OF THE ARKANSAS MEDICAL SOCIETY
Vol.115 • No. 6
DECEMBER 2018

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by CASEY L. PENN

ON THE COVER

MAT (Medication-assisted Treatment): Could it Work in Your Clinic?
Real Discussion from Treatment Providers in Arkansas 126

WHAT HAVE WE DONE FOR YOU LATELY?
DAVID WROTEN, *EXECUTIVE VICE PRESIDENT*
Issue 1 Lost … for Now 124

by CASEY L. PENN
10 Years of Growth & Contributions to the Natural State: American Association of Physicians of Indian Origin (AAPI), Ark. Chapter
Senthil Raghavan, MD, MPH; Appathurai Balamurugan, MD, MPH, DrPH; Naveen Patil, MD, MHSA, MA, FIDSA 125

A Closer Look at Quality 132

Special Section: Short Dermatological Cases
Derm Dilemma: Keratoacanthoma
Hunter Cochran; Kevin St. Clair, MD 131

SCIENTIFIC ARTICLE
HIV Post-exposure Prophylaxis for Victims of Sexual Assault
Vini Vijayan, MD 134

Members of the Arkansas Medical Society 2018 137

Winner of the ASAE Excellence in Communications Award

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WHAT HAVE WE DONE FOR YOU LATELY?

Issue 1 Lost … for Now

DAVID WROTEN
EXECUTIVE VICE PRESIDENT

By a 6-1 vote in *Martin v. Humphrey*, the Arkansas Supreme Court affirmed the circuit court's decision that Issue No. 1 violated Art. 19, Sec. 22's separate-vote requirement and its three-amendment per election limitation. The Supreme Court's ruling means that while Issue No. 1 will appear on the ballot, the Secretary of State is prohibited from counting the votes.

I could spend a couple of pages explaining the Court's decision but suffice it to say, the Court did not want this amendment considered by the voters of Arkansas. They then sought to find a way to reach that conclusion even if it meant jeopardizing past legislatively referred amendments that are now part of the Arkansas Constitution.

The Court's ruling focused solely on Section 1, which proposed a limit on contingent attorneys' fee agreements. They decided that this provision was completely unrelated to the other three provisions. Then they held that there was no "general subject" to which all four sections were reasonably germane. The result then would be that Issue 1's four sections constituted four separate amendments. The legislature is only authorized to submit three amendments.

The test they used came from a California case, but that test did not require any sort of interrelationship between any of the sections. In effect, the Supreme Court's decision changes the rule to require that each section of a proposed amendment "support, develop, clarify, or otherwise aid the function" of the other sections of the proposed amendment. This is contrary to how every other legislatively referred amendment has been judged. It also means that any referred amendment with more than one section is subject to legal challenge.

The best way I know to explain this is to simply quote Judge Shawn Womack, the lone justice who supported our position. In his dissent, he argued that "the proposed amendment easily satisfies" the constitutional requirement, "either under a literal reading of the text or under the test set out by the majority." He stated that "the majority has imposed a much stricter standard in this case than in either *Forrester* or *Brockelhurst* [a previous case in which the Supreme Court considered an Art. 19, Sec. 22 argument]." He also pointed out that many existing amendments could not pass the majority's test, including Amendment 80, which is the "modern foundation of the Arkansas Judiciary" but "never would have survived a challenge in front of this court if we were to use the standard as applied here by the majority." Justice Womack concluded by stating, "in summary, the majority has used an extraconstitutional, judicially created test, imported from California, to stop the people of Arkansas from exercising their public policy making power to either accept or reject a change proposed by their elected senators and representatives."

Why did we not see this coming? I've been asked that. The simple reason is that it has never happened before. Many other legislatively referred amendments have had multiple sections and have not been thrown off the ballot because of it. It is only necessary that the sections be somewhat related, which the four sections of issue 1 certainly are. Amendment 80, mentioned by Justice Womack, is a perfect example. It contained multiple parts and made changes to the entire Arkansas judicial system.

What this means is that future referred amendments will now be subject to legal challenge if they contain more than one moving part. For example, we might be able to file an amendment that only implemented caps on non-economic damages. Now there's a thought.

The AMS would like to extend a debt of gratitude to the hundreds of physicians who supported this campaign; the county medical societies, the specialty societies; and our professional liability companies – particularly our partner, SVMIC. Your contributions, time and energies are deeply appreciated. It is extremely disappointing that Arkansas voters were deprived of the opportunity to vote on this issue. AMS

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10 Years of Growth & Contributions to the Natural State:
American Association of Physicians of Indian Origin (AAPI), Ark. Chapter

Senthil Raghavan, MD, MPH; Appathurai Balamurugan, MD, MPH, DrPH; Naveen Patil, MD, MHSA, MA, FIDSA

American Association of Physicians of Indian Origin (AAPI) USA is a national organization representing the interests of about 100,000 physicians, scientists, physicians-in-training, and medical students of Indian origin and is one of the largest professional medical associations in the USA (www.aapiusa.org). AAPI Arkansas (www.aapiarkansas.org) was founded in April 2008 by a group of dedicated physicians of Indian origin serving the natural state. There are around 500 physicians of Indian origin in Arkansas, and the Arkansas chapter of AAPI currently has around 300 members in various specialties from all areas of the state. AAPI Arkansas has four regional affiliates - Northwest Arkansas, Hot Springs, Batesville, and Northeast Arkansas.

AAPI Arkansas embodies the principles of charity, education, and networking among physicians. AAPI Arkansas offers several professional advancement opportunities for its members, including monthly dinner talks on current medical topics to inform and educate members. AAPI Arkansas works with several health care organizations across the state on various health care initiatives. AAPI Arkansas members worked with Arkansas Department of Health to support the continued funding of Arkansas Tobacco Quitline. AAPI Arkansas works with hospital systems across the state on physician recruitment, licensing, and orientation of new trainees and practicing physicians newly coming to the state. Recently, the association worked with Arkansas Hospital Association to implement the Sepsis Collaborative for 2019 that helps several smaller hospital systems in the state. Several community health initiatives, including disease and wellness awareness lectures, were initiated this year to improve the health and wellbeing of Arkansans.

At AAPI Arkansas's Grand 10th Anniversary Annual event on August 25, 2018, at Statehouse Convention Center in Little Rock, Gov. Hutchinson

delivered the keynote address. Rep. French Hill and Lt. Gov. Tim Griffin were also in attendance. Several health care leaders from across the state, including UAMS Chancellor, CEOs of Baptist, CHI St Vincent, Arkansas Children's Hospital, Veterans Affairs Hospital, St. Bernard's, National Parks, Mercy Health, Arkansas State Medical Board, and the Arkansas Medical Society were all in attendance.

Gov. Hutchinson and our chief guests presented the Annual Awards for Excellence in Academics, Community Service, and a Native Arkansan award for significant contribution in advancing the health in the state. Scientific poster sessions were held at the annual event and awards were presented to top three best posters. A pilot research grant in the amount of $2,000 was also given out at the annual event.

Charitable and scholarship activities were driven through the generous contributions made by AAPI Arkansas members and its affiliates. Over $20,000 in high school merit- and need-based scholarships were given to 15 students from Little Rock School District & Pulaski County Special School District. Charitable contributions totaling $15,000 were given to Little Rock Police Department Foundation, Little Rock Fire Department, and the Arkansas State Police. AAPI Arkansas regional groups have also engaged in charitable activities in their local communities. Over the past 10 years, AAPI Arkansas contributed over $300,000 to various charities and scholarships across the state, of which $100,000 has been donated this year alone commemorating AAPI Arkansas's 10th Anniversary. AAPI Arkansas and its members have been a longstanding supporter of Harmony Health Clinic, a Little Rock clinic that serves the medical needs of uninsured and underinsured Arkansans living in Central Arkansas. Many AAPI Arkansas physicians volunteer in the clinic and have monetarily supported the clinic with over $28,000 in the last five years. AAPI Arkansas and its members recently donated about 300 pieces of lightly used school uniforms and school supplies for 150 students attending Pulaski County Special School District this year. AAPI Arkansas has also supported several local organizations such as the Arkansas Rice Depot 'Food For Kids' program, the UAMS Family Home for caregivers of patients, Salvation Army, Dorcas House, and Compassion Center. AAPI Arkansas has supported victims of natural disasters such as earthquakes and hurricanes.

