HEALTHCARE JOURNAL of Little Rock

JANUARY / FEBRUARY 2014

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Appears to be Model Solution

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Stopping Cancer at the Source

When someone is diagnosed with cancer, killing the tumor cells has traditionally been the primary goal. But scientist Robert Griffin, Ph.D., knows it's not just tumor cells we should target; it's also tumor blood vessels.

His research at the UAMS Winthrop P. Rockefeller Cancer Institute is searching for ways to shut down the blood vessel structure that feeds tumors and allows them to spread throughout the body. This includes studying common cancer treatments such as radiation and thermal therapy and finding ways to make them more effective. It also means working with experimental drugs to understand how they interact and affect the blood vessels and tumors.

"If we control the blood vessels...we control the tumor cells."

"One blood vessel cell can provide nutrients for up to 2,000 tumor cells," Griffin said. "If we can control the blood vessels that support tumors, we may also be better able to control countless tumor cells that are otherwise very hard to eliminate."

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Robert Griffin, Ph.D.

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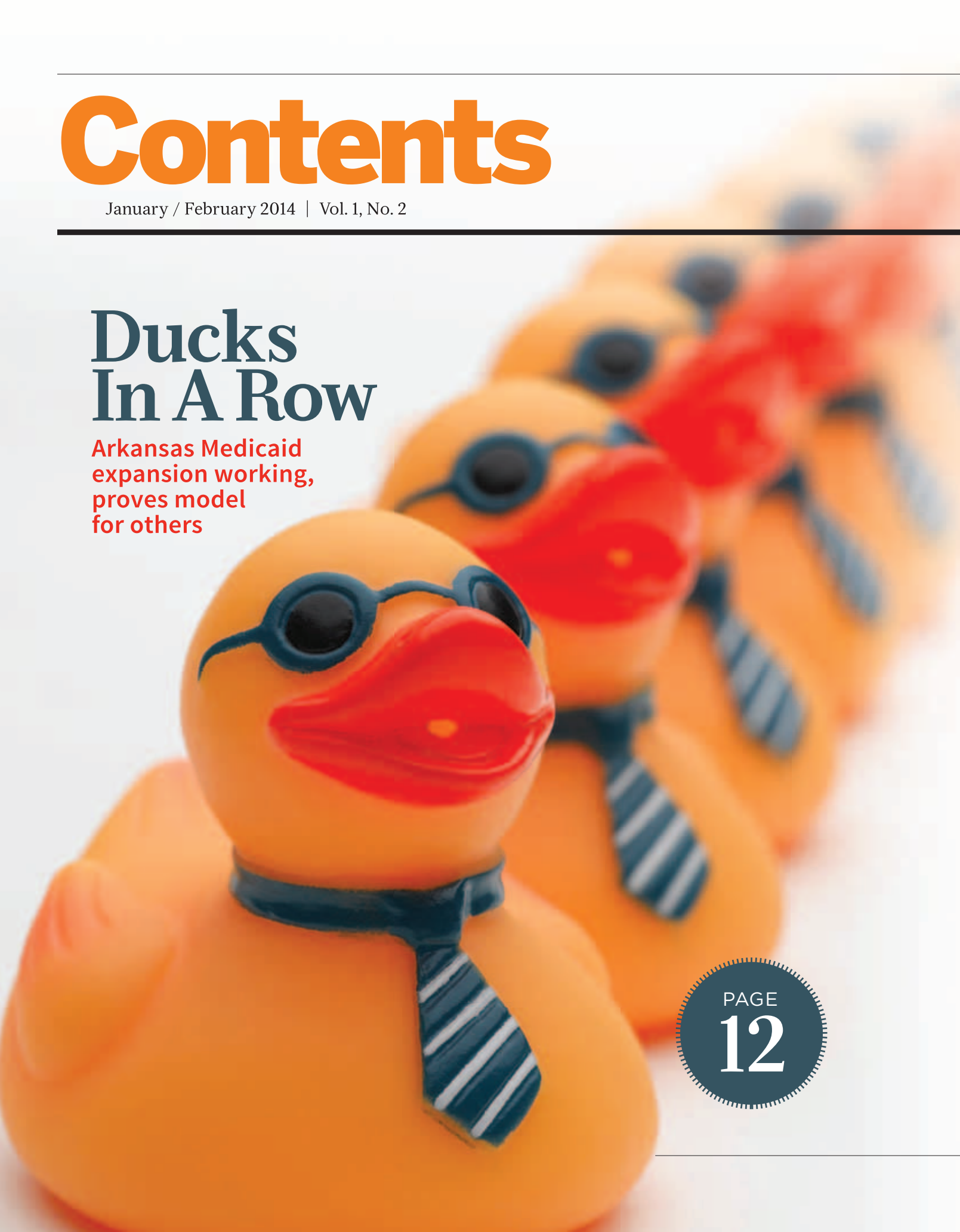

Ducks In A Row

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Imagination is more important than knowledge.

— ALBERT EINSTEIN

As the new year rolls in, so do the possibilities in health.

The federal government will be working on their enrollment glitches. Providers are aligning and making sense of the new payment mechanisms. Patients are wondering what this all means to them. Change can give us all an opportunity to do some things differently.

We've used this Jan/Feb issue to cover in depth Arkansas's private option. The payment and enrollment systems will always provide lively discussion due to the many and various points of view on healthcare issues. These issues are important. But, as we move forward into the year, healthcare leaders also have the opportunity to explore new options in improving health. One such example is genome testing.

It's estimated that in 10 years the genome testing industry will be greater than $20 billion dollars annually. While still in its infancy, genome sequence testing can offer patients and their health providers enhanced diagnostic tools and information from individualized DNA testing that can not only be used to better guide patients, but also can become a cost-effective tool for care, thus offering possibility as an insurance covered diagnostic test.

Currently, genomic testing is expensive and has varying degrees of accuracy. But, as we've all seen in technology over recent years, improvement will be made while the cost will likely decrease.

Enhanced testing is just one possibility to improve health. We have an opportunity to improve health at the source. The more we learn about factors such as the environment, nutrition, and other public health issues, the more we have an option to make educated choices with regards to our collective and individual health. In addition, we are becoming more aware of factors such as stress as it relates to overall well-being and health.

2014 can be an interesting and productive year. Those of us with the gifts of research, analysis, and open-mindedness can lead the way to better health for all of Arkansas's citizens. Here's to a blessed and wonderful new year.

Smith Hartley
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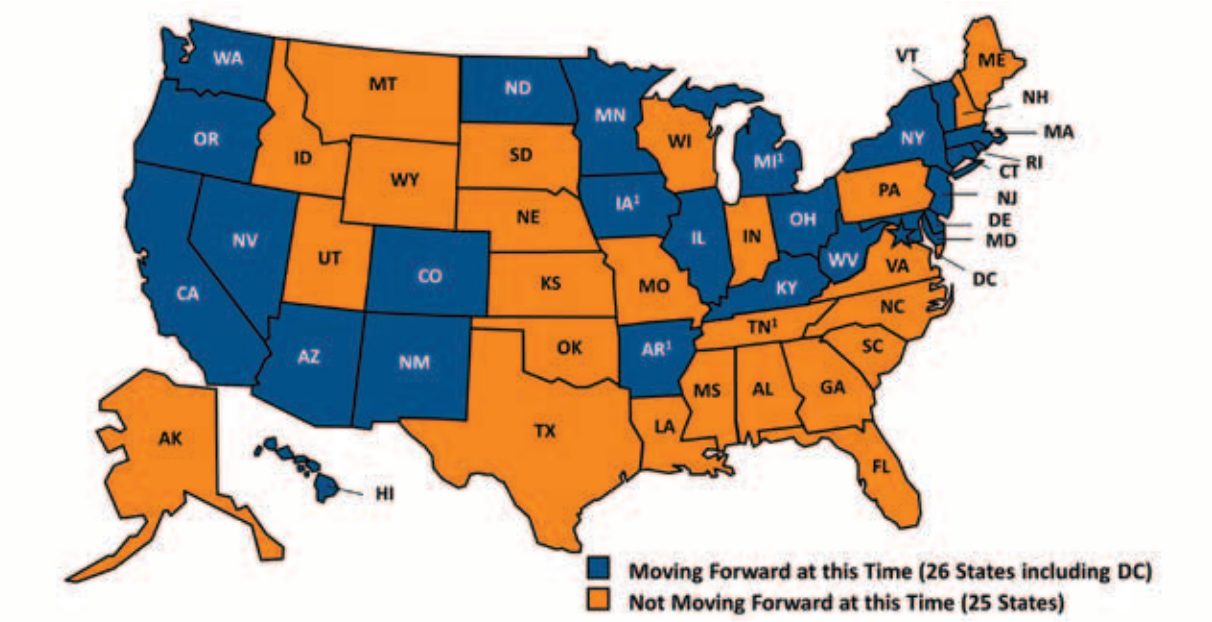
Arkansas Medicaid Expansion Working, Proves Model For Others

By Karen Tatum

GETTING OUR Ducks IN A ROW

With all the digging in of heels, gnashing of teeth, and crashing of websites it would be easy to view the implementation of the Affordable Care Act, popularly dubbed "Obamacare" in nothing but a negative light. And with the spectacular flop that was the launch of Healthcare.gov, there has been plenty of ammunition for naysayers, whose voices have only grown louder.

Current Status of State Medicaid Expansion Decisions, as of November 22, 2013



NOTES: 1 - Exploring an approach to Medicaid expansion likely to require waiver approval.
SOURCES: State decisions on the Medicaid expansion as of November 22, 2013. Based on data from the Centers for Medicare and Medicaid Services, available at: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html. Data have been updated to reflect more recent activity.

SOURCE: "The Kaiser Family Foundation State Health Facts. Data Source: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

Yet in the midst of all the muddle, at least one state has been quietly chugging along with implementation of its own answer to one aspect of Obamacare and is getting some attention from around the country. Arkansas's hard fought for private option may well be the model to emulate.

When the Supreme Court upheld the Affordable Care Act, but overturned the mandate for states to expand their Medicaid programs, many, mostly Republican, governors took that as affirmation of their resistance to all things ACA, particularly expansion of Medicaid eligibility to 138% of the federal poverty level. However, as their constituents have grown increasingly vocal about the wisdom of turning down a plan that will not only address the issue of the working uninsured, but is also fully subsidized for the first three years, many of those states are now looking for other approaches. Arkansas's approach, which gained approval on September 27th as a waiver from the Department of Health and Human Services is the one most mentioned by national leaders and press alike.

