



# JOURNAL

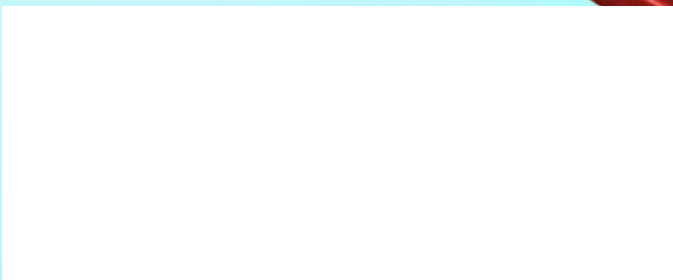
## OF THE ARKANSAS MEDICAL SOCIETY

FALL 2022 VOLUME 119 NUMBER 2



# BEHAVIORAL HEALTH

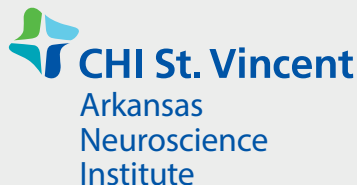
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# JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

Established 1880, the Journal of the Arkansas Medical Society is owned and edited by the Arkansas Medical Society and published quarterly under the direction of the AMS Board of Trustees.

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**DISTRIBUTION:** The Journal of the Arkansas Medical Society (ISSN 0004-1858) is published quarterly by the Arkansas Medical Society, 10 Corporate Hill Drive, Suite 300, Little Rock, AR 72205. Subscription rate: \$30.00 annually for domestic; \$40.00, foreign; \$3.00, single issue.

Periodicals postage is paid at Little Rock, AR, and at additional mailing offices. The Journal is printed by Walsworth Press Inc., Fulton, MO 65251.

**Postmaster:** Send address changes to:  
The Journal of the Arkansas Medical Society,  
P.O. Box 55088, Little Rock, AR 72215-5088.

Articles and advertisements published in The Journal are for the interest of its readers and do not represent the official position or endorsement of The Journal or the Arkansas Medical Society. The Journal reserves the right to make the final decision on all content and advertisements.

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# GRAY AND WHITE MATTER MATTERS

BY **SETH M. BARNES, MD, FACP**  
 PRESIDENT, ARKANSAS MEDICAL SOCIETY

It happens in every office and hospital every day. No specialty is immune to matters of mental health. No doubt the recent social issues associated with the pandemic have brought a lot of these diagnoses to the forefront, but isolation and social interruptions have taken somewhat stable patients with mental health issues and caused dramatic exacerbations. I've been concerned with my own patients' loneliness and how this can destabilize otherwise stable medical conditions.



## HERE ARE JUST A FEW EXAMPLES FROM RECENT CLINIC VISITS.

The elderly couple living alone with one spouse suffering from dementia. Medical concerns are addressed and that is usually straightforward, but what about the mental side of the case? Safety concerns are a significant issue, not only for the patient, but for the caregiver. As we all know, the caregiver slowly becomes a live-in nurse and social worker quickly progressing to a 24/7/365 tour of duty. How exhausting for the caregiver. There are gero-psychiatric units available for inpatient treatment, but this is for extreme cases and offers no real help for the outpatient. What support is there for this situation? Where do we turn for help? How do we provide for both the patient and caregiver to treat both with kindness and dignity? Are their affairs set up to provide for progressive disability for both of them (powers of attorney, asset protection, etc)?

A young man with severe anxiety, with depression also playing a role. Medications are prescribed, but he still has significant issues with job performance, social engagements, family, and personal relationships. What other avenues of help are there for him?

The veteran suffering from PTSD. He's trying to cope but now has resorted to heavy alcohol use and some illicit drug use. Where is the safety net for him?

A new mom with severe postpartum depression who is taking care of a young child at home alone. Sure medications can be prescribed, but what else is there to support her and allow her to be the best mother she can be?

A nurse with emotional fatigue and burn out symptoms from many, many extra shifts and Covid 19 patients. Job performance is an issue. Where can we get her the best help?

And what about us - the doctor? Where do we turn when we have reached our limit with stress, anxiety, and possible burnout? Most of us put up a facade and carry on but is this healthy?

Obviously, many more questions than answers are here in these few examples, these issues are faced daily by physicians of all specialties.

We need more investment in mental health. Much more needs to be done to help support these types of patients and their attending physicians. Once again legislation is the key. Without appropriate funding, programs cannot be put into place to improve mental health care. Our government is happy to invest in all sorts of things; what about a call to invest in mental health? For far too long, a stigma has been associated with mental health conditions. Shouldn't the safety and welfare of the population be at the forefront of legislative efforts?

This issue of the Journal hopefully will shed some light on these matters and provide some guidance as where we need to start. ■

**I'VE BEEN CONCERNED WITH MY OWN PATIENT'S LONELINESS AND HOW THIS CAN DESTABILIZE OTHERWISE STABLE MEDICAL CONDITIONS.**





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# BEHAVIORAL HEALTH

## INTEGRATING MENTAL HEALTH INTO PRIMARY CARE

BY CASEY L. PENN



**M**ental health. While its importance has long been understood by physicians, it has become forefront in the national consciousness recently, in part due to the pandemic's effects. An August 2022 article by Stacy Weiner for The Association of American Medical Colleges,<sup>1</sup> reports how mental health issues skyrocketed after COVID-19. It reads, **“At the height of the pandemic, 40% of adults reported symptoms of anxiety or depression — compared with 11% pre-COVID. Over time, this dipped to 33% in June 2022, still higher than pre-pandemic levels.”**

That rise has led to another concern already on medical radar screens: the shortage of mental health professionals. Weiner reports, “Regardless of the great need the U.S. has too few mental health professionals ... within a few years, the country will be short between 14,280 and 31,109 psychiatrists, psychologists, social workers, and others will be overextended as well.”

Weiner's article is one of many highlighting a mental health crisis and sharing efforts by leaders to find solutions. “Some are using telemedicine to meet patients wherever they are,” she wrote. “Others focus on recruiting and training a fresh crop of psychiatrists. And still others aim to educate and support primary care providers (PCPs), the frontline physicians who treat most mental health patients.

Such a collaborative, interprofessional approach is crucial in filling the psychiatry gap.”

Seeking to understand the climate of a “collaborative, interprofessional approach” to the mental health needs of patients here in our state – particularly from a primary-care perspective – The Journal reached out to Arkansas physicians who have experienced this approach and to one of the experts they've turned to for help.



A local physician heavily consulted in this approach, **Patty Gibson, MD**, is board certified in psychiatry, addiction medicine, and anesthesiology. She has extensive knowledge and experience assisting family medicine, internal medicine, and other primary care physicians in integrating behavioral health into their practices.

Dr. Gibson is currently a psychiatric consultant for Arkansas Health Group/ Baptist Health System, an adjunct clinical assistant professor of Psychiatry at UAMS, an instructor for The REACH Institute ([thereachinstitute.org](http://thereachinstitute.org)), and a co-founder and chief medical officer of the Arkansas

Behavioral Health Integration Network (ABHIN). Formerly, she was medical director for Baptist Health's Behavioral Health Integration Network and later worked for Alleviant Health as chief medical officer. She first became immersed in a working behavioral health integration system while working at the Veteran's Administration.

Her expertise affords unique insights into behavioral health integration as a solution to our mental health crisis. “We know there aren't enough mental health providers,” she began. “Of those who get referred to mental health by their PCPs – 80% never make it to a mental health appointment. Aside from associated fear, stigma, etc., they must find someone that takes their insurance, and then they may wait several weeks to see a counselor and several months to see a psychiatrist. Research shows that when people need this help and don't get it, it leads to their having trouble keeping and succeeding at jobs, using drugs, getting put in jail, and other consequences.”

Dr. Gibson confirmed that most mental health care is already being done by PCPs. “The problem is many don't have the training to feel comfortable with it,” she said. “Many need more education in best practices to screen patients for mental health issues and develop a plan for their patients. Part of the solution for PCPs can be building relationships with mental

health specialists or hiring specialists to assist them in their practices.”

### CPC+ AND ASSOCIATED TRAINING

Working with The REACH Institute, Dr. Gibson organized training in 2017 for 48 Baptist PCPs. “Several Arkansas physicians attended and later called on me for psychiatric collaboration on some of their patients,” she said. “We were participating at the time in a Centers for Medicare and Medicaid Services initiative called Comprehensive Primary Care Plus (CPC+), a value-based care program where CMS and several commercial payors gave incentive funds to participating practices over a five-year period to adopt a team-based care model that included behavioral health specialists, dieticians, pharmacists, and care managers. Evidence shows that for people to get better in their overall health care, we needed to address their emotional and mental health issues.”



**Larry Braden, MD**, participated in the CPC+ initiative before retiring from family practice at Ouachita Valley Family Clinic in Camden. He offered a compelling comparison of the practice “before-versus-during” the initiative. “For the first 30-35 years of my practice, we were pretty much on our own relative to mental health care for our patients,” shared Dr. Braden. “We’re in south Arkansas, and we had a government-funded counseling service in town, but no real psychiatrists involved. We did the best we could in the context of a model of care that gave us 10-20 minutes per patient. When we had an acute psychiatric need, it required a lot of time and was disruptive to an established appointment system.”

Enter Dr. Gibson and the CPC+ initiative. “At first, we were cautious – not resistant, but cautious. Before it was over, we were enthusiastic as a group. It was two years there of psychiatric bliss,” recalled Dr. Braden. “Dr. Gibson’s idea was to

make sure we had a basic knowledge of psychiatry and she would always be available for psychiatric consultation – something we had never had. We had backup by telephone, and she would refer to a psychiatrist when needed.

“The next step was the winner,” he continued. “We brought in master-level counselors, which enabled us to have soft referrals in clinic. If patients were manifesting some psychiatric need, I would offer them this new in-clinic service. We started with one counselor; before long, we had two, all-day, in-clinic counselors seeing patients. They would come at our call, spend 10 minutes with the patient of our concern, plan follow up, and return to their counseling work. They took over referrals as needed and worked with me when there was a need for medication. It was much more efficient.”



**Bill Dedman, MD**, is still a practicing partner at Ouachita Valley Family Clinic and worked with Dr. Braden during the clinic’s CPC+ initiative. Currently staffed by three physicians and four physician extenders, the Camden clinic serves a patient population of about 6,000.