AAPI Arkansas has grown to be one of the largest physician organizations in the state and is committed to promoting the health and wellbeing of all Arkansans! AMS

by CASEY L. PENN

MAT (Medication-assisted Treatment): Could it Work in Your Clinic?

Real Discussion from Treatment Providers in Arkansas

In recent issues of *The Journal*, we shared work being done by AMS physicians and others to curb abuse and overdose deaths related to opioids. Continuing on topic, we focus this month on **medication-assisted treatment** for patients with opioid use disorder. We'll draw from credible academia, impart insight from MAT providers here in Arkansas, and leave you with resources for further study.

Evidence Supported, Underutilized

The Substance Abuse and Mental Health Services Administration defines MAT as "the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders."

New medications for addiction continue to surface (perhaps a topic for another month), but commonly used FDA-approved medications include methadone, naltrexone, and buprenorphine. Most used among the physicians we spoke to is a buprenorphine/naloxone combination, as in the drug Suboxone®. (Suboxone® was the first and once the only formulation of this drug combination, approved by the FDA some 14 years ago. Today, this formulation is marketed by multiple drug manufacturers.) "A synthetic opioid, Suboxone® has some characteristics of opioid but doesn't provide any euphoria," explained Gene Shelby, MD, an expert in the treatment of OUD. "The buprenorphine creates a strong bond with opiate receptors in the brain. Once people transition to buprenorphine, they lose their craving for opioids because those opiate receptors are covered, which prevents their withdrawal from opioids."

A former member of the Arkansas House of Representatives and a past AMS president, Dr. Shelby practices in central Arkansas MedExpress clinics, operates a monthly HIV Clinic in Hot Springs, represents AMS as a member of the AMA Opioid Task Force and, with his wife Faridah Katkhordeh, operates an opioid addiction treatment clinic, The Shelby Clinic. (Find detailed coverage of Dr. Shelby's work, including a first-hand patient account, in *The Journal,* August 2016.)

Prescribers must be certified to prescribe MAT. Physicians take an eight-hour course on the medicines and on opioid dependence and then receive a DEA number to prescribe in an outpatient setting. (APRNs and PAs can be certified, with longer required course hours.) Find information about online training at SAMHSA.org.

Supporting evidence for using MAT is strong. According to SAMHSA, this treatment approach has been shown to "improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity among people with substance use disorders, increase patients' ability to gain and maintain employment, and improve birth outcomes among women who have substance use disorders and are pregnant."

Gene Shelby, MD

The AMA Opioid Task Force recently released a report, "**The AMA Urges Removing All Barriers to Treatment for Substance Use Disorder.**" Citing the National Institutes of Health; the National Institute on Drug Abuse, the U.S. Surgeon General, and other sources, they described MAT as "Unequivocally Established," and associated it with fewer overdose deaths, reduced transmission of infectious diseases, reduced health care expenditures and utilization, and other benefits.

Despite increased awareness and supporting evidence, they reported, MAT is underutilized – in part, due to extra burdens faced by those providing this treatment. Prior authorizations were among the hurdles, as were misconceptions and myths related to this treatment.

Here in Arkansas, things are improving on the insurance front, according to Dr. Shelby. "There's been a trend to make it easier to get the medication through different pharmacy programs," he said. "Four years ago, even private carriers required prior authorizations every few months. Now, some Blue Cross Blue Shield plans no longer require them. Those that do, it's generally simple and you get authorization for at least a year for the person who has entered treatment."

Medicaid is a different story. On one of our attempts to reach Dr. Shelby about the question of barriers to treatment, his late response helped illustrate his point. "I'm sorry I didn't get back to you sooner," said Dr. Shelby, who has been forthcoming about his battles with Arkansas Medicaid. "I spent two hours today with Medicaid getting a prior authorization for a new patient. It's easy to see why primary care may not want to treat these patients – at least those on Medicaid. Arkansas has put big hurdles in the way of the Medicaid population. They make it so difficult to get prior authorization for treatment. I've gone to their review committee about it, and they did change their prior authorization process recently. They said they were making it easier, but I just saw the new prior-authorization-request form, and they've made it even harder than it was."

Administrable from Various Clinic Settings

The question of how – and where – MAT is best administered continues to evolve. For decades, people diagnosed with substance use disorders typically received care from a dedicated treatment facility. Many such centers have expanded to include opioid treatment and as such have become certified Opioid Treatment Programs (OTP).

According to SAMHSA.org, legislation passed in 2000 (Drug Addiction Treatment Act of 2000) expanded the clinical context of medication-assisted opioid dependency treatment. "DATA 2000 reduces the regulatory burden on physicians who choose to practice opioid dependency treatment by permitting qualified physicians to apply for and receive waivers of the special registration requirements defined in the Controlled Substances Act."

In the nearly two decades since DATA, numbers of certified physicians *have* increased, but

there are still relatively few physicians in Arkansas who provide MAT from *any* treatment setting. According to research by UAMS, there are around 85 MAT-certified prescribers in Arkansas – and only about half of those are thought to be *actively* prescribing. Other states have far more certified prescribers – Tennessee, for example, shows around 800. (The Department of Health told *The Journal* that they are currently working on a better way to pinpoint exact numbers of providers at any given time. SAMHSA shares some tracking of DATA-waived practitioners; search there to see, by state, how many practitioners are *newly* certified per year to provide buprenorphine treatment for opioid dependency.)

Michael Mancino, MD

Dr. Shelby wants to see more physicians take up this fight. As opposed to a behavioral-health-center-based approach, he would prefer to see more physicians adopt a primary-care-based approach to treatment. "In a behavioral health clinic, you don't always have physicians there who can prescribe the medication. I have a few patients in South Arkansas who go to these centers for the behavioral health, but they must drive to me to get their medicine," he said. "In contrast, by going through primary care practices, you have physicians who can prescribe medicine and then work with mental health professionals to get patients to counseling (rather than the other way around). We must learn to better incorporate MAT into primary care. I believe that's what it's going to take to have an impact on the opioid crisis. The opportunities are there. The goal we should be looking at is for any good-sized clinic to have one or two physicians who have taken the online training for MAT so that patients can benefit from that."

Dr. Shelby isn't alone in his thinking. In *the New England Journal of Medicine* editorial, "Primary Care and the Opioid-Overdose Crisis—Buprenorphine Myths and Realities," authors Sarah Wakeman, MD, and Michael Barnett, MD, encouraged primary care physicians to offer office-based addiction treatment with buprenorphine and blamed federal regulations and misconceptions for their hesitations. "In part, the overdose crisis is an epidemic of poor access to care. One of the tragic ironies is that with well-established medical treatment, opioid use disorder can have an excellent prognosis," the authors said. "… To have any hope of stemming the overdose tide, we have to make it easier to obtain buprenorphine than to get heroin and fentanyl … We believe there's a realistic, scalable solution for reaching the millions of Americans with opioid use disorder: mobilizing the primary care physician workforce to offer office-based addiction treatment."

Pulling no punches, these authors debunked myths – particularly the idea that buprenorphine is simply "a replacement" and that patients become "addicted" to it. "Addiction is defined not by physiological dependence but by compulsive use of a drug despite harm," they wrote. "If relying on a daily medication to maintain health were addiction, then most patients with chronic health conditions such as diabetes or asthma would be considered addicted."

Learning from the Experienced

No matter the clinical setting, we can learn much from the experiences of those administering MAT. With that in mind, *The Journal* reached out to a handful of MAT clinics to find out more about their medicines, counseling, and practice habits.

The Psychiatric Research Institute's **Center for Addiction Services and Treatment** at UAMS includes both methadone and buprenorphine treatments. CAST incorporates individual and group therapy sessions into its treatment of opioid addic-

> *Continued on page 128.*

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Evidence shows medication-assisted treatment (MAT) works.

Treatment Reduces Illicit Drug Use, Disease Rates, Overdoses and Crime. "Patients who use medications to treat their opioid use disorder remain in therapy longer than people who don't; they are also less likely to use illicit opioids. MAT helps to decrease overdose deaths and reduce the transmission of infectious diseases, including HIV and hepatitis C."[2] FDA-approved MAT for Opioid Use Disorder includes buprenorphine, naltrexone, and methadone.