While others were snubbing their nose at Medicaid expansion, Governor Mike Beebe looked for a way to do it that was more palatable to Republican legislators. While few will deny that the Medicaid program is not without problems, expanding eligibility does have its benefits. That's because the expansion will capture many citizens who are working, but don't receive health insurance from their employers and can't afford it on their own. Implementation of the ACA requirement that most employers must offer insurance or pay a fine was likely to prove burdensome for many smaller private companies. If many of the working poor can gain coverage through the private option, that

> **"As we kicked the tires we began to recognize that this was both an alternative to Medicaid and a way to infuse and strengthen competition in the private insurance marketplace."**

Andy Allison, Arkansas Medicaid Director

relieves some of the burden.

The hardest thing to resist about Medicaid expansion is the offer of federal funding. Even though states will eventually have to pick up 10% of the tab in 2020, the first three years of the expanded program is fully funded by the Feds, and then the vast majority thereafter. That's a lot of money at which to turn one's nose up. Yet despite looming shortfalls, Arkansas leaders weren't interested in expanding the program as is. Instead, with considerable input from legislators and health officials they crafted the private option and submitted it to the Feds for approval at the end of the summer.

The private option expands eligibility for the Medicaid program to 138% of the federal poverty level, but uses federal Medicaid dollars to purchase insurance for those newly eligible through private insurers on the health exchange. "Arkansas has broached what could be a deal-making compromise, giving Washington the increased coverage for the poor it wants and Republicans something that looks less like government and more like business," reported Kaiser Health Network writer Jay Hancock.

Arkansas Medicaid Director Andy Allison admitted the plan came together in parts with input from many quarters. Initially the conversation started with trying to figure out how to purchase coverage for the highest level of income under the expansion, because with just a modest increase in income, those individuals would automatically transition into tax subsidized coverage in the marketplace. "From those conversations it became evident that we might be able to consider doing this for the entire expansion population," said Allison. "As we kicked the tires we began to recognize that this was both an alternative to Medicaid and a way to infuse and strengthen competition in the private insurance marketplace."

Allison said the private option is not just an alternative to Medicaid, but a way of bolstering and improving private health insurance in Arkansas by drawing additional insurance companies into regions of the state they didn't serve in the past and even drawing additional competitors to Arkansas. That competition is expected to keep rates more affordable.

Many states already engage in some form of privatization of their Medicaid program, contracting with managed care companies to handle their Medicaid population, explained Allison. "What no state has done is to take a meaningful number of covered lives and buy coverage in the private market for them. A key distinction is that Medicaid managed care doesn't necessarily fall under the purview of an insurance commissioner, under the regulatory structure of the state, whereas our program does. We're buying private, regulated insurance and it's the same insurance product that other individuals are buying. And that's unique across the whole country. No one has done that before in the individual market." Allison said the closest thing to this approach he's seen is some states will use Medicaid dollars to pay the employee share of an employer-based plan, but generally only for a limited number of individuals.

The private option also addresses another major criticism of Medicaid expansion—access. Many have argued that simply adding millions more to the rolls of Medicaid and issuing them a card doesn't mean they will have access to healthcare. Indeed, those already on Medicaid often find themselves challenged to find a doctor that will treat them or complain that their treatment may be less timely or complete than for those with private insurance. Declining reimbursement and the impending growth in numbers of patients has led many providers to opt out of the Medicaid program. With Arkansas's private option, new eligibles will have the same menu of options for private insurance as everyone else. They won't have a Medicaid

card, but a Blue Cross, QualChoice or other participating insurance company card. The provider networks offered by those insurance plans are often much more extensive than those normally available to Medicaid members.

As the plan was developed and submitted, states who were contemplating Arkansas's approach watched with interest to see if the private option would gain approval. Previous requests for partial or customized expansions from other states had been met with an "all or nothing" response from the Department of Health and Human Services. Allison said one of the first hurdles to getting the plan approved was convincing the Centers for Medicare & Medicaid (CMS) that it was a cost-efficient method of providing coverage. While there were some concerns that it would cost more to provide private health insurance through the exchange than traditional Medicaid, the hope is that competition among insurers on the exchange will keep rates down enough to offset that difference. Also many of the newly eligible will be younger, working people, offsetting some of the risk incurred by insurers who can no longer turn away those with pre-existing conditions. In addition, private insurance tends to offer more continuity of care, more of a focus on wellness, etc. that helps keep those members healthy and away from more expensive healthcare. That balance of the risk pool is essential to the success and continued affordability of the exchanges say health insurance officials.

"This program may actually double the size of the insurance marketplace and really improve the risk profile of that marketplace," said Allison. "I think that addresses some of the concerns that have been raised about the viability of these marketplaces given the low levels of enrollment early in the process. We've got the reverse in Arkansas. We've got very strong enrollment and the private option is going to help anchor a more competitive insurance marketplace in Arkansas than could have existed otherwise." Allison also expects to see more of an impact on the insurance marketplace and competition going forward. Insurance companies only had a few weeks to respond after the bill passed and before their health plan and premium information was due to the insurance commissioner in order to do business on the exchange. And that was prior to the Feds' approval of the private option. "There really wasn't an opportunity for health plans this year to decide to come into the state or to extend into further regions of the state, but that will be true in the coming years," said Allison.

State health officials believe the purchasing power of the private option in the marketplace is what will drive costs in the private insurance marketplace down, saving rate payers and the federal government money outside the expansion. Over time

That's because the expansion will capture many citizens who are working, but don't receive health insurance from their employers and can't afford it on their own.

this could translate into lower premiums for those outside of the expansion, who are above 138% of poverty level. "That will also save the federal government or federal treasury money because they will be subsidizing a lower premium," said Allison. The expansion is anticipated to save the state money because the federal government is assuming such a high percentage of the cost initially and it allows the state to stop spending money on the uninsured. The expansion also saves, not the first year, but the second and following years, larger businesses from a potential tax liability for individuals who enroll in the exchange and get tax subsidies. That was predicted to total between $30 and $40 million a year according to Allison.

The private option is only available to those who are newly eligible under Medicaid expansion. Those already covered by Medicaid in the state, including children, the very poor, and the very sick, will still be covered by the existing Medicaid program. Applicants for the private option will be screened to see if they more properly belong under regular Medicaid. "We are screening the high costs or high needs patients out and putting them back in the regular Medicaid program and that's a key aspect of the proposal and is innovative, in my view," said Allison.

Despite the rather balky start to the federal health exchange, within weeks of open enrollment Arkansas already had about a quarter of those eligible for the private option enrolled, putting the state far ahead of pace for the approximately 250,000 it expects to enroll. "They very astutely reached out to the people on food stamps who had already been income tested and they knew they were below the 138% poverty level," pointed out Ray Hanley, President and CEO of the Arkansas Foundation for Medical Care. By directly contacting a large group that was already income eligible the state was able to jump start the program, he said. Those applicants, once approved, were directed to the InsureArk website to select a plan. Others, who were not directly contacted by the Department of Human Services can apply for the private option via mail, phone, or the Access Arkansas web portal.

Prior to implementation of the ACA, approximately 540,000 Arkansans had no insurance and 449,000 were covered by Medicaid (including CHIP). Medicaid expansion will add an estimated 250,000 new members to Medicaid.

Those not eligible will be directed to the federal Healthcare.gov site, which is finally up and running, but reportedly still a bit buggy.

"Our systems appear to be working and improving over time—in taking applications and determining eligibility, assessing the health status and health service needs of our enrollees, and then giving them a choice of health plans for the private option. We are making great strides in their selection of health plans in the tens of thousands. That has all worked," said Allison. "Like every other state we were not able to electronically communicate with Healthcare.gov, which is limiting our enrollments from the federal government and our ability to share with them individuals who really should be enrolled in the tax subsidies and exchanges as opposed to the private option. It's communication with the Feds that's not yet up and running."

Hand in hand with Arkansas's private option is the new Payment Improvement Initiative which not only seeks to standardize costs, but also reward providers based on the quality of care they provide rather than the volume. The state's new payment innovation will apply across Medicaid, Medicare, and private payers. Insurance companies that are participating in the private option are required to participate in the new payment initiative. "We think the private option expansion will help to accelerate and complete the payment reform process," said Allison. "Our payment reform effort in Arkansas is intentionally a multi-payer if not all payer effort. We really think that providers need to be rewarded for performance and that reward shouldn't depend on who's paying the bill." The private option enables the state to extend the payment reforms that they've already made in Medicaid and that Blue Cross has begun in some of their programs in the private marketplace, said Allison. "So the private option allows the state to leverage what has already become a very successful package of payment reforms and extends them to the rest of the marketplace."

Despite these positives there are some who are not in favor of the new program because it still represents an expansion of Medicaid, which they regard as wasteful and inefficient. That could be a potential problem as the program funding requires yearly renewal by a Republican majority Legislature. Allison is not concerned. "I think we have had success, but we have more successes to come with this program. I am very optimistic about that," he said. "There are all kinds of reasons that legislators would go for or against continuing to fund the Medicaid program and the private option. Politics might be one of those, but I certainly wouldn't want to dismiss the real questions legislators have. I'm optimistic that we'll be able to answer those questions and that the case for the private option will be even stronger this year than it was last year. I believe by February legislators will be able to see the value of the private option, even more than they did when they decided with overwhelming majority last session to pass it."

Allison, who is Immediate Past President of the National Association of Medicaid Directors, said he has been approached informally by Medicaid directors from other states many times over the last year. "Iowa is actively pursuing and expanding under a variance of this model so we have worked with them," said Allison. Other states that have taken a close look at Arkansas's model or exploring similar ones are Virginia, Florida, Nebraska, Ohio, and Tennessee. "We have a lot going on here—it's an enormous team effort and we are pretty proud of it." ■

one on one

with **Michael E. Stock**
President & CEO
QualChoice

Michael E. Stock joined QualChoice in August 2002 and served as CFO and COO from 2002-2007. He became President and CEO in January 2008. He has over 30 years of experience in the public accounting and insurance industries. This experience includes 14+ years with Ernst & Whinney and Price Waterhouse, where he served three years on their national health care staff. His insurance experience includes 9+ years with New York Life companies, and wholly owned insurance subsidiaries of Methodist Health Care System in Houston, Texas.

"I DON'T THINK THE EXCHANGES REALLY HAVE AN IMPACT ON THE PRICE OF HEALTHCARE."