A long-time family physician, he echoed his colleague’s enthusiasm towards CPC+ and touched on the importance of treating mental health. “I’ve done all kinds of family medicine including obstetrics,” began Dr. Dedman. “I deal with various emotional and behavioral issues in children and adults. Anxiety and stress are so common that we must deal with it ... attention deficit, too. If I don’t do it, they may not get help for months. That’s why family doctors are so important when it comes to delivering that care, as are pediatricians and internal medicine physicians.”

Of the training he and his partners received through The REACH Institute, he continued, “It was one of the best conferences I’ve been to in terms

of helping primary care physicians understand and have confidence in managing and treating behavioral health integration. The subsequent CPC+ experience and the financial help it provided was an extraordinary program that we miss. For a period, there was no cost to the physicians or the patients.”

Between COVID and the CPC+ funding ending, the clinic has been unable to get a counselor back in the clinic. “We’re trying,” said Dr. Dedman. “I’m not sure it’s something we can do without financial support. Most physicians will say this is something that is so important to us – probably 20 or 30% of patients that we see every day need this – but to get that financially reimbursed is a struggle.”

Meanwhile, it’s back to the old way at the Camden clinic: relying on local area counselors as needed. “It’s slow to get in, and it’s not nearly as effective and efficient as having someone in house,” said Dr. Dedman. “Then, too, some counselors will take insurance, and some will not. The financial part of seeing a counselor can be a blockade for patients.”



**STEPHANIE CODY, MD**, is another family physician determined to maintain behavioral health assistance even after losing CPC+ funds. She practices at Hillcrest Baptist Clinic in Little Rock and currently benefits from one in-house licensed social worker, Darren Reeves, LCSW.

“Mental health has always been important to me, so when I had the opportunity to bring it into the clinic, I jumped at that,”

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recalled Dr. Cody, who has seen immense changes since bringing on Reeves to her practice. “Sometimes, patients can name that they’re having anxiety and depression or other mental health issues. Sometimes, it will hide behind some other physical symptom. Once such a need arises in a patient, he or she is often reluctant to therapy. Having Reeves in-house helps lessen patient fear.”

Dr. Gibson elaborated, “Reeves was part of the Hillcrest clinic five days per week while under the CPC+ program, but that had to be reduced to 1.5 days per week after the program ended. When they tried to move him from her clinic, he was such a priority to Dr. Cody that she restructured her clinic to keep him. It speaks to the fact that once the primary care doctor has someone like that, it makes such a difference for their patients.”

Clearly, CPC+ funding enabled these physicians and others from across the state the opportunity for this integrated model of care. That funding ended on 12/31/21, and as a result, some clinics

have lost their therapists, either partially or completely. “It always comes back to financing,” said Dr. Gibson. “It gets looked at like it’s dessert and not a main-course part of health care, but statistics show that doctors and patients are happier, and patients get better – not only their mental health, but their physical health – if you treat their mental health and their stress.”

Other clinics are part of a hospital system and seem to be faring better. Dr. Gibson said some of these include clinics in the Baptist system, UAMS, the White River Medical system, and the VA Medical Centers.



Baptist’s program is an example of a working system that started with CPC+ funding and has continued to expand post-initiative. **Rick Tyler, MD**, directed the CPC+ program for all 48 Baptist system

clinics and continues to be over the system’s value-based care programs. He said, “Around five years ago, we started integrating licensed clinical social workers into our primary care practices to provide a variety of services.”

Like within the clinics mentioned above, patients benefited from counselors who were available in-house. “It was convenient,” continued Dr. Tyler, “and our goal was to expand as much as we could with the money being provided through the CPC+ program. We were able to cover eight clinics at one time, but with 48 clinics, the question was how to scale up and provide the same level of integrated primary care services for numerous clinics across the state.”

At Dr. Gibson’s recommendation, Baptist settled on a form of integrated behavioral health known as collaborative co-management (CoCM), which offers mental health services in a virtual environment. “An outsourced company provides mental health care



**STATISTICS SHOW THAT DOCTORS AND PATIENTS ARE HAPPIER, AND PATIENTS GET BETTER – NOT ONLY THEIR MENTAL HEALTH, BUT THEIR PHYSICAL HEALTH – IF YOU TREAT THEIR MENTAL HEALTH AND THEIR STRESS.**

## WHY Integrated Behavioral Health?

Evidence supports a strong link between behavioral health conditions and chronic illness

- **2 - 3 times more costly** with chronic medical and behavioral health comorbid conditions
- **4 - 5 times more likely** to be hospitalized

More than **half of all behavioral health treatment** occurs in the general medical system

- PCPs serve as the **primary managers** of psychiatric conditions in about one-third of their patient panels
- **PCPs prescribe 59% of all psychotropic medications**, including 62% of antidepressants, 52% of stimulants, 37% of antipsychotics, and 22% of mood stabilizers
- 70% of primary care visits are related to psychosocial issues



**Estimated 9 - 17% of total healthcare expenditures could be eliminated with integration between medical and behavioral healthcare**



## AT DR. GIBSON'S RECOMMENDATION, BAPTIST SETTLED ON A FORM OF INTEGRATED BEHAVIORAL HEALTH KNOWN AS COLLABORATIVE CO-MANAGEMENT (COCM), WHICH OFFERS MENTAL HEALTH SERVICES IN A VIRTUAL ENVIRONMENT.

managers that initially talk to patients referred by the providers,” explained Dr. Tyler. The care managers gather patient information and send it to a psychiatrist for an evaluation, who then provides diagnostic and therapy recommendations and agrees with or tweaks what the PCP has prescribed or diagnosed. “Physicians use that information in the management and treatment of patients. Because it’s virtual, we can scale up and cover all of our clinics.”

As Baptist implements the virtual system through a company called Mindoula, it also has been able to retain four embedded therapists who cover six of its clinics and two counselors working centrally for its Population Health Services Organization. Dr. Tyler explained, “These take referrals from care coordinators and providers and then reach out to patients mostly by phone to do some long-term case management.”

### WORKING ON PAYMENT BARRIERS

As grants and federal initiatives end, payment and reimbursement challenges grow. “Some payors are trying to figure out how to make the change, but it’s a puzzle,” said Dr. Gibson, who mentioned the need to identify gaps in the current payment system (such as value-based payment, codes, reimbursement, credentialing, co-pays, visit limitations). “We need insurance payors (Medicare, Medicaid, private insurers) to willingly pay for integrated behavioral health. It sounds logical that they would, but the system is set up mostly for mental health care in ‘mental health’ settings. Practices need payors to pay for mental health care in a ‘medical setting’ so that PCPs can have trained people to help in their clinics.”

“Payor systems are now appreciating the collective cost to the system if behavioral health is not done,” offered Arkansas BlueCross BlueShield’s Mark Jansen, MD, of the current payment situation. Currently the vice president and chief medical officer for AR BCBS, Dr. Jansen is a former primary-care physician who has long been a proponent of integrated behavioral

health. “I have appreciated, both on a personal and academic level, the impact of behavioral health.

“BCBS recognizes the impact of behavioral health in Arkansas, as evidenced by its \$5.29 million in grants announced last year for certain behavioral health programs in Arkansas and its investment, early on, in the formation of the nonprofit ABHIN. We helped get it running, then removed ourselves from governance of that to avoid any conflict.”

Noting a substantial change in the last few years, Dr. Jansen said, “Early in the pandemic, we removed the requirement that the patient be seen in-person first before telehealth visits could commence. When I look statistically for telehealth visits for traditional medical care visits as the pandemic has calmed down a little bit, the slope of that line has dropped to the negative, but I have not seen much decrease in telebehavioral health. **One thing about virtual care is it’s removed the stigma of proximity to the provider (e.g., your car in the parking lot). You can access it in a confidential way. It’s been a silver lining that’s come out of the pandemic.**

“Curtis Barnett, Arkansas BCBS president and CEO, has made behavioral health his top priority. We know that having the mental health embedded in the clinic is going to give the patient the best access to care.”

But can independent clinics afford to do this? Can they embed behavioral professionals in their clinic and use those specialists to offer the best access to care for their patients in a way that is financially sustainable and supported by third-party payors for both their clinic and the patients?

Asked for his thoughts, Jansen said of AR BCBS, “We are emphasizing the enhancement of the delivery of behavioral health in the state of Arkansas – not just for people who have our insurance, but for all Arkansans. I can’t give you all the

answers, but I can tell you, we clearly understand the question and we’re deploying significant effort and resource to answer in an appropriate way.”

The Journal thanks the many sources consulted for this article. Physicians interested in learning more about behavioral health integration or associated training may email [patty.gibson@abhnetwork.org](mailto:patty.gibson@abhnetwork.org).

Reference:

“**A growing psychiatrist shortage and an enormous demand for mental health services,**” By Stacy Weiner, Senior Staff Writer August 9, 2022 <https://www.aamc.org/news-insights/growing-psychiatrist-shortage-enormous-demand-mental-health-services>



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# THE NEXT CHAPTER IN PRIOR AUTHORIZATION REFORM

BY DAVID WROTEN

EXECUTIVE VICE PRESIDENT, ARKANSAS MEDICAL SOCIETY



Very few things get physicians fired up more than the endless onslaught of prior authorizations. Over the past few legislative sessions, AMS has led the fight to address these problems through a series of laws that have resulted in improvements in areas such as access to a physician reviewer, step therapy requirements, transparency, (i.e., in the criteria) turnaround time and more.

**While these have helped, one thing continues to frustrate just about everyone. That's the length of time on the phone in order to get a prior authorization approved.**

Maybe it's time to take the next step.

Our understanding is that most prior authorizations are approved. If that's the case, why have it at all? Some carriers point to the "sentinel" effect. If you

know a procedure must go through prior authorization, physicians will take the time to consider if the procedure is really needed or consider an alternative. I'm not sure I agree with that.

Maybe it's time to acknowledge that this is an unnecessary hassle that delays patient care and places a resource burden on physicians and their staff. Rather than outright banning the practice, a more measured approach is what is commonly referred to as a "gold card." If virtually all your prior authorization requests for a given procedure are approved, why not remove the burden, at least for a specified period of time.

AMS has considered such legislation in the past, but until recently, no one else had any experience with the concept. Enter Texas. The Texas Medical Association passed a gold card program a couple of years ago.

While it has yet to be implemented due to the slow regulatory process, it does give us the blueprint of what such legislation ought to look like. Also, given the issues surrounding the drafting of their regulations, we also have the benefit of learning from their mistakes. By that I mean that TMA learned a lot of things during the regulator process that, had they known it at the time the legislation was drafted, could have improved the law and shortened the implementation time.