Some Payers Are Removing Prior Authorization For MAT. Several major national insurers, including Anthem, Cigna and Empire Blue Cross, said they will no longer require prior authorization for MAT for all their plans in the United States.[3] If they can do it, why can't all health insurance companies?

MAT Saves Money. "Results suggest that medication-assisted therapy is associated with reduced general health care expenditures and utilization, such as inpatient hospital admissions and outpatient emergency department visits, for Medicaid beneficiaries with opioid addiction."[4]

We all have to work together. The AMA recommends:

1. Physicians should become trained to treat patients with a substance use disorder.
2. All public and private payers should ensure that their formularies include all forms of MAT, and they should remove all administrative barriers to treatment, including prior authorization.
3. Policymakers and regulators should increase oversight and enforcement of mental health and substance use disorder parity laws to ensure patients receive the care that they need.
4. We can all help put an end to stigma. Patients with a substance use disorder deserve the same care and compassion as any other patient with a chronic, relapsing medical disease.

Take action today. Join us to help end the nation's opioid overdose and death epidemic. To learn more visit end-opioid-epidemic.org

Excerpted from AMA Opioid Task Force report at end-opioid-epidemic.org. Used by permission.

tion. "There are few in the state who are providing MAT, so many of our patients drive hours for treatment and others never seek treatment because of these barriers to care," said Michael J. Mancino, MD, program director for CAST. A board-certified psychiatrist, Dr. Mancino also serves as medical director for Recovery Centers of Arkansas. For more than a decade, he has provided MAT – previously at the VA and now at UAMS. In addition, Dr. Mancino helps other physicians through his direction of the MATRIARC (Medication Assisted Treatment Recovery Initiative for Arkansas Rural Communities) program. (See resource listing at article's end.)

• **ARcare** began in 1986 under the mission of Steven Collier, MD, to serve "the least, the last, and the lost." Now one of the largest federally qualified health centers in Arkansas, it serves patients, regardless of their ability to pay, in 44 family practice clinics around the state. A primary care-based organization, ARcare employs more than 60 physicians, physician assistants, and advanced practice nurses and consults with Dr. Shelby (an interim position) for its MAT patients. Prescriptive authority for MAT patients also comes from Sharon Meador, MD, (Little Rock) and Todd Anderson, APRN (Searcy). ARcare is currently in the process of opening a third MAT program in Jonesboro. ARcare, dba as KentuckyCare, also provides MAT in partnership with Four Rivers Behavioral Health and KentuckyCare's medical director John Brazzell, MD, serves as the prescriber.

The FQHC approach to care became possible because of funding through the Health Resources and Services Administration. "A couple of years back, HRSA released funds and encouraged FQHCs, because we are in rural areas, to begin providing opioid treatment," said ARcare Director of Behavioral Health Frank Vega, LMFT. That encouragement led ARcare to a partnership with and adoption of the Hazelden Betty Ford treatment model, COR-12 (Comprehensive Opioid Response with the Twelve Steps), which employs Suboxone® treatment and counseling services.

While MAT must, by law, include some measure of counseling and behavioral treatment, clinics vary in what they require and offer. ARcare believes in stringent counseling requirements for patient's best interests. "We require all patients involved in our program – before they see a physician – to see a social worker or counselor. They go through a complete behavioral assessment to determine if they're appropriate to receive MAT and willing to participate in required activities. We require regularly attending therapy and regularly attending some type of community-based support group – Narcotics Anonymous, for example.

"One of the largest longitudinal studies ever conducted in the United States, The Adverse Childhood Experiences Study, is considered the gold standard when it comes to trauma and trauma-related care in this country," explained Vega. "Researchers in this study found a significant correlation between underlying psychological or emotional trauma and substance use. If you're only going to address the substance use with medication, you're not addressing the underlying issues that contribute to their use."

• **Stockton Medical Group** is based in North Little Rock, with clinics in Hot Springs, Texarkana, Fayetteville, and Jonesboro. Doctors like Charles Cale, MD, use Suboxone® in their treatment. "We use the pills and the strips," he said. "The patient comes in and has a drug screening, sees the counselor, and then they come see the doctor to get their scrip, and they're off for a month."

In addition to Dr. Cale, the Fayetteville clinic employs four physicians – one a psychiatrist. "We each have a cap of about 275 patients per doctor, and we're all nearly capped out," explained Dr. Cale. "It starts with 30 the first year. It used to go up the second year to 100, but that has gone up. I don't why there's a cap. There's a real need for this treatment."

The in-house counseling is a mandatory part of each patient visit at Stockton Medical Group. "Our patients can also come in for counseling anytime they need to between visits," added Dr. Cale. "It's a big part of treatment, because' there are two addictions going on – one physical, one mental. The mental morphs into a disease."

• **Quapaw House, Inc.** is a comprehensive behavioral health organization that provides residential and outpatient MAT to patients with alcohol and drug addictions (largely opioids). The clinic utilizes a variety of buprenorphine-naloxone medications – the most common being Suboxone® – based on each patient's situation. "We utilize Suboxone® strips [in most cases of OUD], but Subutex® is used for pregnant woman or people with a bad reaction to naloxone," said CEO Casey Bright, who went on to share additional situations and suited medications used by the clinic.

Quapaw House has also developed a primary care clinic in recent years. "It allows our clients to have primary care practitioners that understand addiction in general as well as their own journey into recovery," explained Bright. "Quapaw's MAT is

> Continued on page 130.

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administered predominantly by MDs, with one APN and one PA who work under the direct supervision of the MDs in their practice. The clinic has a lower limit of allowable prescriptions per month as mandated by the DEA. As Quapaw House continues to expand MAT throughout the state, we welcome the opportunity to discuss MAT services with interested physicians."

At Quapaw House, counseling requirements are determined by the patient's treatment phase – starting with more restrictive and frequent counseling / self-help requirements and requiring less as they progress. By the time they reach their final phase of treatment, patients require only monthly medication review visits with their physician. "During each visit for medication reviews, clients see a nurse, MD or APN, peer recovery support specialist, and a master's-level licensed clinician," said Bright. "Even then, clients are required to maintain sobriety as well as attend community-based self-help groups and provide proof. Clients must submit to a urinalysis during each visit to evaluate medication and program compliance."

Real Challenges, Real Rewards

Society – and physicians with it – are caught in the middle of a great challenge, as the AMA's report indicated. "Despite a national decline in opioid prescriptions dispensed and an increase in the use of prescription drug monitoring programs, the nation's opioid epidemic continues to worsen. Deaths due to illicit fentanyl and heroin are now leading drivers of the opioid epidemic. Now, more than ever, policymakers must join the AMA in not simply supporting increased access to treatment, but by providing the resources and effort necessary to remove barriers to high-quality, evidence-based care."

Is it time for you to consider offering MAT in your clinic? The rewards can be immense. "It isn't as hard as it might seem. These are difficult patients, but not any more complicated than other patients," said Dr. Shelby, who understands well that some physicians may expect a large burden timewise or may fear working with an addicted population.

Dr. Cale, who practices in Fayetteville's Stockton Medical Group, has found "nothing to fear." The former anesthesiologist was trained at UAMS before practicing at St. John's in Tulsa. Since 1978, he has practiced in Fayetteville. Since retiring in 2012, Dr. Cale has twice been recruited back into practice, first in hyperbaric medicine and next in opioid treatment. Reflecting on his 50 years in medicine, he made quite a statement about his current work providing MAT. "This has been the most satisfying thing I've done in medicine," he said. "It changes people's lives. You know, people lose their kids, their spouses, their jobs … they'll do anything to get their fix. They can take this medication and live a normal life. They can get their kids back. They can work. This changes them immediately."

Further Reading and Research

ARcare is currently developing a training for PCPs and others interested in a treatment-based MAT. For information, contact Frank Vega at (501) 322-9288.

The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study

https://www.cdc.gov/violenceprevention/acestudy/index.html

Additionally, search for "How Childhood Trauma Affects Health Across a Lifetime (TEDMED2014) Nadine Burke Harris, MD, MPH, FAAP."

American Society of Addiction Medicine (asam.org)

The Substance Abuse and Mental Health Services Administration

An accepted resource nationwide, **SAMHSA.org** is a great starting point for all things opioids in general. It contains research and information on approved medications, statistics (new prescribers by state, etc.) and research, training to satisfy DEA requirements to prescribe MAT, and much more.

