grouped into five categories: basic elements of each model (scope, eligibility and participation); payment requirements and structure; care delivery requirements; performance measurement and feedback; and evaluations and results.

Key observations from the assessment included the following:

- Variability in payment structures and participation requirements creates challenges.
- Primary care incentive requirements and impacts are difficult to assess in larger accountable care organizations.
- Evaluation endpoints and timeframes differ significantly across models.

CapView also made a number of recommendations that called for, among other things, the use of uniform performance measures across models to permit greater comparability, standfardization of evaluation endpoints to enhance understanding of primary care's impact, and an increased focus on evaluating patient experience in these models.

Finally, group members voiced other basic questions that deserve further consideration before moving forward, such as

- What is the role of primary care in the future of health care?
- What is the future of small, independent practices?
- Is payment reform or delivery reform needed?
- What are the likely implications of VBP for those now in fee-for-service?

With more than one participant observing that the current health care environment offers a unique window of opportunity to create change, group members agreed to examine these and other takeaways and follow up with action items before meeting again in March.

An Opportunity to Inform

Shane Speights, DO, FAAFP

For many years I resisted the temptation to join the world of Facebook. There are many, many reasons why I didn't. The primary being that I didn't really have time for all of the "stuff."

I wasn't interested in the video of the cat playing the piano or the toddler dancing to a song I'd never heard of. I also wasn't interested in all the opinions and debate that ensues on that platform from people with little knowledge of the subject matter posting comments they would never say in person. Like you, I was busy working, and who has time for anything other than work? But late last year, I finally relented.

Yes, I'm on Facebook, and as someone who has never used it…it's been interesting. Now, you won't see me posting selfies or photos of my dogs or kids. I don't share "memes" or political viewpoints. What you will see - and what I strive to provide in a world of mistrust - is good, fact-based, evidence-supported information to help people navigate this pandemic. It does take a little time, but honestly, I get most of the information daily through the same medical news alerts and emails that you do.

There have been many things that surprised me about this pandemic, but probably the biggest was how much the public questioned "us." By "us," I mean medicine, science, research, and the education that we use to deliver good healthcare to our patients every day. I was truly taken aback.

The same patient that didn't bat an eye about the medication I wrote, or the surgery that I recommended they should have, or the advice I gave them about end of life decisions. That same patient refused to believe anything I said about COVID-19. Handwashing, mask wearing, medications that don't work, medications that do work, "yes" this can kill you. It didn't matter. I was amazed.

The same occurred when speaking to elected officials. Legislators, city and county officials, schoolboard, you name it. "Doctor" didn't carry much weight in those conversations. It didn't matter that I had spent the last 23 years studying disease, the human body, and the practice of medicine.

Last fall, I attended the annual AAFP conference – virtually, of course – and one of the speakers delivered a message that struck a chord with me. He described exactly what I had been experiencing. Apparently, it wasn't just me or you that have run into this. Apparently, this has been happening all over the country, to all of our physician colleagues seeking to bring some knowledge and insight to this national and global crisis.

The speaker challenged those in attendance to speak up. To get active on social media. To speak at public meetings and to civic organizations. He went on to provide evidence (which, of course, I was happy to see) that the vast majority of the population is actually more likely to listen to an expert in the field than they are their second cousin who failed high school biology. Even though my experience felt demoralizing, the data shows that most people want to hear from us. His

presentation went on to point out that we, as a profession, have sat back for so long and have not been engaged on the conversations that pertain to what we do every day. We are the experts, and we have been largely silent.

He inspired me, so I made the leap. With the help of my kids (of course) and my marketing director at NYITCOM, I jumped in the pool. I created a Facebook page where I started posting about the hottest topics regarding COVID-19 that were coming from around the community. Specifically, I posted CDC studies like peer-reviewed studies that showed that masks do work; RCT trials that revealed hydroxychloroquine doesn't work, but dexamethasone in ICU patients does; and the science behind the Pfizer and Moderna vaccines and why I was confident in their safety and effectiveness. When the data changed, as it often does, I posted that too, and I explained why it changed. Sometimes I just posted a link to a topic on the CDC website.

The feedback has been overwhelmingly positive, and many of the posts have been widely shared, some as many as several hundred times. Sure, there were people that engaged with contradictory opinions, and for those that truly wanted to understand, I was happy to chat with them and explain the science. I like to think I've been able to arm people with the knowledge they need to make better decisions about how they'll choose to live in the midst of a pandemic like we've never before experienced.

When I make a post, I try to put it in a format as if I'm speaking to a patient who is sitting in front of me. I approach it as if we are having an honest, open conversation. "This is what we know, this is what we don't know." People should expect that from their physician.