We are currently working with a couple of legislators on a draft. I tell you this because you (all of you) will need to be engaged with your state senator and state representative in order to get this passed. There is a lot of work to be done and some compromises will undoubtedly need to be made. With your help, this is something that we can achieve that will make your job easier. ■

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# PATIENTS WANT — AND DESERVE — CARE DELIVERED BY PHYSICIAN-LED TEAMS

BY SCOTT FERGUSON, MD

AMA BOARD OF TRUSTEES CHAIR, AMA SCOPE OF PRACTICE PARTNERSHIP



**W**e know from experience and from surveys that patients want and expect their care to be led by physicians, the most highly trained and skilled health care professionals. One aspect of the Recovery Plan for America's Physicians, which the AMA unveiled in June 2022, seeks to stop the creep of scope of practice intrusions that threaten patient safety and well-being.

The AMA's Recovery Plan outlines a five-point strategy to strengthen our physician workforce, recover from the trauma of this pandemic, and improve health care delivery by eliminating some of the most common pain points that threaten to drive physicians from practice. The AMA's comprehensive approach includes:

- 1 Supporting further expansion of telehealth to build upon gains in coverage and payment.
- 2 Reforming the Medicare payment system to promote thriving physician practices.
- 3 Fixing prior authorization to reduce the burden on practices and minimize dangerous delays in care delivery to patients.
- 4 Reducing physician burnout and addressing the stigma around behavioral health.
- 5 Stopping inappropriate scope of practice by non-physicians.

Each of these objectives is within our grasp, and achieving them will streamline health care delivery, improve patient care, and support innovation while simultaneously allowing us to respond more effectively to future public health emergencies.

Allow me to zero in on one of these goals in particular: the need to rein in scope of practice creep and emphasize the importance of physician-led teams. Every team needs a leader, and health care teams are certainly no exception. The fact is that physicians are trained to lead, and draw upon the highest level of education in organized medicine – along with unique skills, training and experience – in diagnosing and treating the patients who lie at the center of everything physicians do.

The AMA strongly supports the physician-led team approach in which each member fulfills a clearly defined role based on his or her expertise and training, and we will defend physicians and the practice of medicine against inappropriate scope of practice expansions from nonphysicians.

Patients depend on the clinical judgment and medical decision-making abilities that physicians bring to the health care equation, which are developed through three to seven years of accredited residency and up to 16,000 hours of clinical training. Ensuring that patients receive the best possible care continues to drive the AMA's emphasis on

physician-led care teams, just as it has over the past several decades. You can find a discussion here - <https://www.ama-assn.org/practice-management/scope-practice/what-doctors-wish-patients-knew-about-scope-practice>, of what physicians wish patients knew about scope of practice issues.

At the same time, this emphasis is not intended to diminish, in any way, the vitally important contributions that nonphysician providers continue to make in caring for patients. These contributions have never been more valuable than during the COVID-19 pandemic, when our nation's entire health care workforce was stretched to the very limits of human endurance. The response of the nation's health care community has been and remains courageous and exceptional.

Health care teams often include varying combinations of physicians, nurses, physician assistants, pharmacists, social workers, case managers and other health care professionals. The unique strengths, experiences and perspectives of each team member are an asset in providing the best possible patient care, and these assets are maximized when physicians identify, engage and elicit them from each member.

As the physician's powerful ally in patient care, the AMA has worked for decades to turn back inappropriate scope of practice expansions by nonphysicians by working in close collaboration with state medical associations and national specialty societies. This work has resulted in more than 100 state legislative victories in the last three years alone.

Physician-led team-based care that emphasizes communication and collaboration in patient-focused environment offers the best path toward the highest quality care our system can deliver. ■

**EVERY TEAM NEEDS A LEADER, AND HEALTH CARE TEAMS ARE CERTAINLY NO EXCEPTION.**



## EDUCATIONAL CONFERENCES: DOES MY OFFICE STAFF REALLY NEED TO ATTEND?

BY TEREASA HOMES, CMPE

DIRECTOR OF PRACTICE AND HEALTH POLICY

It's no surprise to any of us how much the health care arena is rapidly evolving. With new guidelines, protocols, policy updates, carrier requirements, referrals, and designated ancillary service, it can be difficult to integrate education and training goals into an already overworked clinic staff schedule. The traditional educational conferences are now making a comeback after a two-year hiatus due to the pandemic, but even now as things return to a new normal, there are some factors to consider before signing up.

A successful physician practice staff requires staff roles of receptionist, appointment scheduler, patient advocate, front office coordinator, and clinic administrator. Some clinics may have a person for each responsibility, while other clinics have a smaller staff that perform all the duties. Providing the most up-to-date training improves the staff's knowledge, leading to better service for the patients. In addition, education improves greater productivity, which increases morale and self-worth among the team. Investing in training can also be a great benefit to add to an employee or potential employee's compensation package.

Professional development is another component of attending conferences. Interaction among the attendees is a great opportunity for health care professionals to learn from each other, but also to build relationships that can be developed throughout the year. Brainstorming and sharing best practices with others is

hard to do in a virtual setting, and staff hearing in-person presentations from different points of view can improve how a practice operates.

Understanding the numerous training opportunities available, clinics must decide which is best for the individual type of practice. Knowing the challenges of the daily practice schedule and staffing concerns, here are some questions to consider:

- Is the information relevant to the practice and to the staff?
- Will it improve the staff's ability to better assist patients?
- Is the timing of the conference convenient?
- Is this information available in a virtual format allowing staff to still be at work or is the conference in-person?
- Are there continuing education hours available, and does your staff need the CEUs to obtain or maintain their certification?

One of the key components of the mission of the Arkansas Medical Society is to provide education to clinic staff and physicians. After being virtual the past two years, AMS was able to host its 19th annual Insurance Conferences again in-person in three different cities. This yearly event allows

clinic staff to come together, regardless of specialty, to hear updates from the major insurance payers that patients use. There's still one opportunity left to attend in person at the Little Rock events on October 26 and 27, so visit [ARKMED.org](http://ARKMED.org) to register. Additional information regarding conferences and resources is listed on the AMS website. As always, you may reach out with any questions or needs by email [tholmes@arkmed.org](mailto:tholmes@arkmed.org) or call 501-224-8967. ■

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# YOUR SUPPORT OF ARKMED-PAC IS ESSENTIAL TO AMS LEGISLATIVE SUCCESS

BY H. SCOTT SMITH, JD  
DIRECTOR OF GOVERNMENTAL AFFAIRS

The importance of building on a solid foundation is a fundamental principle in construction, especially if you want your building to last for a while. This principle applies to all walks of life and all programs...academics, athletics, and the arts. A firm foundation increases the odds of “success” over the long term. For example, some college athletic teams may have seasons that may not meet expectations created by past successes and the raised standards of excellence, but a solid program will have a better chance of rebounding the following season. A theater department may have

a production inferior to previous shows, but over time, the productions will be of a higher quality than a program without a strong foundation.

Our primary job at the Arkansas Medical Society is to advocate for you - the physicians of Arkansas and your patients. Whether that advocacy is at the courthouse, in an administrative hearing, at the U.S. Capitol, or at the State Capitol, we work hard to consistently succeed in our advocacy. But what does success look like, and how can AMS improve the odds of long-term, consistent legislative success?

As in other areas, long-term, consistent success is built upon a strong foundation.

**While AMS has a long history of legislative success, it is vitally important to make sure the foundation remains firm to increase the likelihood of continued successes in the future.**

John Wooden, widely regarded as the greatest coach the sporting world has ever seen, defined success as the **“peace of mind that is the direct result of self-satisfaction in knowing you did your best to become the best that you are capable of becoming.”**

How does the Arkansas Medical Society know we have done our best to become the best in advocating for the physicians of Arkansas and their patients in the legislative arena? When the Society and its members help support physician-friendly candidates, whether those candidates win or not, we know we are doing our best to become the best in our advocacy. Of course, we want every physician-friendly candidate to win, but there is value even in supporting a losing campaign. The willingness to be part of the process, win or lose, is important. To be known as an organization ready to actively participate sends the right message to all - win or lose.

**When we strongly support successful physician-friendly candidates, we build closer, stronger relationships that can continue our ability to provide successful advocacy for Arkansas physicians and their patients. It truly is that simple.** There is nothing more helpful to sustaining continued legislative success than to help physician-friendly candidates win their elections.

The most effective and efficient way for most AMS members to help physician-friendly candidates is to contribute to the political arm of the Arkansas Medical

## A FIRM FOUNDATION INCREASES THE ODDS OF “SUCCESS” OVER THE LONG TERM.

**Join us for the AMS Fall Legislative Meeting November 3-4, 2022**

Every two years, the Arkansas Medical Society meets to discuss issues of concern, share thoughts, and prioritize our legislative package for the upcoming session of the Arkansas General Assembly

Attendees will be able to provide input on already-identified issues that will be addressed in 2023, as well as bring issues of interest that may not have been identified or considered yet. This is also a great opportunity to network face-to-face with peers from all around the state.

**ALL AMS MEMBERS ARE INVITED TO ATTEND.**

**REGISTER TODAY!**  
Scan QR Code or visit [ARKMED.org](http://ARKMED.org)

Society, ArkMed-PAC. Our non-partisan Political Action Committee is led by a board of AMS members from around the state whose job is to help guide contributions to physician-friendly candidates. **ArkMed-PAC needs your financial support.** The stronger

financially ArkMed-PAC is, the more help it can provide to those physician-friendly candidates around the state. Please join us in the fight as we attempt to do our best to become the best that we are capable of becoming. AMS members can join ArkMed-PAC by going

to **ARKMED.org/advocacy**. If you have any questions concerning ArkMed-PAC, please contact the AMS Department of Governmental Affairs at **501-224-8967** or email **ams@arkmed.org**

## SIGN UP TO BE A DOCTOR OF THE DAY

The Arkansas Medical Society will once again sponsor the “Doctor of the Day” program for the 2023 session of the Arkansas legislature. The session begins on January 9, 2023, and will continue for 60 days, but the time can be extended by action of the legislature.

This important service has been provided by AMS members for over four decades, and the Doctor of the Day program has enhanced the effectiveness of the Society’s efforts at the Capitol.

Physician volunteers are needed Monday through Friday. Please remember that Fridays may be cancelled with little notice when the legislature votes to recess

on Thursday afternoon. Please provide your cell phone number on the form for quick notification. The number will not be shared.