Hazelden Betty Ford (hazeldenbettyford.org/education) contains an extensive amount of documented research on both the medication and the behavioral counseling sides of treatment.

MATRIARC (Medication Assisted Treatment Recovery Initiative for Arkansas Rural Communities), part of UAMS' Psychiatric Research Institute, is a resource for programs and health care professionals providing or helping others provide MAT. This features mobile-friendly training access, weekly teleECHO conferences with free CME, and access via telephone. Through the program, Dr. Mancino provides consultation to PCPs, general psychiatrists, advanced practice nurses, physician assistants, and mental health professionals who are providing MAT to OUD patients. Early next year, the Arkansas Psychiatric Society, with support from the American Psychiatric Association (APA), will sponsor local trainings to allow those interested to obtain a waiver to provide MAT without having to leave the state. Dr. Mancino has been selected as the trainer for the state of Arkansas. Those interested in learning more about the benefits of in-person treatment are invited to call Peggy Healey at 501-283-2612.

The New England Journal of Medicine (Jul 5, 2018)

Primary Care and the Opioid-Overdose Crisis — Buprenorphine Myths and Realities

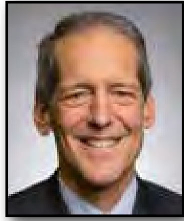
https://www.nejm.org/doi/full/10.1056/NEJMp1802741

The AMA Urges Removing All Barriers to Treatment for Substance Use Disorder

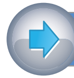
https://www.end-opioid-epidemic.org/

Treating Opioid Use Disorder as a Family Physician: Taking the Next Step Am Fam Physician.

2018 Mar 1;97(5):302-306. AMS



Derm Dilemma: Keratoacanthoma

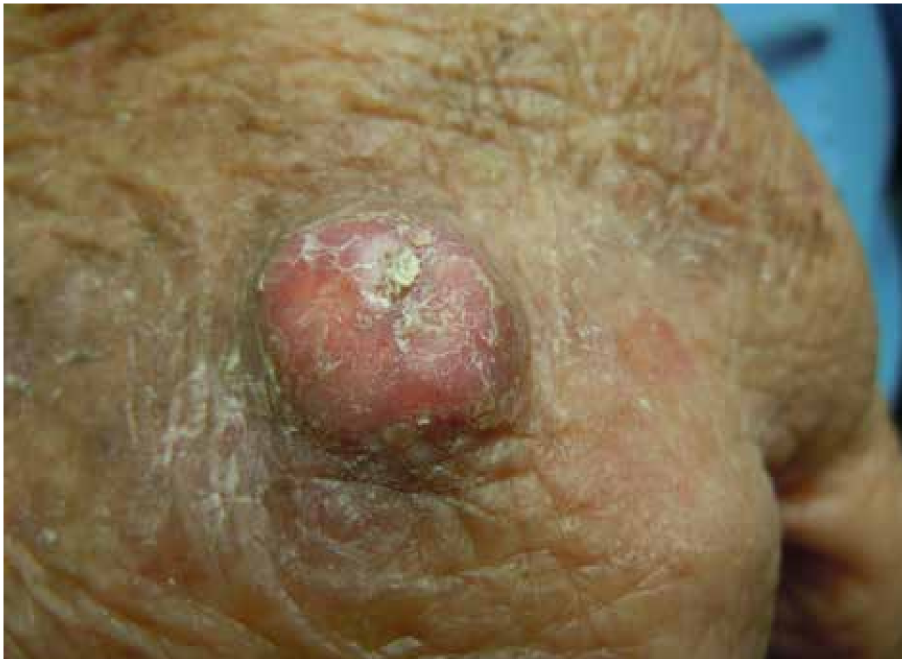


Hunter Cochran[1]; Kevin St. Clair, MD

[1]Candidate UAMS, class 2020

A 60-year-old white male presents complaining of a rapidly enlarging, painless, centrally-umbilicated, papulonodule located on the dorsal hand. The nodule was noted initially about five weeks ago. The patient admits he attempted to drain the lesion at home unsuccessfully. Subsequent appropriate step(s) in the evaluation or management of this patient should include:

A. Destruction by cryotherapy
B. Reassurance and observation
C. Shave biopsy
D. Warm compresses and one-week course of oral cephalexin
E. Intralesional injection of triamcinolone acetonide



Answer: C.

The clinical features of an erythematous, exophytic papulonodule with a central keratin-filled crater located in a sun-exposed area coupled with relatively rapid growth suggest that this lesion most likely represents a keratoacanthoma (KA). Most authorities consider KA a low-grade variant of squamous cell carcinoma (SCC), although untreated KA may resolve spontaneously within a few months. Ethical and medicolegal considerations preclude observation of suspected KA, as aggressive and potentially metastatic SCC may present in a similar fashion.

Following definitive diagnosis via skin biopsy, the most commonly employed treatment modalities are excision or destruction by curettage and electrodessication. AMS

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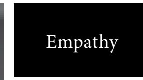

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A CLOSER LOOK AT QUALITY

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Episodes of Care Enhance Quality and Cost-Efficiency

JAMES GALLAHER

In 2011, Arkansas Medicaid started the process to transform Arkansas' health care and payment system to a higher-quality and more cost-efficient system of care. Called the Arkansas Health Care Payment Improvement Initiative (AHCPII), this was a collaboration that included many of the state's major private commercial insurance payers.

AHCPII's leadership felt the collaboration included a large enough portion of the market that there would be a strong incentive for health care providers to achieve the objectives of more efficient and sustainable utilization of Medicaid funds, higher quality of care and improved patient satisfaction. Working closely with hundreds of physicians, hospital executives, patients, families and advocates, the collaborators worked for nearly a year to design and build the new payment system.

EPISODES OF CARE

The result is a bold initiative tailored to the needs of Arkansas patients and providers. The first Episode of Care (EOC) was launched in 2012, the Patient Centered Medical Home (PCMH) soon followed, and in 2017, Arkansas Medicaid launched the first Medical Neighborhood Performance Reports. This year, the initiative continues to evolve and expand into various value-based payment models and informational transparency efforts.

An **Arkansas Medicaid EOC** is a retrospective bundle of paid medical claims submitted from all providers that were generated by a beneficiary's medical procedure, ailment or condition. Each claim in the bundle is examined for relevancy, excluding claims that are not related to the episode's focus. Each beneficiary is profiled and selected for possible risk adjustment. About half of the time, beneficiaries are excluded from the episode, based on either a global exclusion or an episode-specific exclusion. Global exclusions include conditions such as terminally ill patients, patients with certain cancers or patients with other insurance coverage in addition to Medicaid. Episode-specific exclusions are related specifically to the episode's focus. Examples may include pregnancy, age limits of the episode or various comorbidities. Exclusions allow a uniform comparison with other providers.

A principal accountable provider (PAP) is identified as the provider with the most influence towards the cost and quality of care. Quarterly reports are delivered to PAPs describing the cost and quality of care in comparison to other providers.

Financial EOCs are a shared-risk-incentive program providing both positive and negative incentives, commonly referred to as gain share and risk share. Each PAP's average episode cost is measured against financial thresholds and is determined to be either commendable, acceptable or unacceptable. Thresholds are set for measurements related to selected quality-of-care metrics. PAPs who are determined to be commendable in cost and meet quality standards will be rewarded with a positive incentive payment. This is in addition to the previously reimbursed fee-for-service claims. PAPs whose costs are determined to be unacceptable are subject to the recovery of their excess cost. Incentives are realized over a 12-month performance period.

Active financial EOCs include asthma, cholecystectomy, chronic obstructive pulmonary disease, colonoscopy, coronary artery bypass graft, heart failure, perinatal, tonsillectomy, total joint replacement (hip and knee), upper respiratory infection-nonspecific, upper respira-

tory infection-pharyngitis and upper respiratory infection-sinusitis.

Informational EOCs function much the same as a financial EOC but with two significant differences. Informational EOCs have no financial incentive or gain/risk share, provide information only, and there is no performance period. Each quarterly report reflects a 12-month review with a moving average of cost and quality of care. All other aspects of an informational episode are the same as financial EOCs. Beneficiaries' episode costs are risk-adjusted as needed, global and episode-specific exclusions are applied, and average costs and quality of care are reported for comparison with other PAPs participating in the episode.