Chief Editor Smith W. Hartley: *Can we start with, in regards to the health insurance changes, the process QualChoice had to go through to get ready to be part of the exchanges?*

Michael E. Stock: The process to get onto the exchanges involved going through and completing an application we had to file electronically through a software tool used by the National Association of Insurance Commissioners. It was an extensive process that covered many different areas around plan designs and so forth.

I guess to back up a little bit, aside from the actual process of doing the filing we began the process by internally looking at what we thought the risk pool of the state would look like and whether or not that would be an attractive risk pool that we would want to participate in with this initial launch. That was done by working with our actuaries and analyzing our cost data from different segments of the state. We came to the conclusion that that was something we wanted to be involved in.

I think one of the things that tipped us in that direction was the expansion of the Medicaid program known as the private option here in Arkansas. We felt that was going to result in the creation of a larger risk pool than might have existed if we had not expanded Medicaid in the state and it had just been people enrolling through the federal exchange.

So going through the process involved

working with the Arkansas Insurance Department, identifying what the plan designs needed to be to conform with the Medicaid expansion in the state and working with an actuarial tool that was provided to us by the federal Center for Consumer Information and Insurance Oversight (CCIIO) to go through and design benefit plans that conform with the state's rules and the federal government's rules and that fell into one of the four metallic categories: bronze, silver, gold or platinum. Those then had to be priced; we did that with our internal actuaries and also using actuaries outside the company as a validation and then doing all the other filings that went along with the benefit plans in terms of network adequacy and so forth. It was a process that took us probably well over six months to work through and get ready. The filing was originally done and submitted to the state at the end of June this past year.

Chief Editor: *What has been your impression of the exchanges so far aside from all the glitches?*

Mike Stock: There were lots of glitches that we had with the exchanges before they actually went live on October 1. As we were submitting our data to load into the exchange we had to go through a verification process and validate and test the accuracy of the information we were submitting and how it was being loaded into the system. There was a steep learning curve in going through that process. We had challenges just getting into the exchange to do a lot of the validation, so it was not a real smooth process. You can tell that they were sort of learning as they went through the process and working with carriers across the country.

We also thought we would be a lot busier right now than we are because we thought there would be thousands of people coming off the exchanges and there aren't. It's kind of a slow process right now as they try to get this whole thing worked out.

I think it's going to be a real concern. The people in Washington are going to be faced with a real dilemma if the numbers remain this low; they will they have to do something different. We don't have this issue in Arkansas, but in other parts of the country there are millions of people that have been told their insurance policy will go away because it doesn't conform to the new law. If they can't get onto the exchanges to sign up, the last thing a politician wants is somebody who had their policy cancelled, can't get new coverage on the exchange, and they have some kind of catastrophic event that puts that person into a real bad financial situation.

Chief Editor: *Overall how do you anticipate that the exchanges will affect the price of healthcare?*

Mike Stock: I don't think the exchanges really have an impact on the price of healthcare. The price of healthcare is being impacted more by benefit designs that are being offered, the way the regulations or law is written in terms of how the product has to be priced and designed and the fact that there are a number of new taxes being added into the cost of healthcare to create a pool of money to cover the cost of the subsidies. But the actual exchanges aren't really impacting the cost of healthcare. We use exchanges today and have used them for a number of years. We sell products on existing national exchanges at the same price as if we sell those products directly to the consumer here in Arkansas. The only thing the exchange does is create some administrative efficiency because we can process an electronic application rather than a paper application, but otherwise the cost of healthcare is driven by a number of things outside of the exchanges.

Chief Editor: *Have you noticed or anticipate an effect on employer sponsored plans where employers will be ending their plans and sending employees to the exchange?*

Mike Stock: I expect there will be some of that in the marketplace. There have been a lot of studies done by a number of different consulting firms and actuarial firms looking at that. Those estimates have ranged from small percentages to estimated numbers as high as 30 to 35% of the small group market may dissolve and people will be directed into the exchanges to purchase products. So I think there will be a shift in that direction. You may see more of it in the second year if the exchanges are still up and running because a lot of the small group non-grandfathered plans aren't being forced to move onto the essential health benefit products yet. That will start January 1st and will occur each month, as we move through the year, as those groups come up for renewals. I still think there are a lot of unknowns for folks in the small group, small employer world out there, that they don't really understand what the cost impact is going to be for them and as they come up for renewal in 2014 they will see those numbers in reality for the first time and some of those decisions will start being formed.

Chief Editor: *With the government mandated benefits involved through the exchange system can you give me an idea of what you expect the future will bring for health insurance in terms of price, scope? There have been some arguments that insurance companies are becoming almost like utilities. Are they just becoming administrators of a benefit program? Could prices increase as a result of the mandates?*

Mike Stock: Well, to a certain degree all of those things you mentioned could occur. Yes, insurance companies are being treated more like utilities in that our profit margins are being dictated to us much like utilities' profit margins are dictated to them. A utility has to file a request for a rate increase and they have to prove that their costs justify an increase. We are now being asked to do the same thing for segments of our market. One big difference about an insurance company is that when a utility is put in that situation they are given a guaranteed market position; they are the only utility offering in a given geographical area, whereas that's not the case for insurance companies. We are still being asked to compete head to head with other companies in the same geographic areas, so that's a little bit different.

I do think you will potentially see the price

THE PEOPLE IN WASHINGTON ARE GOING TO BE FACED WITH A REAL DILEMMA IF THE NUMBERS REMAIN THIS LOW...

go up in the exchange if there is adverse selection because of the way the law requires us to price products now. Historically, insurance companies have priced products in the small group market and the individual market using two basic tenets that are driven by the same set of data. We in the industry have decades worth of historical cost information that tells us what it costs to deliver healthcare and what amount of healthcare people use at different stages of their life. In the same way that life insurance companies have huge amounts of data that tell them actuarially what the likelihood of death is at different times in people's life. We use that data to set our prices so the cost of the good or service is commensurate with the amount of risk and utilization that will be consumed by the person buying the product.

The government has now said we can't do that anymore. So in the past when we've priced products there was about a 1:5 ratio from the lowest cost products up to the most expensive products. The government told us we have to condense that to a 1:3 ratio. That meant costs for older people came down and costs for younger people went up. The percentage drop for the older people was much smaller than the percentage rise for the younger people. So that raised costs a lot.

They also started saying, "You have to price your products based on how we tell you to price them," not based upon decade's worth of information. That's a big element. And because of that skewed pricing that doesn't really correlate as directly with actual consumption of healthcare, it's created sticker shock in the marketplace. Young people are saying, "It doesn't look like there's value in that product for me because I know what I consume and it's not much, and the price I'm being asked to pay doesn't give me value for what I am being told I have to buy."

That could potentially implode the system. If they don't buy, then you are going to have just the older people buying at what are artificially lower numbers because the government has told us to lower the numbers and let the young people subsidize them. That means there is going to be a shortfall in the pool because consumption of healthcare will exceed the money coming in and that will just drive up costs at an accelerated pace and create what we call a death spiral on the exchanges.

Chief Editor: *Where does QualChoice fit in the Arkansas marketplace in terms of market share?*

Mike Stock: Blue Cross is the largest carrier in the state and they have been in the state longer than any other carrier. There are only two insurance companies that sell health insurance that are domiciled here in the state. Other companies do business here, but their corporate offices are not located in Arkansas. The Blues and QualChoice are the two domiciled companies. Our market share today is estimated to be 7 or 8 percent of the market, according to the best market information we have from culling information from national and state public sources. We've been in business here in the state for almost 20 years.

Chief Editor: *How does QualChoice compete then with a Blue Cross?*

Mike Stock: It's a challenge. We compete by trying to offer comparable products. Our benefit plans follow normal market trends and are very similar to their plans. Our provider network is the same as theirs–just as broad and just as extensive. We cover the whole state. So from that standpoint we look a lot like the Blues. Our pricing is very similar because in order to compete in the marketplace we have to do that. So where we try to differentiate ourselves and win and retain customers in being a smaller company, is we try to be much higher touch and very service oriented so our customers are very happy with their service here and don't want to leave what they have here with QualChoice. One of the things we do is we survey our insured population on an annual basis using an outside third party survey organization. NCQA accredits health plans and they have a standardized survey format that's called CAHPS and we send out that survey to our constituency on a sampling basis and we consistently rate very, very high in terms of satisfaction with service levels. I believe on the last survey nine out of ten of the people we insure today rated us as "satisfied" or "very satisfied" with the service levels we delivered. And nine out of ten members would recommend us to friends and family.

Chief Editor: *So is QualChoice NCQA accredited?*

Mike Stock: We are not NCQA accredited, but we use that survey format. As you know, to be on the insurance exchanges all health plans have to have accreditation by either NCQA or URAC. We are going through the URAC accreditation process right now.

> **They also started saying, "You have to price your products based on how we tell you to price them," not based upon decades' worth of information. That's a big element. And because of that skewed pricing that doesn't really correlate with actual consumption of healthcare it's created sticker shock in the marketplace.**

Chief Editor: *And you said your provider network was comparable to Blue Cross of Arkansas. Is there anything you do differently or any areas you are trying to improve on?*

Mike Stock: The providers we contract with are the same providers Blue Cross contracts with. We contract with every hospital in the state and we contract with any provider that requests to participate in our network, as long as they agree to our terms and conditions. I don't think there is any physician organization or group that we don't have in the state. I can't say we have 100% of all independent sole practitioners, but we have thousands and thousands of providers across the state.

Chief Editor: *Internally, just operationally, has the staffing model changed in the insurance industry over the past ten years?*

Mike Stock: I think the main thing that has changed from a staffing standpoint is you have probably seen some increase in staffing in the medical management area; there are some changes there in terms of our care management protocols. It used to be that insurance companies did a lot of utilization review where they were asking providers to get a "mother may I" if you will, for lots of services before we would pay for them. That has shifted somewhat. Over many years we have learned that it's a small percent of the insured population that drives a large percent of the cost. So we spend most of our efforts in care management now trying to identify potential high risk members before those events occur and reaching out to those people to work with them and intervene if they have some kind of chronic condition. We help them monitor and control that condition to the best of their ability, working with their primary care providers, to avoid blowups and catastrophic events that could lead to significant, acute events and high dollar costs.

So that's one shift in the staffing patterns, the other is operationally, I think you are seeing decreases in staffing levels as more and more things become automated and computer systems continue to improve with electronic transactions and so forth. That allows us to process things in a much more efficient, more timely manner without having people touch transactions as much as they used to. It's no different than what you see in the banking industry where years ago you used to always walk into a bank and deal with a teller and now everyone goes to an ATM. With us, many claims used to all be touched by the claims examiner and processed sitting at a terminal and now nearly 80% of all claims go through the system and auto-adjudicate and process electronically without ever being touched by a person.