Doctors of the Day are asked to arrive at the H. Elvin Shuffield Capitol Infirmary at 9:00 a.m., and the infirmary usually closes around 3:30 p.m. The physician volunteers can attend legislative committee meetings and they have floor privileges in both chambers for introductions during their date of service. AMS coordinates with the Arkansas Department of Health to provide nursing coverage when the infirmary is open. A parking pass will be sent one week prior to the date of service.



Visit **ARKMED.org/advocacy/docoftheday** to sign up to serve for the 2023 Legislative Session. ■

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## Different name, same important work

*Arkansas communities address health care challenges through the Partnership for Community Health project*

MANDY PALMER, RN, CPHQ, CPPS - AFMC, DIRECTOR OF QUALITY

The Quality Improvement Organization (QIO) Program, led by the Centers for Medicare & Medicaid Services (CMS), is one of the largest federal programs dedicated to improving health quality at the community level for Medicare beneficiaries. Arkansas Foundation for Medical Care (AFMC) provides quality improvement assistance and expertise in Arkansas and Mississippi under contract with TMF Health Quality Institute, your state's Quality Innovation Network-Quality Improvement Organization (QIN-QIO). The Partnership for Community Health project is part of this contract with CMS.

You may already be familiar working with the TMF QIN-QIO specialists on the Community Coalitions project. CMS recently made changes to the scope of that project, including changing the project name from Community Coalitions to the Partnership for Community Health. This change is meant to better reflect that it takes the community members working together to improve community health outcomes. We have updated page titles and links

on our website, TMFNetworks.org, to reflect this name change.

### A COMMUNITY BASED APPROACH

CMS has identified specific quality improvement initiatives for QIN-QIOs to address. Working with health care facilities and agencies, as well as with other state, local or community partner organizations, we implement quality improvement interventions to address:

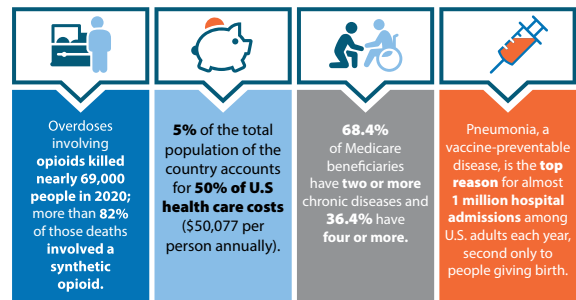
- opioid use and misuse
- chronic disease management
- care coordination
- immunizations

### THE CHALLENGES

#### Opioid Utilization and Misuse

According to the U.S. Department of Health and Human Services, more than 43,000 Medicare Part D beneficiaries suffered an opioid overdose in 2020. What's more, Medicare beneficiaries are especially vulnerable to opioid adverse drug events (ADEs) due to age-related metabolic changes and the health risks asso-

### Why is our work necessary? The statistics tell the story.



ciated with polypharmacy, which is common to the Medicare population. Therefore, making sure this population has access to treatment and to overdose-reversal drugs is important.

Access to mental health services is also vital. According to the National Council for Behavioral Health and the Institute of Medicine, nearly 1 in 5 Medicare beneficiaries live with one or more mental health or substance use conditions. However, fewer than 40% of these older adults receive treatment.

#### Chronic Disease Management

Chronic disease is a public health issue affecting 35% of all Medicare beneficiaries who have at least one chronic condition. Increasing preventive care efforts can help people with chronic conditions better manage

their health conditions, helping them prevent or decrease cardiovascular events through cholesterol management and improving aspirin use, for example. Additionally, effective interventions can prevent Medicare beneficiaries from developing diabetes, and slow progression of chronic kidney disease.

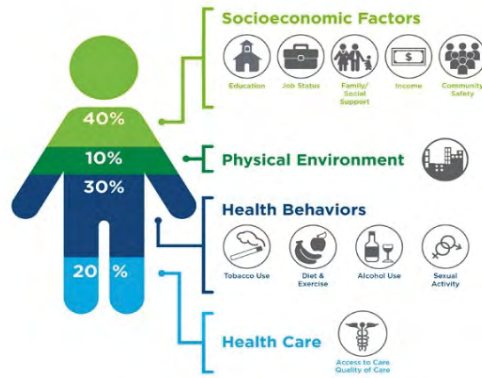
**Care Coordination**

Medicare beneficiaries experienced 1.7 million hospital readmissions within 30 days in 2015, which cost Medicare roughly 14 billion dollars. Most of these readmissions—about a million—could have been prevented with better care coordination upon discharge. Integrated care plans among community-level health care providers and organizations benefits those in vulnerable populations who often need access to social services and other assistance, but may not have the means to secure those services.

Care coordination also requires us to consider social determinants of health (SDoH). Many factors affect beneficiaries' health, including underlying genetics, health behaviors, and social and environmental conditions. In fact, according to the Robert Wood Johnson Foundation, 80% of our well-being is influenced by socioeconomic factors, physical environment and health behaviors (see graphic). Care plans, therefore, should include ways to address the SDoH beneficiaries' can control, such as health behaviors.

**Immunizations**

The Medicare population is particularly vulnerable and are at high risk for illness, hospitalization,



disability and even death from vaccine-preventable diseases like COVID-19, Influenza, and Pneumonia. The Centers for Disease Control recommends vaccinations for adults based on age, health conditions, prior vaccination history and other factors to prevent vaccine-preventable diseases and related outcomes. Increasing immunization could result in an improvement in other health conditions, such as heart disease, which contribute to the disparities in immunization rates in racial and ethnic groups.

**THE LOCAL SOLUTION**

The TMF QIN-QIO is engaging Arkansas health care providers across the continuum of care and communities to:

- Collaborate on the prevention of opioid ADEs by sharing best practices for opioid prescribing, alternatives to opioid use, Naloxone distribution and patient education, increase use and awareness of medication-assisted treatment, and other local solutions developed by each community.
- Prioritize health equity efforts to improve preventive services for racial and ethnic minorities,

individuals with disabilities, sexual/gender minorities, and individuals living in rural areas. Health equity efforts also include helping people better manage chronic conditions.

- Facilitate improvements in how health care services are delivered to Medicare beneficiaries across care settings; implement best practices and evidenced-based interventions to reduce hospitalizations and readmissions, as well as emergency room use.
- Increase vaccinations and immunizations at the community level using plans, strategies, and practices that consider the SDoH and a focus on vulnerable populations.

**LEARN MORE**

Arkansas health care providers are invited to sign up to create a free account on <http://www.TMFNetworks.org> for topic-specific change packages, community level SDoH data reports and other tools and resources to help improve health outcomes and the care experience for Arkansas patients and families. ▲

*Mandy Palmer, RN, CPHQ, CPPS, is the Director of Quality at AFMC. She provides oversight for multiple quality initiatives focused on improving health care quality, patient safety, population health and care transitions. She has more than 25 years in nursing working in Intensive Care, Burn, Cardiac, Hospice and Quality.*



# TRENDS IN TOBACCO, ALCOHOL, MEDICAL MARIJUANA, AND PRESCRIPTION OPIOID USE DURING THE COVID-19 PANDEMIC IN ARKANSAS

BY BALA SIMON, MD, DRPH,<sup>1,2,3</sup> AMIE LEIN, MS, CHES, TTS,<sup>1</sup> ROBERT DELONGCHAMP, PHD<sup>1,2</sup>

1 Arkansas Department of Health

2 Department of Epidemiology, University of Arkansas for Medical Sciences College of Public Health

3 Department of Family and Preventive Medicine, University of Arkansas for Medical Sciences College of Medicine, Little Rock, Arkansas

## INTRODUCTION

On March 11, 2020, the World Health Organization (WHO) declared the COVID-19 a pandemic. On the same day, the first presumptive positive case of COVID-19 was identified in Pine Bluff, Arkansas. This eventually led to the identification of several more cases, numerous school and business closings, and the Governor of Arkansas Asa Hutchinson, declaring a state of emergency for the state. This historic pandemic, and related strategies aimed at stopping its spread caused stress, anxiety, depression, irritability, insomnia, anger, and symptoms of post-traumatic stress disorder.<sup>1,2</sup> Individuals who initiated substances had the highest levels of worry and fear related to the pandemic. In addition, individuals who had achieved sobriety prior to the beginning of the pandemic relapsed at a much higher rate than if they had never used a substance.<sup>3,4</sup>

Preclinical studies have established the key role stress plays in perpetuating drug abuse and relapse through a maladaptive response pathway.<sup>5</sup> The neurobiological mechanism of stress-related risk of addiction and vulnerability to addiction has been explained through the alterations on the corticostriatal-limbic motivational, learning, and adaptation systems that include mesolimbic dopamine, glutamate, and gamma-aminobutyric acid (GABA) pathways.<sup>6</sup> These pathways explain role of stress in initiation or relapse in use of cigarette smoking, alcohol use, substances such as marijuana, and prescription drug misuse.<sup>7-10</sup> In our study, we examined the trends in tobacco, alcohol, medical marijuana, and prescription opioid use during the COVID-19 pandemic in Arkansas.

## METHODS

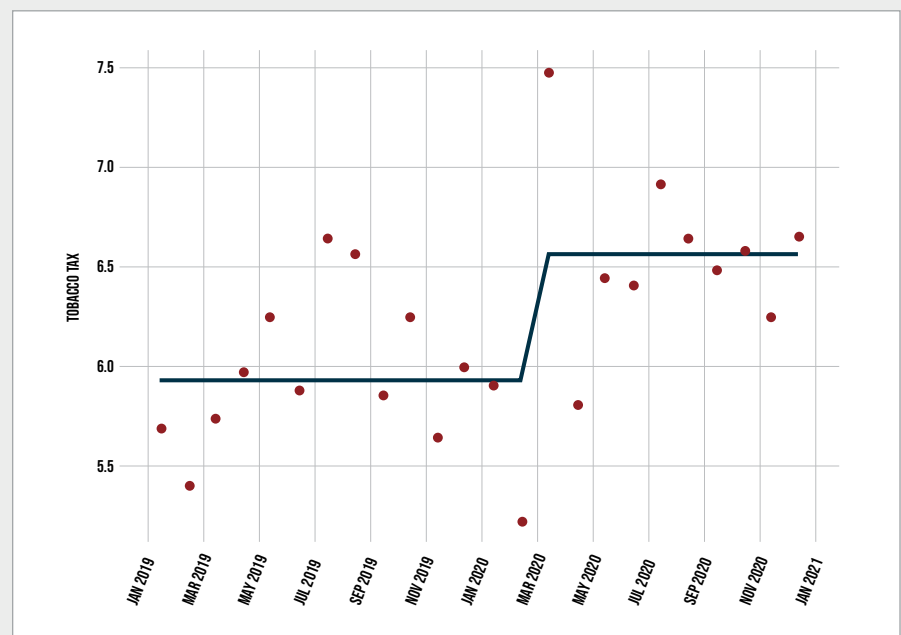
To determine the extent of substance use, before, during, and after the COVID-19 pandemic, we utilized the monthly tobacco, alcoholic beverage, and medical marijuana sales tax data, and the number of opioid prescriptions by month for the period, January 2019 through January 2021. Publicly available tobacco, alcoholic beverage, and medical marijuana sales tax data were downloaded from the Arkansas Department of Finance and Administration's website. A descriptive analysis was performed on prescription opioid dispensation data provided by the Arkansas Department of Health's Prescription Drug Monitoring Program. A trend analysis using joinpoint regression was performed on tobacco, alcoholic beverage, and medical marijuana sales tax data, and prescription opioid use data.