So, to my fellow family physician colleagues around the state: I'm nothing special. Just ask my family. You can do this, too, and you should. You should be posting credible, factual information on social media. For too long, physicians and those with healthcare knowledge and accurate information have sat on the sidelines. It's time to get in the game.

"I don't have time."

"I don't want to get involved."

"I don't want there to be a chance I might offend someone."

"I reserve those conversations for my patients who choose to come see me."

I get it. I was the same way, but that is a disservice to the community. To your community. So please, get involved. I'm glad I did.

And don't forget to follow me on Facebook, @ShaneSpeightsDO!

Shane Speights, DO, FAAFP, is the dean of New York Institute of Technology College of Osteopathic Medicine at Arkansas State University.

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!

Residents

Elizabeth Fike, D.O.

Students

Deva Bharne
Emily Phelps
Katherine Byrd
Dimple Shah
Daniel Chilcote
Sowmya Sivakumar
Aaron Gaul
Jena Stern
Kristina Magas
Vi Tran
Scotty McKay
Kollin Walters
Walter Merriman
Taylor Winn
Vineet Mohanty
Taher Yusufali

COVID-19 Positive Notifications Report

The SHARE COVID-19 positive report bring alerts of positive test results of patients to providers, accountable care organizations (ACO), clinically integrated networks (CIN) and Health Plans. Healthcare teams across Arkansas are using these reports to assist with care coordination, disease management, and telemedicine visits.

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Visit **archildrens.org/HeartCenter** to learn more about our cardiac services.

James Mark Robinette, M.D., 84 passed away at home on Sunday, December 13, 2020.

Dr. Robinette graduated with highest honors from Arkansas High School at Texarkana AR. At Texarkana College he was a Phi Theta Kappa. He attended Henderson College briefly before transferring to the University of Arkansas, College of Medicine. He was an Alpha Omega Alpha, received the Avalon Foundation Scholarship, Mosby Book Club award, The Buchanan Key and graduated in the honors program. He received the Mead Johnson Fellowship while in residency at Flower Hospital in Toledo OH. He started his medical practice in Newark AR. A year later he moved to Jonesboro and opened a clinic. He was drafted shortly after and served in Vietnam as a Captain in the USAF. He worked in private practice in Jonesboro from 1967 to present. He was a charter diplomat of the American Board of Family Practice. In 1977 when taking his first Family Practice Boards he scored highest in the nation. In 1992 he was Board Certified in Geriatric Medicine. Over the years he was Secretary of the Craighead/Poinsett County Medical Society, Chief of Medicine at St. Bernard's, and at Craighead Memorial Hospital held the positions of Chief of Surgery, Staff, and Family Practice. He has held memberships in the American and Arkansas Academy of Family Practice, AMA, Arkansas Medical Society, and the American Society of Addiction Medicine.

James is survived by his loving wife Frances Wells Robinette; children, Angela Lovett M.D. of Little Rock, Lauryl Hynes DVM (Tim) of Fayetteville, Georgia Robinette J.D. (Scott Murphy) of Little Rock, Elaine Roger AOS Culinary Arts, RN, BSN (Barney), James Mark Robinette Jr. J.D. of Little Rock, Robert Robinette (Ashley) of Jonesboro, Sarah Robinette of Jonesboro, Paula Reeves of Jonesboro, Kimberly Stearn (James) of Doha, Qatar; 15 grandchildren, Lane Lovett Jr. M.D. (Leigh) Christian and Grace Lovett, Houston and Grant Hynes, James Bennett Murphy, Luke Robinette, Celeste, Margo and Frazier James Robinette, Rylee Dacus and Grayson Robert Robinette, Coen and Callahan Reeves, Findlay Stearn and one Great-Granddaughter Mary Lane Lovett.

James' passion was helping his patients overcome addiction. He also enjoyed fast old cars, hunting, fishing and frog gigging. However, his family is what he was most proud of. He treasured the annual trips to Rockbridge Trout Ranch where he was surrounded by his family. This family tradition was always the highlight of his year.

Memorials can be made to the John 3:16 ministry, Arkansas Children's Hospital or the charity of your choice.

Our condolences are extended to Dr. Robinette's family and friends.