Chief Editor: *What are some of the projects you are working on at QualChoice? What are you anticipating for the near future?*

Mike Stock: There are a couple of areas. One is we continue to look for ways to get more efficient administratively. That's an ongoing process. The other is we are pretty heavily involved in the Arkansas Payment Improvement Initiative and that involves two elements. One is developing an episodic payment model with providers in the state to pay for certain types of care on an episode basis where the payment model is being designed more to insure that we are paying for value rather than just volume.

The second thing in the Payment Improvement Initiative is we are working with providers in the state to stand up the patient centered medical home model. We participate along with other payers and with the State in what's called CPCI (Comprehensive Primary Care Initiative). That's a federally run demonstration model for developing primary care initiatives in both the commercial and Medicare markets.

We are also working with a couple of provider organizations in the state to develop patient centered medical home models and we are offering those products in the exchange. There are a couple of provider organizations in the state that have developed multi-specialty, clinically integrated delivery networks where primary care and specialty physicians and facilities can jointly come together in a contractual relationship to try and create more of an accountable care organization. They work collaboratively to closely monitor the patients and try to control their costs as much as possible. Down the road we will be offering those products in the commercial market off the exchange also. ■

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PHYSICIAN EMPLOYMENT A GROWING TREND IN ARKANSAS

By John Mitchell

WHY DO HOSPITALS WANT TO EMPLOY PHYSICIANS IF THEY SOMETIMES LOSE MONEY ON THE PRACTICE?

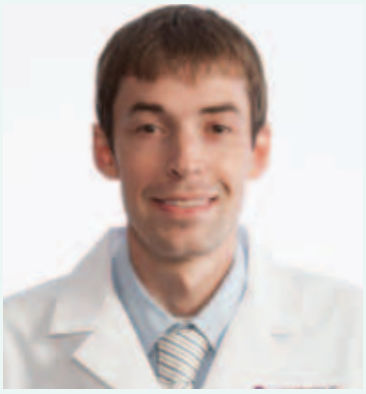
Predicting the future of healthcare is tricky, even for a think tank. But one trend on which all healthcare experts agree, including the Washington D.C.-based nonpartisan Center for Studying Health System Change (HSC) which interviews providers in twelve cities (including Little Rock) is that doctors are less and less likely to work in a private practice.

According to HSC, the "pace" of physician employment by hospitals is "quickening"–and the group is not alone in its conclusion. Becker's Hospital Review, a healthcare trade site notes that forty percent of primary care and twenty five percent of all specialists are now employed by hospitals and/or healthcare systems. This compares to twenty percent of primary care physicians and just five percent of specialists in 2000. Merritt-Hawkins , a physician recruiting firm, reports that in just the one year from 2012 to 2013 the number of hospital-employed physicians has increased by six percent. Paul Cunningham, Executive Vice President, with the Arkansas Hospital Association confirms the growing trend in the state.

"Our hospital members report an upward trend in physician employment, especially in the past eighteen to twenty-four months," Cunningham said. He attributes several reasons consistently echoed by hospitals and doctors. These include: concerns about the financial liability of maintaining a practice; lifestyle balance (doctors have typically worked sixty to eighty hours and are prone to burnout); and the changing nature of healthcare regulations. Newly graduated doctors are especially flocking into employment agreements with hospitals, large group practices, and even locums tenens (temporary assignments).

Married, board-certified pediatricians Robyn and James Wilkerson, MDs who began practice in the St. Vincent Family Clinic North Little Rock in October, are typical of this practice shift.

"Starting a practice is very daunting," Dr. James Wilkerson said. "You have to look at taking out a loan, consider real estate, an electronic medical records system–which is very expensive–all in a regulatory environment that is undergoing rapid change. It's not that we don't pay attention to the business side of the practice–that's important for us to be successful in our relationship with St. Vincent–but we are trained to



Married, board-certified pediatricians James and Robyn Wilkerson, MDs who began practice in the St. Vincent Family Clinic North Little Rock in October.

"It's not that we don't pay attention to the business side of the practice—that's important for us to be successful in our relationship with St. Vincent—but we are trained to practice medicine, not run a small business." *–James Wilkerson, MD*

practice medicine, not run a small business." Dr. Robyn Wilkerson reports that all of the seven residents in their class at the University of Arkansas are employed by hospitals or as locums tenens physicians.

"The fact is this (employment) is what physicians want, so we have to respond to that need," said Doug Weeks, Senior Vice President of Hospital Operations at Baptist Medical Center. Baptist employs primary care physicians and hospitalists, as well as its hospital-based anesthesia group.

"When our surgeons look to the head of the operating table, they want to see the consistency of a familiar face," Weeks added. He noted that anesthesia is a good example of a specialty where reimbursements have decreased in recent years making it more difficult to maintain a private practice structure.

David Foster, MD, President of the St. Vincent Medical Group, which employs 80 mainly primary care physicians, 15 mid-level physician extenders, and a separate 30-member cardiology group, said he hears a lot lately about practice financial stress.

"Physicians have long been entrepreneurial," Dr. Foster said. "But doctors are finding they need to align to meet practice and outcomes payment requirements. It was a tougher job to recruit doctors five years ago–you couldn't get a doctor to return your call. But in the last three years the phone is ringing off the hook."

While Dr. Foster said he is not sure if provisions under the Accountable Care Act (ACA) specifically are spooking doctors, there is a lot of chatter in the media and on physician websites that such is the case. Long time industry observers will attest that the last time medicine experienced this kind of uneasiness was with the Medicare rollout almost 50 years ago. In recent years changing standards related to patient satisfaction, human resource, quality outcomes, and especially electronic medical record expansion driven by the Centers for Medicare & Medicaid Services (CMS), is fundamentally changing how doctors now get reimbursed for their care. It is clear that the traditional fee-for-service payment model is dissipating as population management through Accountable Care Organizations emerges.

"I do a lot of curbside consulting with physicians in private practice, discussing different aspects of how they can make their practice more efficient. We offer contract services through our Management Service Organization to provide expertise in areas such as managing staff, payroll, benefits, and

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"We can provide as many individual pieces of practice management that a physician needs without that doctor being employed. It's a good way for the physician and the St. Vincent System to get to know each other."

—David Foster, MD

information technology (electronic medical records). We can provide as many individual pieces of practice management that a physician needs without that doctor being employed. It's a good way for the physician and the St. Vincent System to get to know each other," Dr. Foster said.

Jim Lambert, FACHE who is President and CEO at the 154-bed Conway Regional Medical Center, also takes a balanced approach in employing physicians.

"About 10 percent or so of our active medical staff is employed," Lambert reports. "It's mostly primary care doctors in our outreach clinics, but we do employ a CV (heart) surgeon because otherwise we would not be able to offer open heart surgery in our community. However, it's not my goal to employ every physician in the market."

Doug Weeks with Baptist echoes this sentiment.

"We have physicians on our medical staff who are in private practice and they wouldn't have it any other way. But as some get closer to retirement, the same scenarios that prompt younger doctors to seek employment, such as life style balance and finances, start to look like a good option," said Weeks.

All three hospitals interviewed also assist private medical practices to recruit needed new doctors into the community. As Lambert with Conway Regional notes, this is still the preferred method of adding needed physicians into the community. In order to provide this assistance to a private practice, which can include income shortfall support and start-up expenses, a hospital must demonstrate a community need for the physician's specialty with a formalized net need data study.

TOP: David Foster, MD, President of the St. Vincent Medical Group.
BOTTOM: Doug Weeks, Senior Vice President of Hospital Operations at Baptist Medical Center.

"Usually private practices will stretch up to 120% of capacity before bringing a new doctor on board," Dr. Foster said. "That way, when the physician begins, they already have a practice base to start generating revenue to cover their overhead."

Under this scenario a newly recruited physician can begin covering their start-up expenses, including salary, within six to twelve months. Such is not always the case for hospital-employed physicians, however, who in some cases never completely cover their practice overhead expenses. This reality begs a question hotly debated by such leading healthcare public policy advisors as Scott Gottlieb, MD, Resident Physician Advisor at the American Enterprise Institute; why do hospitals want to employ physicians if they sometimes lose money on the practice?

There are many opinions, ranging from the conspiratorial (it's easier to control doctors in large groups rather than in small practices) to the entrepreneurial (hospitals are attempting to drive market share to their facility by controlling referrals). But both of these theories may give too much credit to the ability of government and hospitals to control physicians, who are trained as scientists to use independent judgment.

"Hospitals have not always done a great job of managing employed doctors," Conway CEO Lambert offered, voicing a truth to which any experienced hospital administrator will agree. "But we're getting better." He notes, for example, that hospitals have learned to lower overhead charge backs to physician practices that it was in the habit of assessing equally across in-house hospital departments.

Dr. Foster echoes this sentiment. "Physician productivity is still evolving. We have a pay for performance system in which our employed colleagues earn base rate and can earn more if they increase the number of patients they see. But part of their income is also keyed on quality outcomes and

"We have physicians on our medical staff who are in private practice and they wouldn't have it any other way. But as some get closer to retirement, the same scenarios that prompt younger doctors to seek employment, such as life style balance and finances, start to look like a good option."

–Doug Weeks

patient satisfaction, so it requires our physician staff to develop a triple focus, which we think improves care." Dr. Foster also said St. Vincent's medical practices are shifting towards a Relative Value System (RVU) that has long been used in private practice to track physician patient work.

"There is no question that the risk of practices is shifting more to healthcare systems as we employee and contract doctors. So that means hospitals have to make the best of it and improve operations and minimize those risks–just like we've always done," said Weeks with Baptist. He added that physicians are high achievers who will work towards the metrics for which they receive quality, safety performance, and patient satisfaction pay, which is part of an at-risk compensation model.

Physician employment is not a trend limited to Little Rock. In the northeast corner of the state St. Bernard Healthcare, which has been named one of Arkansas' "Best Places to Work for 2013" by *Arkansas Business*, employs nearly 100 physicians. St. Bernard's is currently seeking to recruit a neurosurgeon, gastroenterologist, and internal medicine specialists, according to John Lieblong, Vice President of Physician Services.