## RESULTS

### TOBACCO USE

As shown in **Figure 1**, cigarette and other tobacco product revenue for the calendar years 2019 and 2020 were \$216,961,219.77 and \$232,729,553.76, respectively; an increase of 7.3%. Tobacco sales taxes increased significantly during COVID-19 pandemic (average change: 0.635 per month,  $p=0.0012$ ).

**Figure 1.** Joinpoint regression analysis of tobacco product sales tax. Arkansas, January 2019 to January 2021.



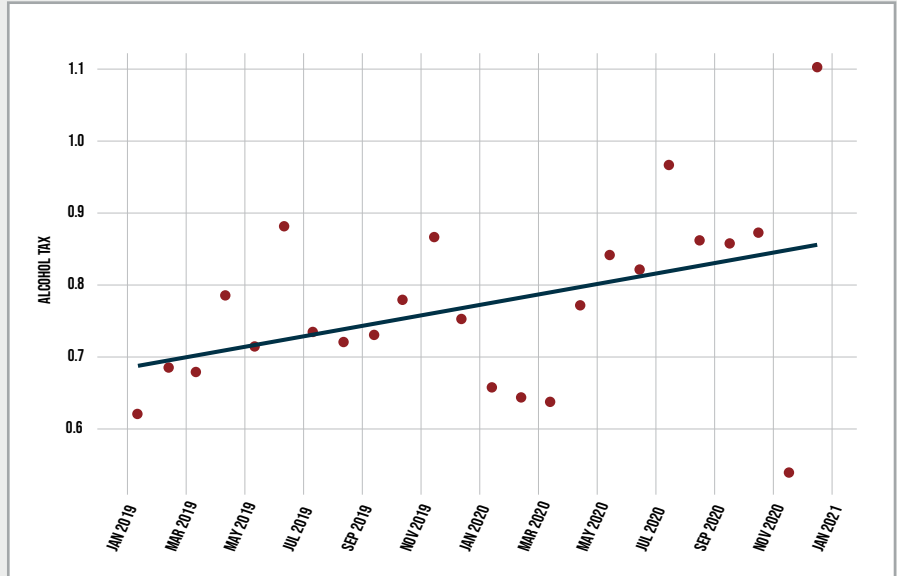
**Figure 1**



## ALCOHOL USE

Alcohol beverage sales taxes for the calendar years 2019 and 2020 were \$26,817,391.00 and \$28,791,979.00, respectively; a 7.4% increase (**Figure 2**). Alcohol beverage sales taxes also increased significantly throughout the same period (trend: 0.088 per month,  $p=0.038$ ).

**Figure 2.** Joinpoint regression analysis of alcoholic beverage sales tax. Arkansas, January 2019 to January 2021.



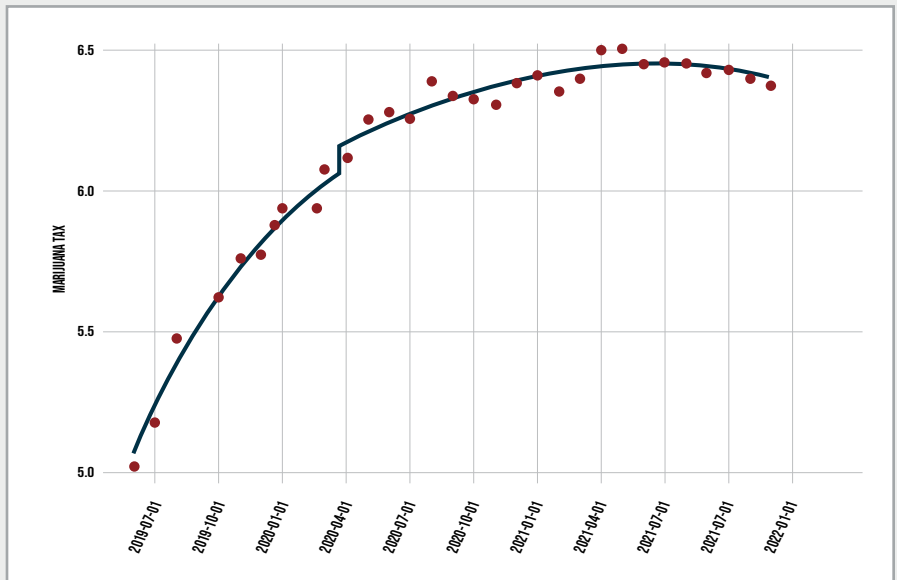
**Figure 2**

## MEDICAL MARIJUANA USE

Medical Marijuana sales tax data collection began in June of 2019; therefore, we only have a little over half of that calendar year's data. Medical Marijuana sales taxes for the second half of calendar years 2019 and 2020 were (\$2,900,536.46 and \$15,179,234.41, respectively). A 423.3% increase. This was a significant increase in Medical Marijuana sales tax after COVID pandemic ( $p=0.0306$ ) as shown in **Figure 3**.

**Figure 3.** Joinpoint regression analysis of medical marijuana sales tax collected. Arkansas, July 2019† through January 2021.

† Medical marijuana sales tax collection was not documented until June 2019.

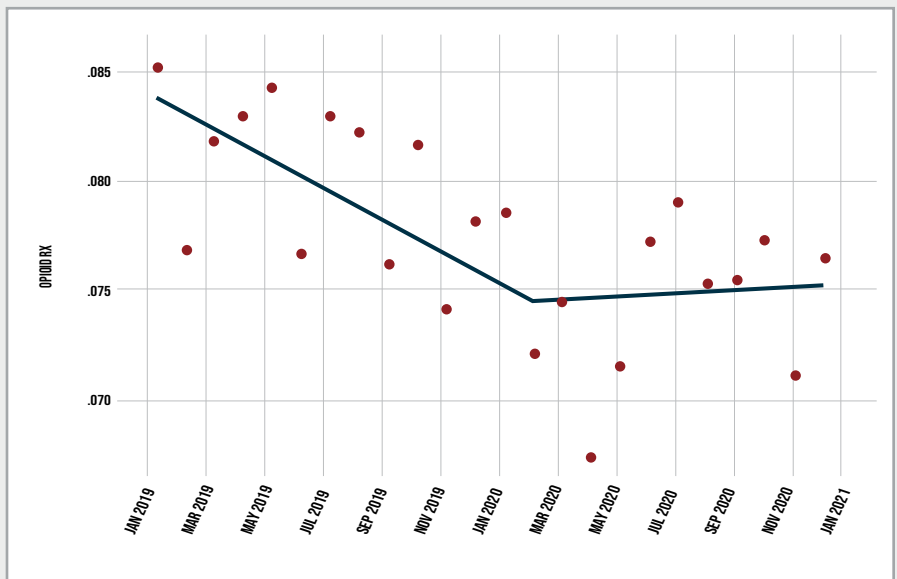


**Figure 3**

## PRESCRIPTION OPIOID USE

The number of opioid prescriptions for calendar years 2019 and 2020, were 2,905,443 and 2,714,624, respectively. A 6.6% decrease. Prior to the pandemic, opioid prescriptions were declining (trend: -0.0085 per year,  $p=0.0017$ ). This decline stopped during the pandemic, and there was some increase, though not statistically significant (trend: 0.00085 per year,  $p=0.79$ ), as shown in **Figure 4**.

**Figure 4.** Joinpoint regression analysis of opioid prescription dispensation. Arkansas, January 2019 to January 2021.



**Figure 4**

## DISCUSSION

It is likely that individuals used alcohol, tobacco, marijuana, and prescription opioids much more than previously to cope with the psychological strain of living during a worldwide pandemic. Prior to the pandemic, cigarette sales tax revenue was slowly, but steadily decreasing, while other tobacco product sales tax revenue was slowly, but steadily increasing from about the end of 2015. Alcoholic beverage sales tax revenue varied widely by beverage type beginning around May 2020. An increase was observable in sale of beer, liquor, and wine. However, there was a significant decrease in liquor sales tax revenue in November 2020. Awareness of waves of deaths due to opioid overdoses, and the U.S. Opioid Epidemic being declared a public health emergency by the U.S. Department of Health and Human Services, possibly contributed to the decreasing number of opioid prescriptions. Additionally, when medical marijuana was introduced to the state, one of the many conditions it was purported to treat included chronic pain.

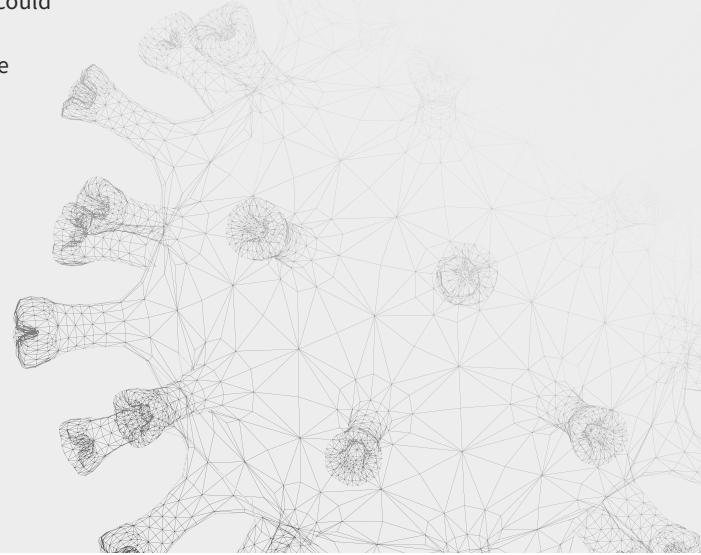
This could also have led to the decrease in number of opioid prescriptions and the increase in medical marijuana sales tax revenue. The increase of 423.3%, therefore, could be attributable to the newly available medical marijuana cards, and then to the subsequent openings of several new medical marijuana retail stores. Overall, the negative psychological effects caused by the pandemic could have increased the likelihood of initiation and relapse of addictive drug use.