Active informational EOCs include appendectomy, hysterectomy, uncomplicated pediatric pneumonia and urinary tract infection. Informational EOCs currently in development are Crohn's disease, diabetic ketoacidosis, lower-back pain and percutaneous coronary intervention. Three informational EOCs are in the initial design phase: hospice oncology, kidney stones and migraine.

MEDICAL NEIGHBORHOOD REPORTS

The Medical Neighborhood is Arkansas Medicaid's data transparency initiative. Providers are increasingly interested in more information to help guide quality and cost-effective improvements in their practices and facilities. Arkansas Medicaid has responded by creating a series of reports that share information among primary care physicians, specialists, surgeons and facilities. Medical Neighborhood reports are separated into several categories: episode-based performance reports, episode-based PCMH cost and quality reports, behavioral health informational reports, and other transparency and specialty reports.

An EOC includes claims from all providers involved in the care and treatment of the beneficiary. For example, a surgeon might be identified as the PAP for an EOC. Claims from all providers associated with that surgical procedure are bundled into the EOC. This would include claims from the facility where the procedure was performed, and claims for any radiology, pathology, pharmacy or other services. **Medical neighborhood performance reports** bridge the information gap among providers. They are designed to provide pertinent information to help providers better understand and influence treatment cost and quality.

Medical neighborhood performance reports are currently available for appendectomy (pending release), uncomplicated pediatric pneumonia (pending release), upper respiratory infection and urinary tract infection (pending release).

Several **episode-based PCMH cost and quality reports** are currently under consideration. These reports will share cost and/or quality information derived from EOCs with the primary care physician. PCMH cost and quality reports currently under consideration include hysterectomy, uncomplicated pediatric pneumonia, upper respiratory infection appendectomy and urinary tract infection.

In January 2018, a new financial profile report was published for behavioral health services providers. The **behavioral health informational report** is in a transitional stage until Arkansas Medicaid's behavioral health transformation is completed in 2019. At that time, this report will focus solely on behavioral health Tier 1 beneficiaries (the less severe cases). It will provide a snapshot into the claims reimbursement activity summarized by a behavioral health condition. Also, it will present information regarding the most commonly found behavioral health diagnoses, comorbidities and various demographic breakdowns of a provider's behavioral health patient panel.

Additional reports are being considered as more data become available. Plans are being made to provide a behavioral health cost contribution report for PCMH providers as well as quality of care reports.

Several other reports have been or are in the process of being created that are of interest to the medical community. An emergency department services report will soon be available that summarizes both medical and behavioral health activity in the emergency department. Other reports are under consideration.

In summary, Arkansas Medicaid's health care information has been compiled into reports to better inform providers and stakeholders. These reports will help beneficiaries' overall health and well-being. Every report includes a summary to help readers understand the data and details behind each report. This information, along with other useful information, can be found online at **www.paymentinitiative.org**. ▲

Mr. Gallaher is a design and development manager in Health Care Innovation, Division of Medical Services, Arkansas Department of Human Services.

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DECEMBER 2018

SCIENTIFIC ARTICLE

HIV Post-exposure Prophylaxis for Victims of Sexual Assault

Vini Vijayan, MD

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ABSTRACT

Sexual assault of adolescents and adults places these individuals at risk of acquisition of sexually transmitted infections including HIV. The Centers for Disease Control and Prevention provides recommendations regarding HIV postexposure prophylaxis (PEP) following non-occupational exposure to blood and body fluids.

Clinicians encountering victims of sexual assault in their practice should be familiar with the use of HIV PEP as prompt initiation of PEP is associated with a reduced risk of HIV seroconversion. We describe HIV risk assessment and evaluation, management of individuals exposed to potentially hazardous body fluids through sexual contact, and review recommended prophylactic regimens for HIV.

INTRODUCTION

Sexual assault of adolescents and adults often raises concern of transmission of sexually transmitted diseases (STIs), including human immunodeficiency virus (HIV).[1] In a nationally representative survey of adults,[2] nearly 1 in 5 (18.3%) women and 1 in 71 men (1.4%) reported experiencing rape at some time in their lives. Of these, 42.2% of female rape victims were first raped before age 18, 29.9% of female rape victims were first raped between the ages of 11-17 and 12.3% female rape victims and 27.8% of male rape victims were first raped when they were age 10 or younger. Sexual assault itself is often underreported and underestimated, and this makes the study of HIV transmission after sexual assault difficult.[1,2]

In 2016, the Centers for Disease Control and Prevention published updated guidelines for use of HIV postexposure prophylaxis (PEP) for persons with nonoccupational exposure (e.g., sexual contact; sharing of injection drug needles, or other equipment) to blood and body fluids. The updated guidelines incorporate the use of rapid antigen/antibody (Ag/Ab) combination HIV tests, revised preferred and alternative 3-drug antiretroviral PEP regimens, an updated schedule of laboratory evaluations of source and exposed persons as well as updated antimicrobial regimens for prophylaxis of sexually transmitted infections and hepatitis.[3,4]

This article aims to update clinicians regarding current guidelines and recommendations for HIV PEP following nonoccupational exposures to blood and body fluids, thereby enabling them to make an informed decision on when HIV PEP is indicated for adolescent and adult victims of sexual assault.

General Principles Regarding Initiation of HIV Post-exposure Prophylaxis

Health care providers should rapidly evaluate patients for PEP when care is sought ≤ 72 hours after a potential exposure that presents a substantial risk for HIV acquisition. When deciding whether to recommend PEP, the clinician should assess and carefully weigh the following factors:

1. Patient's risk of HIV acquisition based on the type of exposure
2. Knowledge of the HIV status of the alleged assailant
3. Amount of time that has elapsed after exposure as PEP should be administered as soon as possible and within 72 hours.
4. Whether the victim is ready and willing to complete the 28-day PEP regimen

Risk of HIV Transmission Following Different Types of Exposures

The frequency of HIV transmission is relatively low, given that the risk of transmission in consensual sex is 0.1% to 0.2% for vaginal and 0.5% to 3% for receptive anal intercourse.[5] Although most perpetrators are not HIV positive, estimated risk per act varies depending on the type of exposure and cases of HIV transmission following sexual assault have been described. It is also important to consider that HIV prevalence in sexual assailants may be higher than that in the general population. Additionally, particular characteristics of the assault

Type of Exposure	Risk per 10,000 exposures
Receptive Anal Intercourse	138
Insertive Anal Intercourse	11
Receptive Penile-vaginal Intercourse	8
Insertive Penile-vaginal Intercourse	4
Insertive and Receptive Oral Intercourse	Low
Biting and Spitting ^	Negligible

* Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load.
^HIV transmission through these exposure routes is technically possible but unlikely and not well documented.
Source: http://www.cdc.gov/hiv/policies/law/risk.html