Perhaps the biggest under-cited benefit for administrators and physicians to be employed by hospitals is that it aligns quality and outcomes interests. Historically, medical staff in private practice did not always necessarily share a hospital's challenges and problems. If the federal government, for example, enacted a quality measure that all patients over the age of 65 should receive the pneumonia vaccine and a physician in private practice disagreed with that measure, they could ignore its implementation. It is the hospital that is noncompliant and not the physician. However, if that doctor is employed by the hospital, the new measure becomes a shared goal. Dr. Foster at St. Vincent described this transition this way.

"Traditionally we (physicians) have been physician or care setting-centric. By aligning providers (hospitals and doctors) we make the possibility of being patient-centric more of a reality. Independent providers tend to produce independent results. By aligning these same providers we increase our capacity of performing coordinated, team-based care."

Weeks, of Baptist, takes an even broader perspective on physician employment, including overall collaboration.

"In the past few years we're working differently with all physicians–regardless of whether they are aligned through employment, a management services agreement or on staff in private practice." He cited illegible handwriting as an example.

"We're all more aware of the data that is being collected on quality and safety related to illegible handwriting. It's subject to peer review, it can no longer be ignored. Doctors and hospitals have become very active and alignment is much better to improve care."

All the hospital officials interviewed agree that the trend towards physician employment in Little Rock and Arkansas will continue. ■

Telemedicine Extends Reach Across Arkansas

RURAL DOESN'T HAVE TO MEAN remo

By *Kelly Taber*

After a year and a half of working at the Eudora Health Clinic in Chicot County, Dr. Brian Hoang found himself wondering about an underutilized telemedicine station at the clinic.

"Why is this thing here? Why are we not doing anything with it?" Hoang said.

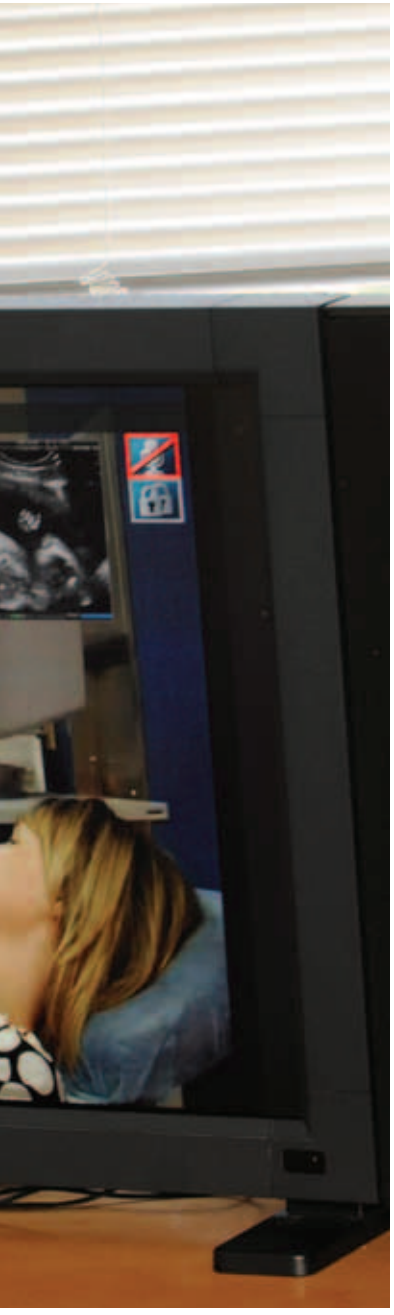

te

Curtis Lowery, MD, Chair of Dept. of Obstetrics & Gynecology at UAMS College of Medicine, demonstrates telehealth technology.

Telemedicine, more broadly called telehealth, is the use of electronic information and telecommunications to provide health at a distance. It can be performed in a variety of ways – everything from a primary care clinic consulting with a specialist on a video call to a diabetic recording blood sugar readings from home to an emergency room sending patient charts within seconds to a surgeon hundreds of miles away.

In 2010, University of Arkansas for Medical Science (UAMS) received a three-year $102 million federal stimulus grant for broadband equipment and installation in more than 450 institutions across the state, making Arkansas the most wired state in the nation for telehealth, second only to Alaska.

Now that the network has been established, it's time for every institution to implement telehealth into daily business practices and participate as a consortium of providers, said Tina Benton, oversight director of the UAMS Center for Distance Health. UAMS has well-established telehealth programs for stroke patients, infant and maternal health, as well as continuing education, administrative solutions, and research.



“I think it’s about everybody using it. Everybody in the state that has the technology to assess how this technology can improve their efficiency to deliver services. You have to develop different workflows; that’s part of using any kind of technology.”

– Tina Benton

“I think it’s about everybody using it. Everybody in the state that has the technology to assess how this technology can improve their efficiency to deliver services. You have to develop different workflows; that’s part of using any kind of technology,” Benton said.

Michael Manley, director of AR SAVES within the Center for Distance Health, said the Center receives calls weekly about training from people around the state and across the country. Manley said that telehealth is one way to improve care with limited resources. For example, he said telehealth allows four neurologists serving Arkansas to cover 43 emergency rooms if a stroke patient arrives in need of care.

“This is part of how we are going to be able to take care of so many patients with so few resources. We’ve got to be smarter about it and this gives us the resources to do it,” Manley said.

Benton and Manley said telehealth in the event of trauma for emergency room patients will continue to be one of the fastest growing uses of the new technology.

Using the Arkansas eLink network, if someone needs to be flown from their local emergency room to a larger hospital for surgery, “the receiving hospital can already make a plan of care before you get there that can be lifesaving in very bad trauma,” Benton said.

One of the biggest challenges is expanding telehealth from the academic and public sphere into the private sector. Private insurance does not currently cover telemedicine consultations, said Dr. Randy Minton, interventional cardiologist at Arkansas cardiology, a department of Baptist Health.

Currently telemedicine appointments are covered by Medicaid and Medicare;

> **"If they can't come now because it's two hours away, then they may come two weeks later in an ambulance or by helicopter as a much more critical patient."** – Randy Minton, MD

however Dr. Minton said that he predicts private insurers will adapt, especially as more patients complain about unnecessary driving to follow-up visits that could be taken care of closer to home through the use of telemedicine.

Dr. Minton is now starting to work with his colleague Dr. Hoang in Eudora. He stressed that telehealth is not only a matter of efficiency requiring less time and less driving. Most importantly, it improves access to under-served areas of the state.

"If they can't get treated, they can't get better," Minton said. The goal is to "keep them out of the hospital and obviously not have them suffer a heart attack."

"If they can't come now because it's two hours away, then they may come two weeks later in an ambulance or by helicopter as a much more critical patient."

Dr. Hoang agreed that telehealth has great potential for his rural patients. Using a stethoscope with a Bluetooth connection, a patient in Eudora can receive a diagnostic test from Dr. Minton in Little Rock without having to travel.

"Most of the patients here very seldom get out of Eudora much less go all the way to Little Rock," Hoang said. "A lot of times they have family members who are chronically ill and they have to make arrangements for someone to be at home when they leave."

Hoang said he sees great potential for increased patient education through telehealth.

"If they were able to utilize that to speak to the cardiologist with telemedicine it would be more accessible to speak to the cardiologist about therapy or lifestyle modifications that need to change," Hoang said. "Using the telemedicine and seeing Dr. Minton through there on a routine basis ... [for someone with chronic hypertension] it would definitely improve overall treatment outcomes and compliance."

Telemedicine not only connects patients between distant doctor's offices and hospitals. It also connects patients at home to their health provider.

Benton, who also directs ANGELS at UAMS, said this is especially effective for post-partum care. ANGELS (Antenatal and Neonatal Guidelines, Education, and Learning System) provides services including telemedicine conferences between primary care physicians and maternal-fetal specialists and high-risk pregnancy ultrasound readings.

For example, women with high blood pressure during pregnancy may still need to be monitored following delivery; yet they don't want the extra expense and discomfort of an extended hospital stay.

"When the patients are discharged home, you can still watch how they're doing physiologically so that they don't get readmitted back so that they stay healthier," Benton said.

Patients are sent home with a tablet, similar to an iPad, with a Bluetooth capable blood pressure cuff that hooks into the tablet. The tablet is configured to the eLink system, which is fully HIPAA compliant. Measurements are sent to a call center to make sure that the readings stay within a healthy range. A similar system is available for pregnant diabetic patients. Readings are taken throughout the day to make sure blood sugar does not spike too high for the safety of the fetus and mother.

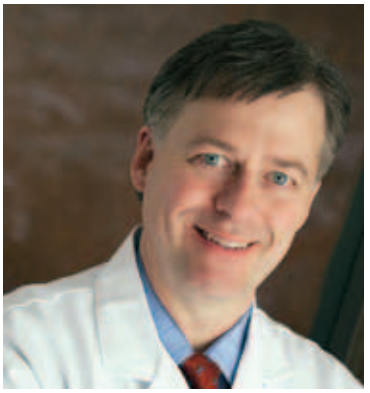
Telehealth not only helps to heal bodies, but hearts too – and not in the cardiac sense of the word.

Emry Walker was born weighing just one pound-three ounces at UAMS when her mother, Holly, was 20-weeks pregnant. Holly, Jeff, and sister Alli Walker spent many hours at the hospital during Emry's 88-day hospital stay. With the use of telemedicine equipment, called the Angel Eye camera, they also were able to watch Emry in NICU from their home.

The Angel Eye camera helped Holly cope with the stress of having her newborn daughter struggling for life in the hospital when she was at home. During those weeks, she slept with her laptop by her bed. "All I'd do at night if I woke up I'd click on it and check and a lot of times the nurses would leave us a little note saying how she was doing," Holly said in an interview with KATV in Little Rock.

Emry is now a healthy two-year-old. Holly and Jeff nicknamed her their "little hummingbird" when doctors began to feed her sugar water in the hospital. They were so relieved by her recovery that they created The Hummingbird Foundation to help other families during harrowing hospital stays.

The Walkers created a Facebook page and a blog dedicated to Emry and their foundation: http://thehummingbirdfoundation.blogspot.com. This year, the foundation raised enough money to donate another Angel Eye camera to UAMS hospital. ■



Randy Minton, MD

Michael Manley

"This is part of how we are going to be able to take care of so many patients with so few resources. We've got to be smarter about it and this gives us the resources to do it."

– Michael Manley

Little Rock Surgeon Operates on Orangutan

By Cindy Hicks

Monkey Business

IN THE OPERATING ROOM

It isn't unusual for Eric Paul, MD to be called in to assist with a surgery, but he never imagined that he would someday be summoned for an operation at the Little Rock Zoo.

Chiquita feeling much better after surgery.