Unfortunately, pandemics are almost impossible to predict. Therefore, mitigation strategies to reduce alcohol, tobacco, marijuana, and substance use should be included in future pandemic preparedness. These strategies may include prioritizing public health messaging on mental health and how to cope with stress and

providing healthy coping skills that can be used long-term.

Disclaimer: The views expressed in this paper are not necessarily those of the Arkansas Department of Health.

References can be found at [ARKMED.org](http://ARKMED.org). ■



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# UAMS: WHITE COAT CELEBRATION REFLECTS EXPANSION AT TWO CAMPUSES

In a historic first for the University of Arkansas for Medical Sciences (UAMS), incoming College of Medicine freshmen donned their white coats on stage in both Little Rock and Fayetteville in an Aug. 5 ceremony reflective of the college's growth at two campuses.

UAMS faculty and loved ones applauded the new medical students as they completed the rite of passage in the first in-person ceremony since the start of the pandemic. The program was live-streamed between the two auditoriums and online for other well-wishers.

The Class of 2026 is the largest in UAMS history with 188 students. Seventeen are based at the UAMS Northwest Regional Campus in Fayetteville, including three who are in the Primary Care Scholars accelerated three-year MD track that was established last year for highly qualified students who plan to enter careers in primary care.

This is the first year UAMS has had students from all four years of medical school based at UAMS Northwest Regional Campus. In addition to the freshmen, they include nine sophomores who started in Fayetteville last year. They are joined by 20 juniors and 16 seniors this year, more than a decade after UAMS began placing third- and fourth-year medical students at the Fayetteville campus to learn with faculty physicians and health care facilities throughout the region.

"The expansion of our medical education program in Northwest Arkansas is a crucial aspect of our commitment to generating much-needed physicians for our state," said Susan S. Smyth, MD, PhD, executive vice chancellor and dean. "Each of these campuses has distinct features that will be appealing and beneficial for individual students, but they both provide exceptionally high quality medical education."



Top: UAMS freshmen recite the Medical Student Oath in Little Rock. Bottom: UAMS freshman Suzette Lopez dons her white coat in Fayetteville.

Students choosing the Little Rock campus often cite the comprehensive, major medical center and biomedical research environment as a plus. "The opportunity to collaborate and learn from in-house experts provides invaluable means for academic growth," said junior Conor Roset.

Students at the Fayetteville campus appreciate being part of a tightknit group, with small clinical rotation teams and significant individual attention from faculty. "I really enjoy the small class size and the relationships I've built with my classmates and the program leaders at UAMS Northwest," said freshman Kelly Fowler. ■

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## ARCOM: MEDICAL STUDENTS VOLUNTEER AT CHARITABLE CLINIC

Students at the Arkansas College of Osteopathic Medicine (ARCOM) are continuing to make positive contributions to the region by volunteering their time to help with local charitable organizations. One organization benefitting from ARCOM student volunteers is the Still Clinic. Named after the founder of osteopathic medicine Andrew Taylor Still, MD, DO, The Still Clinic is sponsored by the ARCOM chapter of the Student American Academy of Osteopathy and is located at the Good Samaritan Clinic in Fort Smith.

The Still Clinic is open once a month and is completely run by student doctors. This includes all logistics work, planning, and recruiting of DO faculty to serve

as clinic providers. Students work alongside the DO faculty to provide osteopathic manipulative treatment and musculoskeletal evaluations to patients that have been referred to the clinic.

In addition, bilingual students volunteer to accommodate Spanish-speaking patients. ARCOM students have resumed their Medical Spanish classes, led by Monica Rojas, MD, Medical Director of International Medicine & Cultural Education at ARCOM. Dr. Rojas' class meets twice a week and includes activities, games, and conversation in Spanish.

Dr. Rojas stated, "I also give cultural notes for students to understand the

Hispanic community includes people from many different countries and each of them has their own way of expressing their issues. It's important for medical students to understand that one word can mean different things to two people from different countries." ■



## NYITCOM: STUDENT PROFILE - COLIN MAYER



Mayer's journey led him from Northwest Arkansas to Hendrix College, where he majored in biology, minored in chemistry and played linebacker on the Warrior football team. Having spent most of his life in Rogers and Conway, more affluent parts of the state than many others, Mayer had never really experienced health care disparities, but one of his first exposures to a medically-underserved community impacted him greatly.

"One of my teammates who was from a rural part of Northeast Arkansas told me that his family usually had to drive an hour to Jonesboro to get medical care," Mayer said. "When I went home with him one weekend, I noticed that in that town there was one medical clinic and the doctor was only there once a week. That made me start to consider how great it would be to practice in an area where the need for physicians is significant."

Upon graduating from Hendrix, Mayer ended up not too far from that teammate's hometown. In 2019, he began medical school at New York Institute of Technology College of Osteopathic Medicine in Jonesboro, where he received numerous opportunities to participate in health

outreach programs in rural communities, like the Delta Care-A-Van. At those free health screenings, Mayer again saw real needs and felt great opportunity.

"The location of NYITCOM at A-State is so perfect for its purpose," Mayer said. Jonesboro is in the middle of the Delta with so many rural areas right around it. Those are really the people that we're trying to target. I love the clinical rotation sites around the state that give us multiple locations that expose us to a lot of different demographics within them."

Mayer is scheduled to graduate from NYITCOM at A-State next spring and plans to specialize in family medicine. He hopes to match into a program in his home state that will allow him to give back to the people who have supported him so much.

"The state and the schools have invested so much time in me and I want to give back here," Mayer said. "Arkansas has one of the largest physician disparities in the country. I want to practice in a community that wants me and needs me. I love the state so much and I feel very fortunate to call Arkansas home." ■

Rogers native Collin Mayer had never thought much about a career in medicine until a harrowing experience during his high school years inspired him to pursue a profession that would allow him to help people in unique ways.

"My best friend in high school developed acute myeloid leukemia and ultimately passed away from it," Mayer said. "He was a very selfless person who would do anything for anyone, and it was awful to watch him go through that. I decided I wanted to help people avoid situations like that as much as possible, and I knew medicine would be a great avenue for that."

## MEMBERSHIP IS KEY. RENEW FOR 2023

The definition of the word “key” has multiple meanings. Sometimes a key is that small piece of metal that unlocks a doorknob, and other times means an explanation of or a solution to a problem. For the Arkansas Medical Society, the “key” to our success and the success of Arkansas physicians is membership. As you know, the AMS membership calendar runs from January to December, but in a few weeks, members will receive dues invoices by mail and email for 2023.

### There are four easy ways to renew your membership:

**ONLINE** – There will be a link in your email or PDF invoice where you can pay using our secure online payment system. You may also log into your AMS Info Hub profile to pay.



**MAIL** – There will be a section on your invoice that you can detach and send with a check for your full dues payment to AMS, PO Box 55088, Little Rock, AR 72215.

**CALL US** – Call **501-224-8967** and we can take your credit card payment over the phone.

**AUTO RENEWAL** – In your online invoice, there is an option to select auto renewal for 2024. Reminders will be sent before any charges are completed through our secure payment processing system.

As a member of the Arkansas Medical Society, it is important that we have your correct contact information. If you have completed residency, retired, or moved out of state, please call **501-224-8967** or email **ams@arkmed.org** to let us know. You may also update your contact information in the AMS Info Hub (See below for instructions on how to set up your account).

### By renewing today, you won't miss out on the many benefits of AMS membership:

A voice at the state Capitol where AMS fights for you and your patients on issues like scope of practice, prior authorization, and Medicaid reimbursements.

Experienced practice management staff to provide you with personalized support, answering your questions about your

## MEMBERSHIP IS KEY RENEW FOR 2023



practice, and providing educational opportunities for you and your staff on a variety of topics.

Information you need to know through subscription to the Journal and AMS's email newsletters, Chart Notes and Legislative Updates.

Networking opportunities for physicians of all specialties from all over the state to come together to build relationships.

Resources and education on public health outreach programs like the Our Fight is Against COVID campaign, which helped fund over \$400,000 in vaccine storage equipment to clinics around the state.

Exclusive access to AMS members-only benefits, including State Volunteer Mutual Insurance Company and Panacea Financial.

And because membership is “key” for AMS, that means that we can't do it without you. The more members we have, the more influence we have in heading off adverse legislation, protecting the profession and protecting patients from harm. Renew today!

## CREATING YOUR ACCOUNT IN THE AMS INFO HUB

The AMS Info Hub is the member-only portal where members can connect with the Society and peers in a virtual environment. You can update your contact information, access member-only resources, set up payment profiles and automatic billing for dues and PAC donations, and more!

To create your member login, visit <https://members.arkmed.org/MIC/Create>.

If you cannot find your member information, it may be because we do not have your email on file. Send us your email by filling out this form and we will send you instructions on how to join. (Note: Do not fill out another application unless you are a new member! Call us at 501-224-8967 for assistance).

After entering your name and email, you will receive an activation link will be sent to your

email. Follow the instructions in that email to complete the set-up process.

Once logged in, make sure your contact profile is complete and update-to-date so others can successfully connect with you.

Explore the Info Hub and have fun taking advantage of special members only access, including:

**SEARCH THE DIRECTORY LISTING** – your contact information and our other members are available in the “members only” hub.

**PERSONALIZED MEMBER LISTING PAGE** – included in the directory is your own information page on the website which can include a description area, location, logo, photos and contact details based on your membership level.

**RESOURCES** – being part of the Society includes access to key sites, documents, and other information to help you thrive in our community, including posting classified ads.

**EVENTS** – advertise your upcoming events to other members and/or on our public site. Login to create your event page and submit to us for review/approval. Also, check out and register for upcoming events on our calendar.

**FORUM** – network with your peers by creating discussions with your peers on topics that are important to you and your patients.

If you have any questions about your AMS Info Hub member profile, email **lhaywood@arkmed.org** or call **501-224-8967**.

## AMS WINS NATIONAL COMMUNICATIONS AWARD

The Arkansas Medical Society has been awarded the Profiles of Excellence Award in Communications from the American Association of Medical Society Executives (AAMSE) for its marketing and communications efforts in the Our Fight is Against COVID campaign.