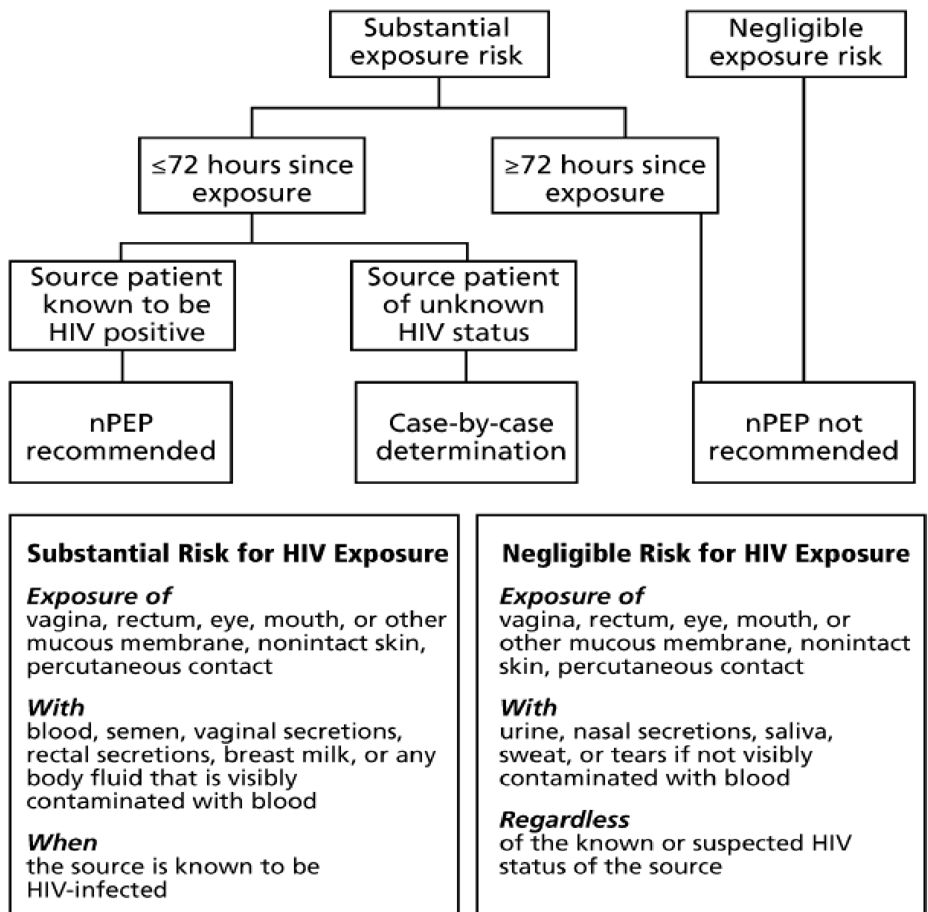
Key Issues to Discuss With The Victim Before Initiating nPEP
Potential Benefits of HIV Pep
Potential Toxicities Associated With Medications (Nausea, Fatigue, Vomiting, and Diarrhea, Rash, Myalgia, Allergic Reactions)
Instructions on How and When to Give the Medications
Importance of Adherence to the Medication Regimen
Duration of Medication Regimen, Monitoring Schedule, and Follow-Up
Plan for Accessing the Full 28-Day Supply of Appropriate Anti-Retroviral Therapy Promptly

may increase the likelihood of transmission of HIV. This would include assault with multiple assailants, perpetration of multiple sex acts, anal penetration, and the presence of preexisting STIs.[5,6]

Considering the HIV Status of the Alleged Perpetrators/Source Person

Whenever PEP is initiated, the potential for drawing HIV serology from an identified suspected perpetrator should be considered. If the alleged perpetrator subsequently is found to be HIV negative and has no symptoms of HIV infection; discontinuation of prophylaxis of the victim may be appropriate when in consultation with an infectious disease specialist. In most cases, the alleged perpetrator is not available for testing and therefore PEP should be initiated and the 28-day course should be completed. Initial treatment of a patient should never be delayed pending results of serologic testing of an alleged perpetrator. If the alleged perpetrator is known to be HIV infected, the clinician should attempt to obtain information of the perpetrator's HIV status, including viral load, medication list, and resistance mutations. This data will be helpful in choosing an appropriate HIV PEP regimen for the victim. If the source person is known or suspected to have infection with HIV that is resistant to antiretroviral medications, seek expert consultation in selecting an appropriate PEP regimen.

Table 2



Decision Algorithm for Evaluation and Initiation of Treatment

PEP is most effective when initiated as soon as possible after HIV exposure, and it is unlikely to be effective when instituted >72 hours after exposure.[3,7] Therefore, persons should seek PEP as soon as possible after an exposure that might confer substantial risk. PEP should not be provided for frequent recurring exposure. To assist in the determination of which patients should be offered HIV PEP, the algorithm from the US Department of Health and Human Services Working Group on Nonoccupational Postexposure Prophylaxis is shown below.[3]

Implementing Post-Exposure Prophylaxis

When the decision to initiate PEP is made, clinicians should communicate this recommendation to the patient, considering his/her emotional state and ability to comprehend the nature of antiretroviral treatment.

Antiretroviral Regimens for Pediatric/Adolescent HIV Post-Exposure Prophylaxis

All persons offered PEP should be prescribed a 28-day course of a 3-drug antiretroviral regimen.[7,8]

The preferred regimen for otherwise healthy adults and adolescents >13 years is shown below:

- Tenofovir disoproxil fumarate (tenofovir DF or TDF) (300 mg) with emtricitabine (200 mg) once daily

plus

- Raltegravir (RAL) 400 mg twice daily or dolutegravir (DTG) 50 mg daily.
- Alternative regimen for otherwise healthy adults and adolescents is
- Tenofovir DF (300 mg) with emtricitabine (FTC) (200 mg) once daily

plus

- Darunavir (DRV) (800 mg) and ritonavir (RTV) (100 mg) once daily.

Health care providers considering using antiretroviral regimens other than those listed in these guidelines as preferred or alternative are encouraged to consult with health care providers who have expertise in HIV.

Laboratory Evaluations of Victim of Sexual Assault

Baseline laboratory testing should be performed to document HIV infection status of the

> Continued on page 136.

Preferred Prophylaxis after Sexual Victimization: Postpubertal Adolescents and Adults	
For Gonorrhea	Ceftriaxone 250 Mg Im X 1 Dose
Plus	
For Chlamydia	Azithromycin 1Gm Po X 1 Dose
Plus	
For Trichomoniasis and Bacterial Vaginosis	Metronidazole 2 Gm Po X 1Dose ¥
For Hepatitis B	Administer Hepatitis B Vaccine if not Fully Immunized or if Patient Found to be Hepatitis B Non-Immune (I.e. Hepatitis B Surface Antibody Negative)
For HPV	HPV Vaccine Series Should be Initiated if > 9 Years of Age and if not Already Given or if not Fully Immunized
*for those >8 years and not pregnant ¥ May be given at home to minimize side effects especially if Plan B has been given or if patient has ingested alcohol **± The patient should have a negative pregnancy test**	

victim, identify any conditions that would affect the PEP medication regimen such as hepatitis B, and to monitor for safety or toxicities related to the regimen. Testing for other sexually transmitted infections such as syphilis, hepatitis B, hepatitis C, gonorrhea, and chlamydia should also be provided at presentation to care.[9,10] (Table 2)

Because of the complexity and potential adverse effects of the PEP regimens, follow-up care of the exposed patient should be provided. Initial follow-up of the victim should occur within 14 days, if possible, to evaluate adherence, monitor toxicities, tolerance, and side effects. Side effects such as nausea, vomiting, and abdominal pain should be managed aggressively in order to maximize the likelihood of adherence to PEP.

At the 4-6 week follow-up visit, serum creatinine, alanine transaminase, aspartate aminotransferase, syphilis serology, and pregnancy testing should be performed. Evaluation should be done for gonorrhea and chlamydia if presumptive treatment was not provided at the baseline visit or if patient is symptomatic at follow-up visit.

A fourth-generation HIV antigen/antibody combination test is the recommended serologic screening test for victims of sexual assault. HIV testing should be obtained at baseline, week 4-6 and week 12 post-assault. If the exposed person presents with signs or symptoms of acute HIV seroconversion, an HIV serologic screening test should be used in conjunction with a plasma HIV RNA assay to diagnose acute HIV infection. A negative HIV test result at 12 weeks post-exposure reasonably excludes HIV infection related to the exposure. If at any time the HIV test result is positive, an FDA-approved confirmatory assay must be performed. Immediate consultation with a clinician experienced in managing ART should be sought for optimal treatment options.

Testing for HIV at six months post-exposure is no longer recommended unless hepatitis C was acquired during the original exposure. Follow-up six months after exposure should also be performed in patients who were susceptible to hepatitis B or hepatitis C at baseline. Individuals who were determined to be infected with syphilis and treated should undergo serological syphilis testing six months after treatment.[3, 7-9]

Clinicians should provide risk-reduction counseling to exposed persons to prevent secondary transmission during the follow-up period. This should include advice regarding use of condoms to prevent potential sexual transmission, avoidance of pregnancy and breastfeeding, avoidance of needle-sharing, and abstaining from donating blood, plasma, organs, tissue, or semen.