That is exactly what happened in mid-November when Dr. Paul performed a difficult procedure on a 44-year-old female orangutan named Chiquita. Dr. Paul, a general surgeon who specializes in minimally invasive laparoscopic bariatric surgery, couldn't have been more surprised.

"When I graduated from medical school, I never imagined I would ever perform surgery on an orangutan," said Dr. Paul. "I admit I was jealous when I heard that another surgeon was getting ready to operate on her."

Zoo staff had noticed that Chiquita's abdominal area was swollen. Since she had an ovarian cyst that was previously drained, Dr. Kim Rainwater, the zoo veterinarian, was concerned that the cyst had returned. Rather than drain the mass once again, Dr. Rainwater sought a more permanent solution by removing it, but first she had to find the right surgeon. That's because healing from surgery can be especially hard for animals like Chiquita as they will pick at surgical incisions which can lead to infection and further complications.

"Dr. Rainwater felt that Chiquita would benefit from laparoscopic surgery due to the ease with which patients can return to their normal activities," said Dr. Paul.

Unlike conventional surgery, laparoscopic surgery leaves minimal incisions for a curious orangutan to pick apart. Dr. Rainwater first called Dr. Kevin Forte, the radiologist who helped diagnose the mass in Chiquita, to ask for a recommendation of a surgeon to assist with the surgery. He led her to Dr. Julia Watkins with the West Little Rock Women's Center who then recommended Dr. Brian Burton, a physician that specializes in laparoscopic gynecological surgery.

"Dr. Burton was originally called to deal with the cyst problem involving her ovaries," said Dr. Paul. "He called me during the surgery when he found that she didn't have a cyst, but a large incarcerated umbilical hernia instead," said Dr. Paul.

When Dr. Paul arrived, Dr. Burton had already established a pneumoperitoneum, which is an essential component for laparoscopic procedures. Dr. Paul proceeded to correct the small defect that was present in the patient's midline, likely from birth, using multiple sutures. He says while the condition

Left to right, Eric Paul, MD; Julia Watkins, MDS, OB/GYN; Brian Burton, MDS, OB/GYN.

THE HERNIA WAS UNDOUBTEDLY CAUSING HER CONSIDERABLE PAIN.

"He called me during the surgery when he found that she didn't have a cyst, but a large incarcerated umbilical hernia instead."

wasn't life threatening, the surgery definitely improved the quality of Chiquita's life.

"The hernia was undoubtedly causing her considerable pain," said Dr. Paul.

While it may seem strange to call medical doctors, who normally see human patients, to work on a zoo animal, Dr. Paul says their anatomy is very similar to humans. One of the biggest differences between operating on Chiquita and a human was the hard work it took to get her to the operating room. Zoo officials say the orangutan had to be sedated first, then the team had to work fast to get IV access and get her intubated before the sedation started to wear off.

The surgery prep was also different because she has long hair all over her body and her pelvis is much smaller than that of a human. Another obvious difference is her arms. They are longer than a human's so instead of putting her long arms at her sides, they were laid on top of her legs.

The entire operation was definitely a team effort, involving the expertise of:

• Operating Room Nurses, Pam Wood, Holly Carmen, Monica Smith, and John Morris

• Anesthesiologists: Harjot Hunjan and Lydia Hunjan, MDSs with Baptist Health

• Stryker Endoscopy: Ryan Harvey and Craig Carey

• General Surgeon: Eric Paul, MD with Surgical Clinic Arkansas

• Brian Burton, MDS, OB/GYN with The Woman's Clinic, PA

• Julia Watkins, MDS, OB/GYN with Little Rock Women's

• Kimberly Rainwater, DVM, with the Little Rock Zoo

• Ashley Davenport, Veterinary Technician with the Little Rock Zoo

• Keepers with the Little Rock Zoo: Ann Rademacher, Catherine Hopkins, Daphne Brock Pfeifer

• Marci Polett, Zoo Intern

• Sydney Tanner, Curator of Primates

• Addie Olson, DVM, with Interstate Animal Clinic and After Hours Animal Hospital.

Her keepers report that Chiquita was soon eating normally and was back outside enjoying the outdoors. Zoo staff says that Chiquita's quick recovery time can be credited not only to the use of minimally invasive surgery, but the properly-dosed anesthesia given by Drs. Harjot and Lydia Hunjan.

"She did great, and was reintroduced to her enclosure within the day," said Dr. Paul. "I want to go back to see Chiquita and take my children with me." He added that he wouldn't hesitate to do this type of work again.

"I felt honored to be a part of this, and was grateful that something that I trained to do was able to help our city in an unexpected way," said Dr. Paul.

Dr. Paul spent his residency at University of Oklahoma from 2004 to 2009 and his fellowship at Emory University in Atlanta from 2009 to 2010, before going to work at the Surgical Clinic of Central Arkansas.

Chiquita has lived at the Little Rock Zoo since 2006. She was born in 1969 at the Toledo Zoo and also lived at the Cleveland Metroparks Zoo. She shares a habitat with Rok, a 28-year-old male orangutan who has lived at the zoo since 1988. ■

HEALTHCARE briefs

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STATE

Arkansas Wins Text4baby Contest

Arkansas has been named the winner of the 2013 Text4baby State Enrollment Contest in the medium state category. Between May 12 and Oct. 21, 2013, 1,938 Arkansans enrolled in the free service that provides critical health and safety information related to pregnancy and babies up to one year of age.

Winners were determined based on new participants who enrolled in the service during the contest period as a percentage of eligible moms. States and territories were separated into three categories—large, medium, and small—based on their estimated number of new pregnancies and new infants. The Arkansas Department of Health (ADH), in conjunction with community partners and organizations across the state, promoted Text4baby through innovative media campaigns featuring media tours, billboards, and social media. In addition, local African American sororities in the ADH's Sisters United program promoted the text4baby service through grassroots efforts such as awareness events for local women, including baby showers, vigils, and community events.

Although the 2013 Text4baby State Enrollment Contest is over, anyone who would like to receive health tips and advice about pregnancy and newborns is encouraged to enroll in the free Text4baby service. Arkansas citizens may sign up by texting BABY (or BEBE for Spanish) to 511411 to receive three free text messages a week, timed to the baby's due date or the baby's birth date, through pregnancy and up until the baby's first birthday. The messages address topics such as labor signs and symptoms, prenatal care, urgent alerts, development milestones, immunizations, nutrition, birth defect prevention, safe sleep, safety, and more.

Text4baby is supported and promoted by a public-private partnership of over 1,000 health departments, academic institutions, health plans, businesses, and the federal government. Text4baby is the largest national mobile health initiative reaching over 555,000 moms since launch in 2010.

Arkansas to Receive Share of CVS Caremark Settlement

Caremark LLC, a pharmacy benefit management company (PBM), will pay the government and five states a total of $4.25 million to settle allegations that it knowingly failed to reimburse Medicaid for prescription drug costs paid on behalf of Medicaid beneficiaries, who also were eligible for drug benefits under Caremark-administered private health plans. Caremark is operated by CVS Caremark Corp., one of the largest PBMs and retail pharmacies in the country. A PBM administers and manages the drug benefits for clients who offer drug benefits under a health insurance plan.

Under the terms of the agreement, the government will receive approximately $2.31 million. In addition, five states—Arkansas, California, Delaware, Louisiana, and Massachusetts—will share $1.94 million.

"It is vitally important that cash-strapped Medicaid programs receive reimbursement for costs they incur that should have been paid for by other insurers," said Assistant Attorney General for the Justice Department's Civil Division Stuart F. Delery. "We will take action against those who seek to gain at the expense of Medicaid or other federal health care programs."

Caremark served as the PBM for private health plans that insured a number of individuals receiving prescription drug benefits under both a Caremark-administered plan and Medicaid. When an individual is covered by both Medicaid and a private health plan, the individual is called a "dual eligible." Under the law, the private insurer, rather than the government, must assume the costs of healthcare for dual eligibles. If Medicaid erroneously pays for the prescription claim of a dual eligible, Medicaid is entitled to seek reimbursement from the private insurer or its PBM, in this case Caremark.

According to the government, Caremark allegedly used a computer claims processing platform called "Quantum Leap" to cancel claims for reimbursement submitted by Medicaid for dual eligibles. The government alleged that Caremark's actions caused Medicaid to incur prescription

drug costs for dual eligibles that should have been paid for by the Caremark-administered private health plans rather than Medicaid.

The allegations arose from a lawsuit filed by Janaki Ramadoss, a former Caremark quality assurance representative, under the qui tam, or whistleblower, provisions of the False Claims Act. Under the Act, private citizens can bring suit on behalf of the government for false claims and share in any recovery. The Act also allows the government to intervene in the lawsuit, as it has done in this case. Ramadoss will receive approximately $505,680 from the federal government's share of the settlement. Ramadoss also will receive additional amounts from the settling states.

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation.

This case was jointly litigated by the U.S. Attorney's Office for the Western District of Texas; the Justice Department's Civil Division, Commercial Litigation Branch; and the attorneys general for the states of Arkansas, California, and Louisiana. The case is captioned *United States ex rel. Ramadoss v. CVS Caremark Inc.,* SA-12-CA-929WRF (W.D. Texas). The claims settled by this agreement are allegations only; there has been no determination of liability.

BreastCare Screening and Diagnostic to Continue

The Arkansas Department of Health (ADH) issued assurances that the ADH BreastCare program will continue to provide breast and cervical cancer screening and diagnostic services. Confusion surrounding the program stems from the fact that the Breast and Cervical Cancer Treatment Category 07 Medicaid program ended December 31, 2013. This is not the ADH BreastCare program.

According to Dr. Namvar Zohoori, Director of the Center for Health Advancement and Chronic Disease Branch at ADH, BreastCare will continue to serve eligible women across Arkansas by providing mammograms, Pap tests, and diagnostic procedures. Even though the implementation of the Affordable Care Act in January 2014 increases access to breast and cervical cancer screening services for many women, there will still be a need to serve the thousands of Arkansas women who will remain eligible for BreastCare.

Since 1999, BreastCare has provided services to thousands of women who may not have otherwise received services. Last year alone, BreastCare served 13,355 women. In addition to providing screening and diagnostic services, BreastCare will expand its focus in education and outreach efforts to increase cancer screening rates for all women regardless of their insurance status. Regular screening is an important factor in the early detection of breast and cervical cancer and BreastCare will continue to encourage women to make regular screenings a part of their health care.

For more information on BreastCare, visit www.arbreastcare.com or visit the Arkansas BreastCare Facebook page at www.facebook.com/BreastCareArkansas.