UAMS Receives $4.6 Million Grant to Address Rural Physician Shortage – Preceptors Needed

The University of Arkansas for Medical Sciences (UAMS) has received a $4.6 million grant from the U.S. Department of Health and Human Services. The Arkansas Medical Education Primary Care Partnerships project aims to increase the number of primary care physicians practicing in rural areas and other medically underserved parts of the state by:

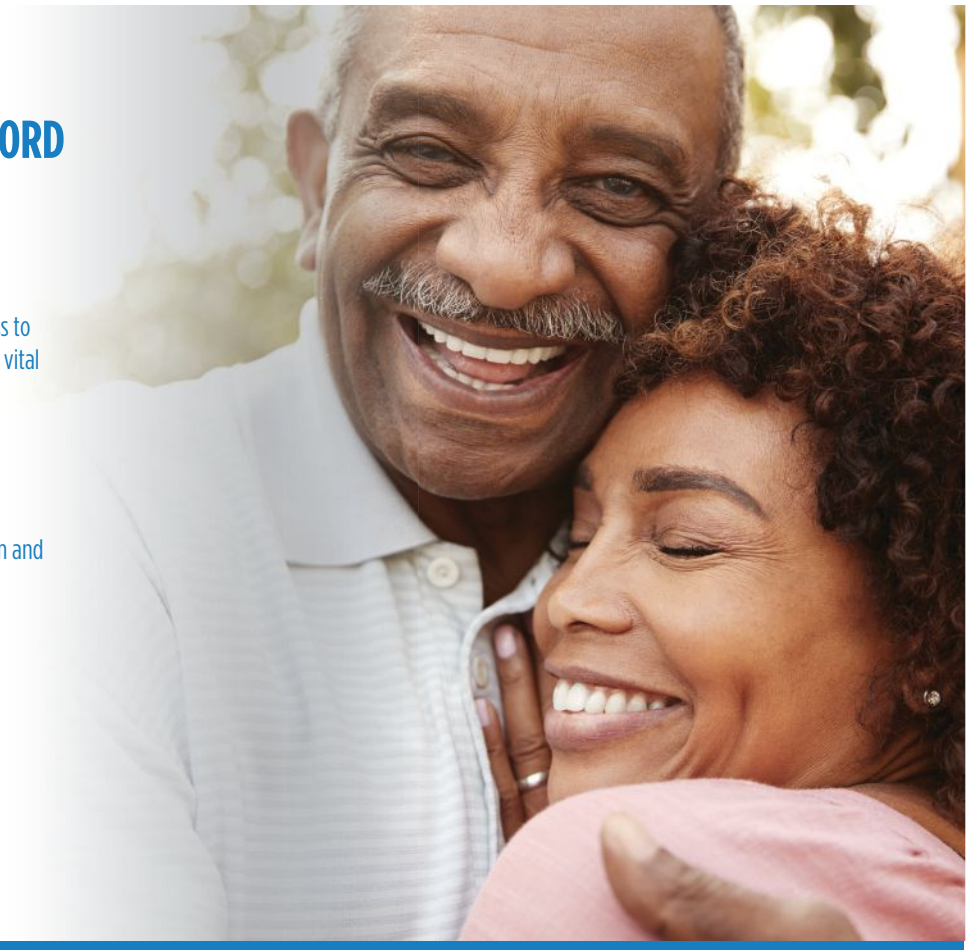
- Strengthening the long-term health careers pipeline by recruiting and retaining more students from rural and underserved areas of the state, because such students are the most likely to return to practice in those areas.
- Creating more opportunities for medical students to experience primary care practice in rural and underserved communities across Arkansas.
- Increasing the number of rural clinical rotation sites and preceptors available to teach medical students in federally qualified health centers, critical access hospitals and other rural clinics and settings.

- Providing training and faculty development opportunities for new clinical faculty and preceptors at these new clinical sites.
- Strengthening partnerships with the Community Health Centers of Arkansas, Arkansas Rural Health Partnership, and historically black colleges and universities at the University of Arkansas at Pine Bluff and Philander Smith College in Little Rock.

Physicians who are interested in becoming a preceptor may participate in one or more of the following opportunities:

- ***Rural/Underserved Continuity Clinic Program*** provides early clinical experiences for medical students during their first year of school. Family medicine physicians will precept a student one half-day per week throughout the academic year.
- ***Family Medicine Summer Preceptorship Program*** provides clinical experience to medical students who have just completed their first year of school. Physicians will precept a student each day for a two or four-week period.
- ***Honors in Rural and Urban Underserved Primary Care Program*** provides medical students with a longitudinal experience, preparing them to provide medical care for underserved populations in rural and urban settings. Primary care physicians will serve as mentors throughout the four-year program.
- ***Senior Elective Rotations*** provide clinical experiences to senior medical students in communities around the state. Primary care physicians will precept a student each day for a four-week period.

To become a preceptor or for more information, please contact Jessica Bursk, UAMS Regional Programs Coordinator, at jlbursk@uams.edu or 501-686-5260.



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To learn more about the Patient Access to Care Program and order your clinic brochures contact Cara Clements at cclements@arprostatecancer.org or 501-313-4179.