Given each year at the AAMSE annual conference, the Profiles of Excellence Awards recognize one AAMSE member organization that has achieved excellence in advocacy, education, membership, leadership, communications, and diversity, equity, and inclusion. With the ongoing global crisis, the 2022 Awards program was keenly focused recognizing the contributions the societies are making to the profession. The Communications award recognizes initiatives that disseminate an important message or promote a medical society's mission through effective content and delivery methods.

In coordination with Little Rock marketing firm Magnum Holcomb Partners, AMS's Our Fight is Against COVID campaign launched enhanced communications strategies to educate and prepare clinics to be successful participants in the vaccine promotion program and to promote the vaccine to the public.



Print and video materials were created to encourage vaccination, including the use of a vibrant social and digital media presence. In addition, AMS developed education and training tools for clinics shared on the AMS website, which also includes a vaccine finder of only medical clinics that is the only effort of its kind in the state.

AAMSE is a professional association for more than 1,500 medical society professionals throughout the country that advances the profession of medicine through education, communication of knowledge, leadership development, and collaboration. ■

## AMS PRESIDENT WELCOMES FRESHMAN CLASS AT UAMS

The Arkansas Medical Society sponsored lunch for the incoming UAMS M1 students on August 4, 2022 at both the Little Rock and Northwest Arkansas campuses. AMS President Seth Barnes, MD, attended and welcomed the medical school students to this new journey in their career and shared with them the importance of membership in AMS.



**Right:** Olivia Tzeng, Vice Chair of the AMS Medical Student Section, with AMS President Dr. Seth Barnes.

# PHYSICIAN DRUMMING FOR BUSINESS IN HOT SPRINGS

BY: RAY HANLEY

The competition for patients has taken many forms over the years - some legitimate and some quite unscrupulous. In Hot Springs, Arkansas, an early and accepted practice was for physicians to enter arrangements to become the “house doctor” for hotels. Suspect of the financial arrangements between the doctors and hotels, one critic described the system saying, “The enterprising physician, who has more financiering ability than medical skill, first selects a hotel for which the hotel staff will refer to the doctor any patient who might need a doctor’s attention.”

The smaller hotels and boarding houses used a different approach, employing an “inside man” to hang out in the lobbies and dining areas and listen for visitors discussing ailments they had. The “inside man” would then pose as a patient saying he was likewise afflicted but had “just been cured of it by Dr. A.” or “I was nearly dead with it when I came to Hot Springs and have been completely restored to health under treatment of Dr. A.”

By 1900, the chase for patients shifted to agents intercepting potential patients traveling to or arriving at the Hot Springs train depots. This practice came to be called “drumming”, borrowed from the more honest name for traveling salesmen, “drumming for business.” They would board Hot Springs-bound trains in Little Rock or other cities, intercept spa city-bound travelers, and steer them to their doctor employers.

As the Hot Springs visitors experienced more and more of the drummers’ attention, they began to complain to the city, who responded with passing an ordinance declaring “drumming, running, or soliciting strangers or visitors a misdemeanor subject to a fine of at least \$10 but no more than \$25.” But the ordinance had little effect, so the city regrouped and responded with a new ordinance that required the drummers to wear metal badges that identified themselves as agents for physicians. The lull in abuses was temporary, but competition drove the agents to work harder for commissions by offering free rides, medical treatments, and meals to disembarking passengers.

Frustrations continued and the city took a few extra steps to regulate the drummers by requiring them to stay in a designated area at the train station, but this proved unenforceable and arriving passengers still faced a gauntlet when they stepped off the train. One passenger noted the scene as being “one of unparalleled confusion,” with “perspiring, excited crowds of hotel, boarding house, and doctor’s runners, hackmen and porters.”

Finally, the federal government, who controlled the bathhouses and the thermal hot springs, stepped in and warned that any bathhouse or hotel that employed drummers would have their use of the springs shut off. In 1904, President Theodore Roosevelt signed a regulation governing the behavior of



1910 postcard highlighting the abuses of doctor “drummers” and what confronted the arriving visitor who came to alleviate their ailments.

Hot Springs physicians, and the Arkansas Medical Society was asked to review licensed doctors who prescribed the baths and thermal waters.

By 1916, the city of Hot Springs sought to outlaw the practice completely. Calling on the Garland County Medical Society under the leadership of Dr. Albert Tribble, the county society worked with the city and federal officials to deny access to the hot springs for patients of drummer physicians, which helped to officially end the practice of drumming. As one observer commented, “the purchase and sale of invalids...no longer exists in Hot Springs.” ■

Sources:

“Invalids for Sale in Hot Springs” by Tom Dillard. Arkansas Democrat Gazette, July 2019

“The American Spa, Hot Springs, Arkansas” by Dee Brown



# COURTNEY SICK, MD

RENAISSANCE WOMEN'S CENTER P.A.

**City:** Conway

**Specialty:** Obstetrics and Gynecology

**AMS member since 2015:** Currently serves as trustee for AMS District 2.

**Why are you an AMS member?** Being a member provides me a way to get involved with the legislature and advocate for issues that are important for my colleagues and my patients.

**What do you like most about being a doctor in your specialty?** Ob/Gyn gives physicians the unique opportunity to care for women throughout their lives. From teenage years to menopause, we are able to see them through all of these stages. I also love the procedural side of obstetrics and gynecology.

**What inspired your career in medicine?** I was a RN for about three years before I started medical school. I worked with residents and attendings in the Burn Center at Arkansas Children's, and I saw the dedication and impact physicians had on patients day in and day out. As a nurse there was only so much I could do to help

my patients, and I wanted to be the one that had the knowledge and ability to do it all and advocate for my patients.

**What is the most critical health care issue facing Arkansas today?** From an Ob/Gyn perspective, it is a woman's reproductive rights and access to care. There is a lot in the media about elective pregnancy terminations, and that is the issue that politically is often debated. However, often a less talked about issue is Arkansas' ranking in regard to maternal mortality and morbidity. As we restrict access to abortions, we must work on improving access to care for these women and to help ensure adequate prenatal care that will help decrease our maternal mortality numbers.

**What is an important cause to me?** Perinatal bereavement is extremely important to myself and my family. I have a daughter, Lucille, that passed away shortly before she turned 6 months old. After her death, I have become involved with Mamie's Poppy Plates and serve as an active volunteer and board member. Mamie's Poppy Plates is a non-profit that provides ceramic plates with the

footprints, date of birth, and weight for babies that were stillborn or infant deaths. We are currently providing plates for families in over 20 states, and the organization was started in Little Rock. ■



# DARRELL OVER, MD, MSC, FAFAP

ASSOCIATE PROFESSOR AND ASSOCIATE PROGRAM DIRECTOR, UAMS SOUTH CENTRAL FAMILY MEDICINE CENTER, VICE-CHIEF OF STAFF AT JEFFERSON REGIONAL MEDICAL CENTER

**City:** Pine Bluff

**Specialty:** Family Medicine

**AMS member since 1996:** Currently serves as trustee for AMS District 4 and member of Jefferson County Medical Society

**Why are you an AMS member?** To network with colleagues to advocate for policies impacting our profession and our patients.

**What inspired your career in medicine?** As a student I always had a love of the biological sciences. This coupled with

my experiences as an enlisted U.S. Army medical specialist – pursuing a career as a physician was a natural progression.

**What is the most critical health care issue facing Arkansas today?** The shortage of primary care physicians.

**Do you have a personal motto or favorite quote?** "Once you carry your own water, you will learn the value of every drop."

**What do you like to do in your days off or weekends?** Non-medical reading. ■



# ARKANSAS MEDICAL SOCIETY BOARD OF TRUSTEES MEETING MINUTES, AUGUST 24, 2022

BY **DANNY WILKERSON, MD**  
CHAIRMAN OF THE BOARD

The Arkansas Medical Society Board of Trustees met virtually on Wednesday August 24, 2022. Members attending the meeting were Drs. Lee Archer, Omar Atiq, Seth Barnes, Brad Bibb, Dale Blasier, Samuel Bledsoe, Lyle Burdine, Willard Burks, Joshua Chance, Kay Chandler, George Conner, Scott Cooper, Anthony Davis, Jacob Dickinson, David Dobies, Gina Drobeno, Scott Ferguson, Candace Franks, Matthew Haustein, James Hunt, David Jacks, Anthony Johnson, Larry Lawson, Mimo Lemdja, Nirvana Manning, Gail McCracken, Amanda Novack, Darrell Over, Tim Paden, Naveen Patil, Mark Ramiro, Carolyn Reeves, Chad Rodgers, Jeremiah Rutherford, Alan Schumacher, Eugene Shelby, Courtney Sick, Jerakaycia Smith, Shane Smith, Shannon Swift, Tobias Vancil, Nanette Vowell, Randy Walker, Danny Wilkerson, Mark Wren, Dennis Yelvington, and Stacy Zimmerman. UAMS student trustee present was John Hunton. AMS staff present were David Wroten, Mary Ann Mansfield, Tereasa Holmes, and Scott Smith. AMS Legal Counsel present was Mike Mitchell.

Chairman, Dr. Danny Wilkerson called the meeting to order and the following business was received and transacted:

1. The Chair greeted everyone and called for an Executive Session. The Chair asked everyone who is not a trustee or past president to leave the meeting.
2. The Chair welcomed everyone back to the board meeting and reminded all in attendance of their responsibility to declare and disclose any conflicts of interest.
3. Following disclosures, the board approved the minutes of the May 6, 2022, Board of Trustees meeting.
4. The Chair called upon AMS Executive Vice President David Wroten to give his report. The report was accepted.

5. The Chair called upon AMS Director of Governmental Affairs Scott Smith to give a legislative preview of the upcoming Legislative Session. The report was accepted.
6. The Chair called on AMS Director of Operations Mary Ann Mansfield to give a presentation on Year Two of the Covid Vaccine Grant from the Health Department.
7. The Chair called upon Dr. Chad Rodgers to give a report on the Diversity Committee. Dr. Rodgers asked for time at the AMS Annual Session for an educational activity on diversity.
8. The Chair call upon Dr. Scott Ferguson to present his review of the AMA meeting this past June in Chicago as well as his re-election to the AMA Board of Trustees.
9. Under New Business, Dr. Omar Atiq presented two AMA resolutions for consideration at the next AMA meeting. The Chair asked for a motion from the board to enter into discussion about the resolutions. It was moved and seconded. The motion passed. The Chair called on Dr. Atiq to explain the resolutions. Discussion ensued.