AOMA Endorses LAMMICO

The Arkansas Osteopathic Medical Association (AOMA) recently announced their endorsement of LAMMICO as their recommended medical professional liability insurance carrier. This affiliation was officially acknowledged in a formal letter from AOMA Executive Director, Frazier Edwards, in which he states, "We selected LAMMICO due to their strong commitment to our members and to our healthcare community...They consistently provide excellent customer service and excellent claims management through their network of superior defense attorneys. LAMMICO is committed to working closely with us..." LAMMICO is an A-rated insurance carrier by A.M. Best.

LAMMICO has served the Arkansas medical community since 2007. "A clear endorsement from Frazier Edwards of the AOMA solidifies our service to this emerging market. Through our growing affiliation with AOMA, LAMMICO will strengthen our products and services to better meet the unique needs of the Arkansas healthcare community," said Eric Mason, LAMMICO Marketing Director.

Get Smart About Antibiotics

In November, the Arkansas Department of Health (ADH), the Arkansas Chapter of the American College of Clinical Pharmacy, the Arkansas Foundation for Medical Care, Arkansas Medicaid, and the Arkansas Hospital Association partnered with the Centers for Disease Control and Prevention (CDC) to promote Get Smart About Antibiotics Week 2013.

Get Smart About Antibiotics Week, Nov. 18-24, 2013, brings attention to antibiotic resistance and the importance of appropriate antibiotic use. According to the CDC, the number of bacteria resistant to antibiotics has increased in the last decade. Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and at least 23,000 people die each year as a direct result of these infections.

Repeated and improper uses of antibiotics are primary causes of the increase in drug-resistant bacteria. Misuse of antibiotics jeopardizes the usefulness of essential drugs. Children are of particular concern because they have the highest rate of antibiotic use due to common childhood infections.

"When used correctly, antibiotics are very effective and in many cases, life-saving," said Dr. Gary Wheeler, Branch Chief of Infectious Disease at ADH. "However, if we overuse or misuse antibiotics, we reduce the likelihood that those life-saving medicines will work when we need them the most."

Upper respiratory infections, which are often caused by viruses, account for three quarters of all antibiotics prescribed by office-based physicians. Research suggests that antibiotics were prescribed in 68 percent of acute respiratory tract visits, and of those, 80 percent were unnecessary according to CDC guidelines. Furthermore, data suggests that for all ages combined, more than ten million courses of antibiotics are prescribed each year for viral conditions that do not benefit from antibiotics.

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Brooke Bumpers

Sharon Heflin

ADH and the Arkansas College of Clinical Pharmacy at the University of Arkansas for Medical Sciences also recently sponsored Arkansas's first Antimicrobial Stewardship Conference. The conference brought together healthcare providers and administrators to discuss the importance of developing antimicrobial stewardship programs at healthcare facilities and a statewide antimicrobial stewardship collaborative. Antimicrobial stewardship programs seek to optimize antibiotic prescribing to improve individual patient care and reduce the threat of antimicrobial resistance, as well as reduce the risk of healthcare-associated infections. Also of note, Arkansas's Medicaid program has spearheaded an effort to reduce the unnecessary use of antibiotics for upper respiratory infections with one of its episodes of care projects.

The 2013 observance also marks the fourth year of an international collaboration, which coincided with European Antibiotic Awareness Day, Australia's Antibiotic Awareness Week, and Canada's Antibiotic Awareness Week.

For more information on how patients and healthcare providers can help reduce antibiotic resistance visit www.cdc.gov/getsmart.

Arkansas Hospice and Foundation Elect Board

Arkansas Hospice and Arkansas Hospice Foundation have elected new members to their Boards of Directors for 2014.

Arkansas Hospice Board leadership includes:

- Brooke Bumpers, chair
- Sheila Campbell, chair-elect
- Tim Osterholm, vice chair
- Frank Funk, treasurer
- Donna Baas, secretary
- Ted Gammill, chair emeritus

Other Hospice Board members include: Christopher Cooper, Sharon Davis, Dr. Margarita Garcia, Dr. Mariann Harrington, Sharon Heflin, Stephen Lancaster, John Lile, Diane Mackey, Don Munro, Mike Miller, Dr. David Reding, Doug Wasson, JoAnne Wilson, and Rebecca Winburn.

Arkansas Hospice Foundation Board leadership includes:

- Sharon Heflin, chair
- Kenniann Summerell, chair-elect
- Vivian Trickey Smith, vice chair
- Lindsey Baker, treasurer
- Rob Anderson, secretary
- Walker Sloan, chair emeritus

Other Foundation Board members include: Sharon Aureli, Brooke Bumpers, Greg Hale, James Herden, Carol Lord, Debbie Scrivner, Anne Tedford, Mary Thomas, Judy Waller, and Jessica Worman. Honorary Board members are Gail Arnold and Bishop Kenneth Hicks.

Healthcare Workers Arrested

Attorney General Dustin McDaniel announced that healthcare workers in Baxter County and Crittenden County were arrested following separate investigations by the Attorney General's Medicaid Fraud Control Unit.

Courtney Lynn Goodwin, 23, of Mountain Home was accused of obtaining a controlled substance by fraud, a Class D felony. Goodwin, a licensed practical nurse, is accused of stealing pain medication that had been prescribed to residents at the long-term care facility where she had been employed.

In a separate case, Elaina Brewer, 34, of Marion was arrested for Medicaid Fraud, a Class C felony. Brewer is accused of billing the Arkansas Medicaid Program for attendant-care services that she did not provide.

Goodwin was released from the Baxter County Detention Center on $5,000 bond. Brewer was released from the Crittenden County Detention Center on $2,500 bond.

Goodwin was employed as a nurse supervisor for Pine Lane Therapy and Living Center in Mountain Home. Following an internal investigation and an investigation by the Attorney General's Medicaid Fraud Control Unit, Goodwin was accused of taking for her personal use three hydrocodone/acetaminophen pills that had been prescribed to three residents. Goodwin is no longer employed at the center.

Brewer was contracted by Crittenden Adult Care Services to provide personal assistance to Medicaid beneficiaries who need help with their daily needs. Brewer submitted billing claims to Medicaid stating she had performed personal care services for a specific Medicaid beneficiary from Dec. 31, 2012, to March 8, 2013. However, that beneficiary told investigators that Brewer did not provide services on many of the days for which Medicaid was billed. Brewer is accused of defrauding the state's Medicaid Program of $1,843.60.

Charges are merely accusations, and a defendant is presumed innocent unless and until proven guilty. To report Medicaid fraud or abuse and neglect in nursing homes, call the Medicaid Fraud Control Unit's tip line, (866) 810-0016.

Riley Installed As NCPA President

Dr. Mark Riley, Executive Vice President and CEO of the Arkansas Pharmacists Association (APA), has been elected President of the Board of the National Community Pharmacists Association. Dr. Riley was installed during the NCPA 115th Annual Convention and Trade Exposition in Orlando. NCPA is a national association that represents

Dr. Mark Riley

the interests of America›s community pharmacists, including the owners of more than 23,000 independent community pharmacies, pharmacy franchises, and chains.

Dr. Riley is the chief spokesman and advocate for pharmacy in Arkansas, representing pharmacy practice to the State Board of Pharmacy, state legislators, Arkansas Medicaid, and other state government agencies. He is a nationally renowned expert on Pharmacy Benefit Managers and has served on various committees and on the NCPA Board since 1979.

Dr. Riley joined APA as Executive Vice President in 2003. He has owned East End Pharmacy in Little Rock since 1983 and served as pharmacist-in-charge until 2003. From 1993 to 2003 Dr. Riley was director of provider relations for National Medical Health Card (formerly Pharmacy Associates, Inc.), and from 1971 to 1983 he served as manager/pharmacist at Landmark Pharmacy, both in Little Rock.

Dr. Riley's professional affiliations include: faculty preceptor and guest lecturer, University of Arkansas for Medical Sciences (UAMS) College of Pharmacy; member, Arkansas State Board of Pharmacy 1999-2003; and member of the Dean's Council, UAMS. Dr. Riley served on the Board of Directors and was President of APA in 1984-1985. He was awarded APA "Pharmacist of the Year" in 1988.

He is currently a participant in health and career education at local schools and served as president, baseball commissioner, and on the Board of Commissioners for the East End Community Association.

Medical students honor and express their gratitude for the lives of the bodies they examined during training.

LOCAL

Medical Students Remember Lives of Donors

At an emotional "Ceremony of Gratitude and Reflection" members of the UAMS College of Medicine freshman class expressed deep gratitude for the lives of the bodies they examined during their training. For the class, dissecting bodies donated through the UAMS Anatomical Gift Program is the first time they have had an emotional connection with their education. To express their gratitude, class members conduct a ceremony to honor the donors through art, words, and acts of service toward the donors and their families.

This year's ceremony included music from College of Medicine student and violinist Darby Bedell, a rose presentation in remembrance of the lives, and remarks from faculty, staff, and students. As a new tradition, the class created works of art to represent their course experience, which will be displayed in the College of Medicine's gross anatomy lab.

Micah Hester, PhD, division chief of the UAMS Division of Medical Humanities; Linda Murphy, a freshman student; and Susan McDougal, UAMS Medical Center staff chaplain, offered words of reflection during the ceremony held in the Fred W. Smith Auditorium of the Jackson T. Stephens Spine & Neurosciences Institute.

"The lives of these people became your teachers in their death, and granted you the knowledge of the workings of the human body so that through your hands may come healing," McDougal said. "Their life and their death then are not without meaning."

UAMS-Developed Foot Therapy Cream Goes Retail

Omnibalm Daily Foot Therapy, a cream for general and diabetic foot care developed by Bill Gurley, PhD, a College of Pharmacy pharmaceutical sciences professor at the University of Arkansas for Medical Sciences (UAMS), is now available in 121 Walmart stores across seven states.

Omnibalm Daily Foot Therapy is a non-greasy formula that softens and helps repair dry, cracked skin and keeps feet healthy and shoes smelling fresh. It is marketed by Balm Innovations LLC, a UAMS BioVentures startup company licensed to take UAMS inventions from laboratories to the marketplace.

Omnibalm can be found in the diabetic sections of many Walmart Supercenters, Neighborhood Markets, and Discount Stores in Arkansas,

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Kansas, Mississippi, Missouri, Oklahoma, Tennessee, and Texas.

Gurley's inspiration for the cream came as the result of his own severe sunburn 27 years ago. His research led him to tea tree oil, which comes from Australia's Melaleuca tree and has a long history as an effective treatment for many skin maladies.