Antimicrobial prophylaxis is recommended to include an empiric regimen to prevent chlamydia, gonorrhea, trichomonas, and bacterial vaginosis. Vaccination against hepatitis B and HPV is recommended if not fully immunized. CDC recommendations for sexual assault prophylaxis can be found at www.cdc.gov/std/tg2015/sexual-assault.htm. [9, 10]

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Baskin, Barry, MD
Basu Ray, Indranill, MD
Bates, Stephen R., MD
Bates, Joseph H., MD
Battisto, Elizabeth, DO
Battles, Lourie Ann, MD
Bauer, Thurston, MD
Bauman, David C., MD
Bavineni, Mahesh, MD
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Beadle, Beverly A., MD
Beallis, Randall S., DO
Beard, Amy, MD
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Bearden, Jeffrey C., MD
Bearden, Lisa, MD
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Beaton, J. Trent, MD
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Beau, Scott L., MD
Beavers, H. Kevin, MD
Beavers, Jared C., MD
Beavers, Jessica, MD
Beck, Christie M., MD
Beck, J. Thaddeus, MD
Beck, Joseph M., II, MD
Beck, M. Lowery, MD
Beck, William A., MD
Beck, William C, MD
Beckel, Ron W., Jr., MD
Beckman, James S., Jr., MD
Becton, David L., MD
Beene-Lowder, Hannah L., MD
Behrens, Bing X., MD
Beland, Susan S., MD
Bell, F. Keith, MD
Bell, Jeffrey D., MD
Bell, L. J. Patrick, II, DO
Bell, Linda O., MD
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Bell, Michael F., MD
Bell, Patricia, MD
Bell, Rex H., MD
Bell, Robert A., MD
Bell, Austin Patrick, MD
Bell, Brian, MD
Bell, John E., MD
Belue, Kara D., MD
Benafield, Laureen L., MD
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Benjamin, George H., MD
Bennett, Grant, MD
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Bennett, Leigh A., MD
Bennett, Luke, MD
Bennett, Joe D., MD
Bentley, Frederick R., Jr., MD
Berlinski, Ariel, MD
Berner, Dennis W., MD
Berney, Seth Mark, MD
Berry, Michael, MD
Berry, Robert L., MD
Berry, Donald M., MD
Berryhill, Richard E., MD
Berumen, Mike, MD
Bess, Barbara, MD
Bess, Lloyd G., MD
Best, Thomas H., MD
Bevans, David W., III, MD
Bevill, Gary L., MD
Bhakta, Rupal, MD
Bhakta, Sonal T., MD
Bhamare, Tanmay Anant, MD
Bhaskar, Nutan, MD
Bhaskar, Priya, MD
Bhavaraju, Avinash V., MD
Bhusal, Sushma, MD
Bibb, Bradley R., MD
Bielamowicz, Kevin, MD
Bienvenu, Gregory S., MD
Billings, Christopher, DO
Birch, Candy E., MD
Birch, Scott W., MD
Bird, Mirfat, MD
Birk, Gordon T., MD
Birkett, Ian, MD
Bishop, Jennifer E., MD
Bissett, Joseph K., MD
Bitzer, Lon G., MD
Bizzell, Jamie, MD
Black, Randall W., MD
Black, David, MD
Blackmon, Joseph, MD
Blackstock, Terri, MD
Blackwell, Jeffry, MD
Blagdon, Donald G., MD
Blair, Brian H., MD
Blake, Dennis N., MD
Blakely, Brent M., MD
Blankenship, James B., MD
Blankenship, William F., MD
Blankers, Christian G., MD
Blasier, R. Dale, MD
Blaszak, Richard T., MD
Bledsoe, Gregory, MD
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Blickenstaff, Kyle R., MD
Blue, Leon, MD
Blue, Glen T., MD
Bodemann, Diane K., MD
Bodemann, Donald R., MD
Bodemann, Michael C., MD
Bodemann, Stephen L., MD
Bodenner, Donald L., MD
Boehm, Timothy M., MD
Boger, James E., MD
Bogomilov, Boris V., MD
Bolin, Elijah Holbrook, MD
Bolyard, Keith J., MD
Bone, Sarah, MD
Bonner, Mark A., MD
Bonner, J. Darrell, MD
Bonwich, Janina B., MD
Booker, J. Gregory, MD
Boone, Jamie, DO
Boop, Bradley S., MD
Boop, Warren C., Jr., MD
Boos, Donald L., Jr., MD
Booth, Allison, MD
Bordeaux, Ronald A., MD
Borg, C. Doug, MD
Borg, Robert V., MD
Borja-Cacho, Daniel, MD
Bornemeier, Renee A., MD
Bounds, Andrea, MD
Bourland, Mary Evelyn, MD
Bowen, W. Scott, MD
Bower, Charles M., MD
Bowlin, Randal G., MD
Bowlin, Brian, MD
Box, Ivan H., MD
Boyce, John M., MD
Boyd, Curtis James, III, DO
Boyd, Dusty, MD
Boyd, Charles M., MD
Boyette, Jennings R., MD
Bozeman, Caleb B., MD
Bracey, John W., MD
Bracy, Calvin M., MD
Braden, Lawrence F., MD
Bradford, Daniel S., MD
Bradley, Joe F., MD
Bradley, Lucas, MD
Bradshaw, Jody, MD
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Bradsher, Robert W., Jr., MD
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Branch, Kevin Drake, MD
Branch, Vanessa H., MD
Brander, Brooke, DO
Brandon, Kristen, MD
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Branman, Rhys L., MD
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Brasseux, Stephen, MD
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Brewer, Vernon, MD
Brezina, Daniel Edward, MD
Bricco, Diane Dahlstrom, MD
Brimberry, Ronald K., MD
Brixey, Jonathan, MD
Brock, Wade D., MD
Bromley, Howard, MD
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Brooks, Janice W., MD
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Brotman, David, MD
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Brush-Strode, Natalie J., MD
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Burks, Willard, MD
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Carter, Jerry L., MD
Cartwright, Jefferson, MD