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CLARE RICHARDSON LOVES PUZZLES.

Clare Richardson loves puzzles. In fact, the Hot Springs resident is perhaps best known for solving a puzzle in 2010 involving a black and white mural hanging in a Dairy Queen in Clear Lake, Iowa.

But the most daunting puzzle Richardson has worked has been his prostate cancer treatment plan. With PSA test results increasing every six months, Richardson knew he needed to do something about it. The answer came to him while on a business trip. "I saw a billboard advertising the Arkansas Prostate Cancer Foundation and wrote down the phone number.

"That call, just like those billboards, saved my life," Richardson said.

After working with APCF's Patient Navigator Cara Clements, Richardson began piecing together his new puzzle. He had surgery in October 2014 and soon after began radiation treatments to ensure the cancer stayed away.

However, like many men battling prostate cancer, he still struggles with incontinence and some side effects of the radiation. His hormone therapy injections are expensive, and his insurance will only cover a portion of the total cost. "I was sharing my financial troubles with Cara who mentioned a new program through APCF that might be able to help me – the Patient Access to Care Program."

The program was created to limit the financial burden on men and their families who are undergoing prostate cancer treatment. This can include assistance for medical co-pays, gas cards for transportation to and from doctor visits, and assistance to offset lodging fees associated with treatment.

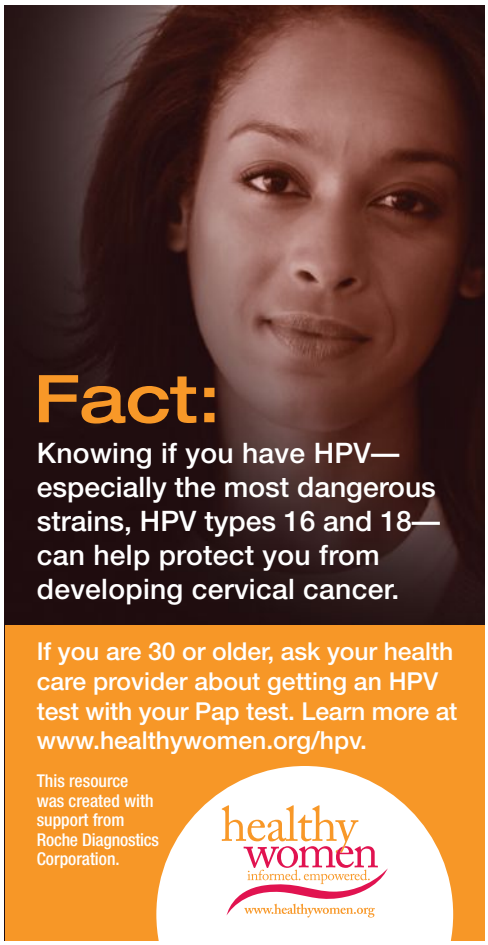
Treating any cancer is expensive, and men with prostate cancer can quickly incur expenses for doctor visits, imaging tests, hospital stays, and transportation costs. Through the Patient Access to Care Program, APCF envisions a day where no Arkansas man diagnosed with prostate cancer will have to postpone or delay any potentially life-saving treatment due to his inability to afford care.

"We really tried to make the application process as simple as possible," Clements said. "Men are already stressed out dealing with their treatment. We wanted this to be easy for them."

Richardson said APCF staff was able to walk him through the application process over the phone. Within a week, he was notified that he would be receiving financial assistance. Today, Richardson says he's feeling good and putting his own personal puzzle pieces back together.

"It's still like having a whole new life," he said. "I often tell Cara 'I'm so glad APCF exists because you really care about others.'"

To learn more about APCF and the Patient Access to Care Program, visit our website at https://arprostatecancer.org/services/patient-access-to-care/.



THE ARKANSAS CANCER COALITION IN PARTNERSHIP WITH THE UNIVERSITY OF TEXAS MD ANDERSON CANCER CENTER PRESENTS

BECOMING A TOBACCO TREATMENT SPECIALIST

Learn how to treat tobacco dependence by effectively delivering tobacco cessation treatment in both a clinical and/or community setting.

DATE: April 19-23, 2021
TIME: 8 a.m. - 5 p.m.
LOCATION: Online
COST: Free

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- Counseling skills
- Motivational interviewing
- Treatment planning
- Pharmacotherapy
- Relapse prevention

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This program is accredited by the Council for Tobacco Treatment Training Programs (CTTTP) and participants will receive Tobacco Treatment Specialist (TTS) Training or Certification (CTTS). We welcome participants from all health care disciplines and cultures. Our goal is to train interdisciplinary health care providers and public health professionals to become tobacco cessation champions for their organizations and communities.

For more information, contact:

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