Following the discussion and Dr. Atiq's request for input from the board on each of the resolutions, there was a motion that the resolution titled **Proposed Resolution for Fairness and Wellbeing of Residents and Fellows** be brought back to the board at their next meeting in final version. It was seconded. The motion passed.

There was a motion that the resolution titled **Proposed Resolution for Fair Compensation of Residents and Fellows** be brought back to the board at their next meeting in final version. It was seconded. The motion passed.

There being no further business, the meeting adjourned. ■

**UNITED STATES POSTAL SERVICE® (All Periodicals Publications Except Requester Publications)**

Statement of Ownership, Management, and Circulation

1. Publication Title: The Journal of the Arkansas Medical Society  
 2. Issue Date: 10/15/2022  
 3. Issue Frequency: Quarterly  
 4. Issue Date for Circulation Data Below: 10/15/2022

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 AGARWAL, NIDHI, MD  
 AHART, CHERYL L., MD  
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 AHMED, JIBRAN, MD  
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 AKINS, JOHN, MD  
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 AL HADDI, SAMER AHMAD SUL, MD  
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 ALAM, MUHAMMAD G., MD  
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 ALE, SHIRSHA, MD  
 ALESALI, MAHER, MD  
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 ALI, SYED FAIZAN, MD  
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 ALLEN, STACI, DO  
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 CALCAGNI, MIKAILA, MD  
 CALDWELL, CHARLES R., MD  
 CALDWELL, JACQUELINE R., MD  
 CALLAWAY, JODY C., MD  
 CALLAWAY, MICHAEL W., MD  
 CAMERON, BRENT, MD  
 CAMFERDAM, ROBERT, MD  
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 CAMPBELL, JENNY M., MD  
 CAMPBELL, KATELYNN KATHER, MD  
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 CANNON, R. DAVID, MD  
 CANON, STEPHEN M., MD  
 CANTU, REBECCA MURPHY, MD  
 CANTWELL, JANET S., MD  
 CAPOCELLI, ANTHONY L., MD  
 CARADINE, KARI D., MD  
 CARD, PEYTON DAVIS, MD  
 CARDENAS, JAIME A., MD  
 CARLLEE, SHEENA WALIA, MD  
 CARLLEE, TYLER LEWIS, MD  
 CARLTON, RANDALL D., MD  
 CARMACK, BRITTANY, MD  
 CARMICAL, JIM, MD  
 CARMICAL, KATELYNN HALIE, MD  
 CARR, LAURA, MD  
 CARRICO, JEREMY, MD  
 CARRILLO POLANCO, LUIS FELIPE AND, MD  
 CARRINGTON, HUNTER, MD  
 CARROLL, JOHN L., MD  
 CARSON, AARON K., MD  
 CARTER, DALE, MD  
 CARTWRIGHT, JEFFERSON, MD  
 CARUTHERS, CAROL S., MD  
 CASEY, JENNIFER N., MD  
 CASH, DAVID L., MD  
 CASH, J. STEVEN, MD  
 CASSAT, MICHAEL, MD  
 CASWELL, JOHN E., MD  
 CATHCART, EVELYN L., MD  
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 CAYME, RODRIGO, MD  
 CESARE, CHARLES, MD  
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 CHAKKA, MANGARAJU N., MD  
 CHAKRABORTY, INDRANIL, MD  
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 CHAMBLISS, JAMES W., MD  
 CHAN, CAMILLE CANDACE, DO  
 CHAN, KENNETH, DO  
 CHANCE, JOSHUA C., MD  
 CHANDLER, ANGELA L., MD  
 CHANDLER, KAY H., MD  
 CHANG, CHIMIN J., MD  
 CHAPA-RODRIGUEZ, ADRIAN, MD  
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 CHAPMAN, KIMBERLY, MD  
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 CHASE, PATRICK R., MD  
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 CHATTERJEE, SUZANNA, MD  
 CHAU, DESTINY FENGER, MD  
 CHAULVIN, EDGAR J., MD  
 CHAWLA, VONITA, MD  
 CHEN, CHIEN, MD  
 CHEN, JIM ZHONGNING, MD  
 CHENAULT, KATHRYN T., MD  
 CHERNEY, STEVEN, MD  
 CHERVINSKIY, SHEVA KHORRAMI, DO  
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 CHISM, B. SCOTT, MD  
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 CLARK, DANIEL COLE, MD  
 CLARK, JOSHUA A., MD  
 CLARY, CATHY J., MD  
 CLAWSON, APRIL, MD  
 CLAY, DAVID, MD  
 CLAYBROOK, KEVIN D., MD  
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 CLAYTON, JEFFERY E., DO  
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 CLINGENPEEL, RACHEL ANNE, MD  
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 COBLE, ANDREW L., MD  
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 COLCLASURE, JOE C., MD  
 COLE, ANDREW A., MD  
 COLEMAN, DOUG, MD  
 COLEMAN, SETH, MD  
 COLETTA, JASON CHARLES, DO  
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 DAVIDSON, JAMES ANTHONY, MD  
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 DEED, MICKY, DO  
 DEER, PHILIP, MD  
 DEERE, DEBORAH, MD  
 DEGRAFF, THOMAS, DO  
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HOLDER, KASEY M., MD  
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HOLT, JEFFREY WAYNE, MD  
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 LEMDA, MIMO ROSE, MD  
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 LENDEL, VASILII, MD  
 L'ESPÉRANCE, JAMES OMER, MD  
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 LEWIS, MARY ELIZABETH, MD  
 LEWIS, PAUL SPENCER, MD  
 LEWIS, ZACHARY, MD  
 LI, RUIZONG, MD  
 LIDE, RILEY SUSANNE C., MD  
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 LIENHART, KRISTEN, MD  
 LIGGIN, REBECCA L., MD  
 LILE, SCOTT A., MD  
 LIM, PAOLO, MD  
 LINCOLN, CANDY SUZANNE, MD  
 LINCOLN, LANCE, MD  
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 LINDBERG, RANI, MD  
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 LITTLEJOHN, NATHAN, MD  
 LITWILL, SCOTT ERIC, MD  
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 MALAK, SHARP F., MD  
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 MALTE, BRIAN IMBAO, MD  
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 NAGY, DAVID JAMES, MD  
 NAHMAS, ZACHARY, MD  
 NAIR, BALAN A., MD  
 NAIR, DEVI, MD  
 NAKAGAWA, MAYUMI, MD  
 NALLEBALLE, KRISHNA CHAITAN, MD  
 NANCE, KATHRYN LEE, MD  
 NAPIER, SHARON MARIE, MD  
 NAPOLITANO, CHARLES A., MD  
 NARAYANA REDDY, KAVYA, MD  
 NARDI, CAROLINE, MD  
 NASH, GARY MONROE, MD  
 NAYLOR, DAVID L., MD  
 NEAL, JEFFREY, MD  
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 NEHUS, EZECHIEL R., MD  
 NEIS, JOHN PAUL, MD  
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 NELSEN, DAVID A., MD  
 NELSON, DAVID G., MD  
 NELSON, GARRETT, MD  
 NESMITH, CLARE C., MD  
 NEUHAUSER, JEFFREY H., DO  
 NEWBERN, D. GORDON, MD  
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 NEWCOMB, T.L., MD  
 NEWMAN, MARK S., MD  
 NEWTON, JAMES ARTHUR, MD  
 NGUYEN, CINDY, MD  
 NGUYEN, DUONG H., MD  
 NGUYEN, LARRY L., MD  
 NIBA, SUH N., MD  
 NICHOLS, SCOTT R., MD  
 NIEMYER, JOSELINE G., MD  
 NIX, JAMES, MD  
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 NIXON, D. ALLEN, MD  
 NIXON, DAVID T., MD  
 NIEL, STACEY W., MD  
 NOLDER, ABBY RENEE, MD  
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 NOLEN, LAUREN, MD  
 NOLEN, MICHAEL T., MD  
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 NORYS, JAMES WILLIAM, MD  
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 NWUDE, EZINNE, MD  
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 OCAL, EYLEM, MD  
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 OCHOA, EDUARDO R., MD  
 O'CONNELL, JOSEPH R., MD  
 ODEN, JON DAVID, MD  
 ODIASE, ELAINE, MD  
 ODUM, NEADUM JOSEPH, MD  
 OGUNSESAN, YETUNDE WURAOLA, MD  
 OLAYA, JULIO R., MD  
 OLGAARD, ERICA JANE, DO  
 OLIVE, ROBERT J., MD  
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 OLUMOFIN, OLABODE, MD  
 O'MALLEY, LAWRENCE KEVIN, MD  
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 ONG, SORAYA, MD  
 ONISEI, ANNA M., MD  
 ONISEI, DUCU F., MD  
 ONTEDDU, SANUEVA REDDY, MD  
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 ORANGE, BETTY L., DO  
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 OWENS, KRISTIN ELIZABE, MD  
 OWENS, M. HEATHER, MD  
 OWENS, R. BRIAN, MD  
 OXNER, TROY W., DO  
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 OZDEMIR, BURCU, MD  
 PACE, DANIEL, MD  
 PACE, JOHN R., MD  
 PACE, STEPHEN, MD  
 PACK, PHILIP PAUL, DO  
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 PADEN, TIM C., MD  
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 PAGE, ROBERT, MD  
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 PAIXAO, ANDRE RODRIGUES, MD  
 PALMER, HAL E., MD  
 PALMER, JONATHON D., MD  
 PALMER, KRISTINE G., MD  
 PALOT, MANZIL, FATHIMA FUJULA, MD  
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 PANDEY, TARUN, MD  
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 PARRAY, TARIQ, MD  
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 PEYTON, SHAWN C., MD  
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 PINTO MIRANDA, VERONICA, MD  
 PIONTEK, JOSEPH, DO  
 PITTMAN, CHRISTOPHER, MD  
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 POPE, MATTHEW, MD  
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SWAFFORD, COLLIN, DO  
SWARD, LINDSEY, MD  
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TARIQ, SARA G., MD  
TARUN, TUSHAR, MD  
TAS, EMIR, MD  
TAS, VILDAN, MD  
TASNEEM, SARA, MD  
TATA, NAZNEEN, MD  
TANAKA, TOMKO, MD  
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TARIQ, SARA G., MD  
TARUN, TUSHAR, MD  
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TAYLOR, CHAD, MD  
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THOMPSON, CHELSEA, DO  
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