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Casteel, Helen, MD
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Causey, Robert, MD
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Chavez, Jaime Rene, MD
Cheairs, John T., MD
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Chen, Lingyi, MD
Chenault, Kathryn T., MD
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Cherry, James F., MD
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Chinn, Albert, MD
Chinwah, Justin Ezekwem, MD
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Choate, Robert B., MD
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Cleveland, Elton R., MD
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Clifton, Ginger, MD
Clifton, E. Cliff, MD
Clingenpeel, Rachel Anne, MD
Clinton, Kimberly S., MD
Clogston, Charles W., MD
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Cloud, Michael Carl, MD
Cloud, Joe A., MD
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Cobb, Joel C., MD
Cobb, Jock S., MD
Coble, Andrew L., MD
Cockrill, H. Howard, Jr., MD
Cockrum, Holly D., MD
Cody, Stephanie G., MD
Coffman, Edwin, MD
Cogburn, Bob E., MD
Cohen, Jeffrey O., MD
Coker, Matthew J., MD
Coker, R. Kirk, MD
Coker, Tom P., MD
Coker, Dana, MD
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Cole, Ezra Lee, MD
Cole, Randall E., MD
Coleman, Doug, MD
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Collins, David N., MD
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Collins, Kenneth P., MD
Collins, Kevin J., MD
Collins, Laura R., MD
Collins, Linda, MD
Collins, E. Morgan, Jr., MD
Collum, Grady R., MD
Cone, John B., MD
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Conley, Thomas D., MD
Connelley, Jay R., MD
Conner, George L., III, MD
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Cook, Deborah Anne, MD
Cook, Kimra Kay, MD
Cook, William Jason, MD
Cooke, Sam, MD
Coon, Jefferydon, DO
Cooper, Edward M., MD
Cooper, James B., MD
Cooper, Scott, MD
Cooper, William Allen, DO
Cope, Michael, MD
Coppola, Angelo G., Jr., MD
Corbett, Janet Kay, DO
Corbitt, Mary, MD
Cordell, Cari Lee, MD
Costaldi, Mario E., MD
Cothern, Teresa Danielle, MD
Counce, James, MD
Council, Robert A., Jr., MD
Courtney, Sherry, MD
Courtney, Willis, Jr., MD
Coussens, David M., MD
Covas, Eve, MD
Covert, Kent J., MD
Covert, George K., MD
Covey, David C., MD
Cowherd, Kristy C., MD
Cowherd, Robert M., MD
Cox, Roni, MD
Cox, Wesley K., MD
Cox, Katy, MD
Crabtree, Donald, DO
Craft, Charles, DO
Craig, Jeffrey A., MD
Craig, Sherrye, MD
Cranfill, General L., III, MD
Crary, Kyler Gordon, MD
Crary, Shelley, MD
Crawford, Janet L., MD
Crawford, Brendan David, MD
Crawley, Michael E., MD
Crenshaw, John, MD
Criner, Owen K., MD
Crocker, Thermon R., MD
Cross, Amy W., MD
Cross, Michael J., MD
Crow, Neil E., Jr., MD
Crow, R. Lewis, Jr., MD
Crow, Joe W., MD
Crowell, Bernard G., Jr., MD
Crump, Mark R., MD
Culp, William C., MD
Cummins, J. Craig, MD
Cupp, Cecil W., III, MD
Curry, Angela K., MD
Cushanick, Katelyn Marie, MD
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Dahdal, Dina, MD
Daily, Joshua, MD
Daily, Richard, MD
Dajani, Nafisa K., MD
Dalabih, Abdallah, MD
Dang, Minh-Tam, MD
Daniel, Jess, MD
Daniel, Charles D., MD
Daniel, Noble B., III, MD
Daniel, William R., MD
Daniels, C. Dwayne, MD
Darden, Lester R., MD
Dare, Jason A., MD
Dare, Shannon Stough, MD
Das, Debasis, MD
Das, Srikant, MD
Dasari, Kanthi B., DO
Dasgupta, Rahul, MD
Dassinger, Melvin Sidney, MD
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Davidson, Andy M., MD
Davidson, Charles D., MD
Davidson, Daniel S., MD
Davies, Faith, MD
Davis, Benjamin Lee, MD
Davis, Cole Brian, MD
Davis, J. Craig, MD
Davis, J. Lynn, MD
Davis, Ked, MD
Davis, Megan Renee, MD
Davis, Orrin J., MD
Davis, Paul W., MD
Davis, Randall, MD
Davis, Rodney, MD
Davis, Scott A., MD
Davis, Sheryl L., MD
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Day, John, MD
Day, Thomas, MD
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De Silva, Shari M., MD
De Silva, Shirin R., MD
Dean, David M., MD
Deaton, C. William, Jr., MD
Decker, Harold A., MD
Dedman, John D., MD
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Deed, E. Ashley, MD
Deel, Amanda, DO
Deer, Philip, III, MD
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Deere, Deborah, MD
Degges, Russell D., MD
DeGraff, Thomas, III, DO
Dehmel, Stephan, MD
Deimel, George, IV, MD
Delacey, Norbert W., Jr., MD
Delap, Susan K., MD
Delgado, Pedro Lazaro, MD
DeLoach, John M., Jr., MD
DeLuca, Amy S., MD
Deneke, Matthew G., MD
Denton, Meredith A., MD
DeRossitt, James, III, MD
Deshpande, Jayant Krishnan, MD
Desikan, Raman, MD
Devlin, Michael A., MD
DeYoung, Bruce, MD
Dhall, Rohit, MD
Dhanireddy, Bharat Reddy, MD
Dharamsey, Shabbir, MD
Diaz, Edwin A., MD
Dickins, John R. E., MD
Dickinson, Jacob L., MD
Dickson, Brian G., MD
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Dietrich, Timothy, DO
Dilday, Bradley R., MD
Dill, Kenneth, MD
Dillaha, Jennifer, MD
Dilley, Meredith Anne, MD
Dinehart, Scott M., MD
Dittmeyer, Kale, MD
Divers, Stephen G., MD
Dixon, Jared, MD
Dixon, Jerry W., MD
Dixon, R. Mark, MD
Dodd, Lawrence D., MD
Dodd, N. Leland, MD
Dodd, Doyne, MD
Dodson, John W., Jr., MD
Dolan, Patrick A., III, MD
Domon, Steven E., MD
Dondeti, Raja, MD
Dorman, Robert, MD
Dornhoffer, John L., MD
Dorroh, Scott, MD
Dorzab, Joe H., MD
Dossey, Amy M., MD
Dougherty, Christopher P., DO
Douglas, Donald S., MD
Douglas, Warren M., MD
Dowdy, Justin Thomas, MD
Downs, Michael R., MD
Doyle, Sean Michael, MD
Doyle, Jennifer, MD
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Driver, Brandon Rex, MD
Drobena, Gina, MD
Drumm, Joseph, DO
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Duarte-Rojo, Andres, MD
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Duke, Anton L., MD
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Dunn, Richard W., MD
Dunn, Donald L., MD
Dunnagan, Steven A., MD
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Durvasula, Venkata Surya P., MD
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Earl, Kevin S., MD
Easter, Rex M., MD
Eastin, Carly Dean, MD
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Eaton, James M., MD
Eaton, Broderick, DO
Eble, Brian K., MD
Eck, Gareth, MD
Eckert, Michelle L., MD
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Edala, Arpana, MD
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Edattukaren, Varghese, MD
Eddington, William R., MD
Edgar-Zarate, Courtney Leann, MD
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Edupuganti, Mohan Mallikarj, MD
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Edwards, Samuel Eric, MD
Edwards, Christopher Wil, MD
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El Sharawi, Nadir Raafat, MD
El Taoum, Katia, MD
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El-Hassan, Nahed, MD
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Elkins, John S., MD
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Elser, Joseph, MD
Eltahawy, Ehab Abdalla, MD
Emery, Robert, MD
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English, Jim, MD
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Engmann, Carl A., MD
Engstrom, Gregory, MD
Ennen, Randy, MD
Ennis, Jared S., MD
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Erbland, Marcia L., MD
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Escue, Michael W., MD
Esquivel, Maria Teresa, MD
Evans, David M., MD
Ewing, Travis, DO
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Farmer, Joseph F., MD
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Farrar, Thomas Crowell, MD
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Ferguson, Max Ann, MD
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Figures, Koyia, MD
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Fletcher, James W., III, MD
Fletcher, Joyce Verna, MD
Fletcher, Terry G., MD
Fletcher, James Julian, MD
Fletcher, Thomas M., MD
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Folk, Benjamin P., MD
Fontenot, Eudice E., MD
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Forward-Wise, Robin Lianne, MD
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Haridas, Aaroop, MD
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Harris, Rex Lee, Jr., MD
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Henry, Richard Y., MD
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Jaeger, Nolan, MD
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Jain, Nishank, MD
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Johnson, Miles M., MD
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Jones, Roy S., MD
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Jones, Steve A., MD
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Kelly, Owen L., MD
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Lowery, Lisa A. J., MD
Lowery, Robert S., MD
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McCourtney, Bill R., II, MD
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Pickhardt, Mark G., MD
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Pierce, Barry D., MD
Pierce, Kelly A., MD
Pierce, Reid G., MD
Pierce, Ruston Y., MD
Pierce, Trent P., MD
Pike, John D., MD
Pillow, Jessica Leigh, MD
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Pina Oviedo, Sergio, MD
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Piontek, Joseph, DO
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Pirnique, Allan S., MD
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Pope, Kevin L., MD
Pope, Norton, MD
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Post, James M., Jr., MD
Poteet-Schwartz, Kim L., MD
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Pouly, Severin Marcel, MD
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Powell, Justin A., MD
Powell, Brenda N., MD
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Powers, Robert E., MD
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Pratt, Cedric, DO
Prayaga, V. Sastry, MD
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Price, Herbert H., III, MD
Price, Lawrence C., MD
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Pritchard, Jamie, MD
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Pritchard, Jack L., MD
Pritchett, Daniel P., MD
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Pullig, Thomas A., MD
Pummill, Daniel, MD
Pumphrey, Carla, MD
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Purvis, Kenneth W., MD
Putman, Chad Wayne, MD
Pyle, David, MD
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Quevillon, Robert D., MD
Quick, Charles M., MD
Quick, Matthew, MD
Quinn, Brian D., MD
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Radvany, Martin Geza, MD
Ragland, James, MD
Ragland, Matthew, MD
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Raisingani, Manish Gope, MD
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Rankin, Katherine Eliza, DO
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Rao, Arun R., MD
Rapp, Richard J., MD
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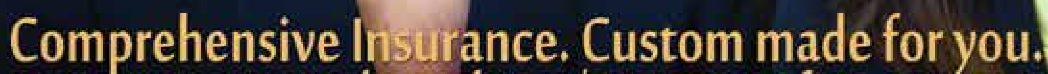

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