"If you dig through the medical literature, tea tree oil has a lot of unique medicinal properties," Gurley said. "It has natural anti-bacterial and anti-fungal properties. And it also acts as a skin permeation enhancer, which allows skin cells to absorb it more quickly."

Lydia Carson, president and CEO of Balm Innovations, learned of the cream while enrolled in the University of Arkansas at Little Rock's Executive MBA program. Her own experience with the cream and the testimonials of others convinced her that it was a good business opportunity.

As a UAMS BioVentures startup company, Balm Innovations has a license to market the cream, while a percentage of profits go back to UAMS and the inventor. Omnibalm is undergoing a clinical trial for use in preventing recurrent diabetic foot ulcers. More information can be found at Omnibalm.com.

Pulaski County Woman Arrested for Medicaid Fraud

A Pulaski County woman accused of defrauding the Arkansas Medicaid program of more than $92,000 was arrested for felony Medicaid fraud in December. Frenchelle Chapple, 61, of Little Rock was arrested following an investigation by the Attorney General's Medicaid Fraud Control Unit. She was released from the Pulaski County Detention Center on $2,500 bond.

Chapple, also known as Frenchelle Conley, operates Great Expectations Developmental Center in Little Rock. According to investigators, Great Expectations Developmental Center filed 1,063 fraudulent claims for speech pathology services allegedly provided to Medicaid beneficiaries under age 21. The total amount fraudulently billed was $92,606.97.

"We expect to prove in court that this company falsely billed Medicaid by claiming it had provided speech therapy to children and youth when, in fact, money was being taken illegally from taxpayers for the personal benefit of the company's owner," Attorney General Dustin McDaniel said. "We will continue to work diligently to investigate instances of Medicaid fraud across the state."

Investigators found that Great Expectations submitted claims to Medicaid for payment for speech-therapy services allegedly provided by three speech pathologists over several months in 2012 and 2013. All three individuals, who had previously worked for Great Expectations, told investigators that they did not provide speech therapy to any Medicaid beneficiaries during that time period nor did they authorize the company to bill Medicaid on their behalf.

Money received from the false claims was deposited into a bank account controlled by Chapple and used for purchases of gas, groceries, fast food, and clothing, according to investigators.

Charges are merely accusations and a defendant is presumed innocent unless and until proven guilty. To report Medicaid fraud or abuse or neglect in nursing homes, call the Attorney General's Medicaid Fraud hotline, (866) 810-0016.

UAMS, ADH Study Links to Stroke Risk

The neighborhood where you live is a risk factor for stroke, says a multi-year study led by Appathurai Balamurugan, MD, MPH, of the University of Arkansas for Medical Sciences (UAMS), and Arkansas Department of Health.

The study, published in the October issue of the journal *Circulation: Cardiovascular Quality and Outcomes*, was conducted by researchers at the UAMS Fay W. Boozman College of Public Health, UAMS College of Medicine and the Arkansas Department of Health. It assessed the neighborhood factors associated with the risk of dying due to stroke by looking at the smallest geographical unit possible — census block groups.

"The study identifies neighborhoods in Arkansas with high rates of death due to stroke and assesses the localized distribution of risk factors," said Bob Delongchamp, PhD, a professor in the Department of Epidemiology in UAMS College of Public Health, and a co-investigator.

The study was the first of its kind to estimate the risk of dying from stroke at the block group level. The study analyzed 8,930 stroke deaths in Arkansas during 2005-2009 at the block group level and found there is a wide variation in risk of death due to stroke, sometimes even a four-fold difference between adjacent neighborhoods.

Investigators have long associated hypertension and high cholesterol, as well as being African-American, with a higher risk of death from stroke. The study showed that neighborhood poverty and low educational attainment play a bigger role than race and ethnicity.

"The findings are significant. Neighborhood poverty and low educational attainment is as important as blood pressure control when it comes to deaths due to stroke," Balamurugan said.

Data for the study came from the Vital Statistics branch of the Arkansas Department of Health and the American Community Survey. Balamurugan, an assistant professor of family and preventive medicine in the UAMS College of Medicine and assistant professor of epidemiology in the College of Public Health, is also medical director for the Chronic Disease Prevention and Control Branch at the Department of Health.

Joseph Bates, MD, deputy state health officer for the Arkansas Department of Health, associate dean for UAMS College of Public Health and a co-investigator, said, "Arkansas is ranked No. 1 in stroke deaths in the United States, and lowering the Arkansas death rate from stroke is a high health priority for the state."

Jawahar Mehta, MD, PhD, who holds the Stebbins Chair in the Division of Cardiology in UAMS College of Medicine and is a co-investigator, said he hopes these findings will increase awareness among physicians of the need to address the risk factors for stroke in Arkansas.

Domestic Violence Support Group Starts

The University of Arkansas for Medical Sciences' (UAMS) Women's Mental Health Program has initiated a support group for women who have been exposed to domestic violence. The group will meet each Wednesday at 5:30 p.m. at the UAMS Psychiatric Research Institute.

Arkansas was ranked fourth in the nation in 2007

TOP Chuck Cook, President, CARTI Board of Directors; Little Rock Mayor Mark Stodola; First Lady Ginger Beebe; Governor Mike Beebe; Mark V. Williamson; Janet Alley representing the Alley Family; Jay Chesshir representing the Little Rock Chamber; Paul Benham; Mark Storey representing ROAPA; Jan Burford, President and CEO, CARTI. ABOVE LEFT Lawrence Mendelsohn, MD, Hematologist/Oncologist and Medical Director of CARTI. ABOVE RIGHT Governor Mike Beebe. BELOW CARTI Physicians in attendance: Mark Storey, MD; Thomas Koonce, MD; Balagopalen Nair, MD; Scott Stern, M.D.; Ann Maners, MD, Lawrence Mendelsohn, MD; Donald Norwood, Jr., MD.

CARTI Cancer Center Breaks Ground

Representatives of the largest not-for-profit network of private cancer care specialists in Arkansas broke ground for the CARTI Cancer Center in a special ceremony in December.

Scheduled to open in Fall 2015, the CARTI Cancer Center will offer medical, surgical, and radiation oncology and diagnostic radiology, as well as hematology services. It will also feature clinics dedicated to imaging, infusion, research, pharmacy, and support programs.

The approximately 170,000 square foot building will sit on 37.12 acres located on Riley Drive just south of Interstate 630 in Little Rock. Projected cost of the building, including furnishings and medical equipment, is estimated at $90 million.

Governor Mike Beebe and Little Rock Mayor Mark Stodola were scheduled to take part in the groundbreaking ceremony. Additional speakers included Jan Burford, CARTI president and chief executive officer; Chuck Cook, Chair, CARTI Board of Directors; and Lawrence Mendelsohn, MD, CARTI medical director.

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in the number of homicides related to domestic violence, with 33 women murdered by male perpetrators. Last year, 17 women were murdered in the state by a spouse or partner. Lori Graham, a clinical therapist in the Women's Mental Health Program, says many women who are involved in domestic violence may not recognize their experience as abusive or coercive.

The group is open to any woman who has experienced domestic violence in the past or is currently in an abusive relationship. Every effort will be taken to maintain a participant's confidentiality. Participants must be at least 18 years of age, but do not have to be a patient of the Psychiatric Research Institute. There is no cost to attend the hour-long sessions, but participants must call to reserve a place.

For a reservation or for more information, contact Lori Graham at (501) 526-8433 or LKGraham@uams.edu

Father, Daughter Convicted of Medicaid Fraud

Attorney General Dustin McDaniel announced that a father and daughter involved in a scheme to defraud the Arkansas Medicaid program have been convicted of felony Medicaid fraud. William Calderon, 56, and Kendall Calderon, 21, both formerly of Rogers, each pleaded guilty to Medicaid Fraud, a Class B felony, in Pulaski County Circuit Court. Judge Barry Sims sentenced each to five years of probation and ordered each to pay a $15,000 fine and $5,000 in restitution.

The two were arrested in September 2012 following an investigation by the Attorney General's Medicaid Fraud Control Unit. William Calderon was a Medicaid beneficiary participating in a waiver program in which he could choose a healthcare provider for attendant-care services that were to be paid for by the Medicaid program. His daughter was identified as that provider. Both were convicted for falsely stating to Medicaid that Kendall Calderon provided healthcare services that she did not provide. Medicaid was billed for $19,566.36 in fraudulent claims.

Investigators from McDaniel's office determined that Kendall Calderon submitted claims to Medicaid for times that coincided with the time that she was attending an out-of-state college. Other claims were for occasions when William Calderon was either hospitalized or was at appointments with other Medicaid providers. Investigators found no evidence that Kendall Calderon ever performed any healthcare services on behalf of her father.

Research Helps Create Award-Winning App

Dr. Julie Meaux, nursing professor at the University of Central Arkansas, collaborated on a mobile application that has been selected as the first place winner in the Shire ADHD Transitions Challenge sponsored by Health 2.0 and Shire Pharmaceutical. Collaborators will receive $100,000 to bring the application closer to public availability.

"This mobile app is a great tool to help young people take control of their ADHD symptoms. Designed on the latest research, the Traxion app will help young people learn about multiple strategies for managing ADHD symptoms and help them track their progress over time," Meaux said.

Meaux collaborated with professionals from Rebar Interactive and Omniscience Mobile to develop Traxion mobile app to support young adults with attention deficit and hyperactivity disorders (ADHD) who are transitioning from structured to unstructured environments.

She was approached by Rebar in spring 2013 to serve as content expert on the project due to her professional and lay publications in this area and particularly her focus on self-management. In addition to providing expertise to the project, Meaux conducted initial focus group testing that resulted in the Traxion mobile app.

Meaux's research is focused on adolescents with ADHD. She will continue to provide expertise and be involved with the team as the work evolves.

The developers hope to partner with Shire Pharmaceutical to make Traxion available as a free mobile app. Plans include a clinical trial to determine the effectiveness of the Traxion app.

To learn more about the Shire ADHD Transitions Challenge or to see a full list of winners, visit http://www.health2con.com/devchallenge/shire/.

UAMS Offers Online Continuing Education Credits

A new University of Arkansas for Medical Sciences (UAMS) website portal, learnondemand.org, allows healthcare professionals to hear lectures and take classes online to earn continuing education (CE) credits, whenever they want.

"Anybody who has any type of Internet access from a smartphone or tablet, a laptop or a desktop, can reach the website and video lectures archived there 24 hours a day and take a class for credit," said Sarah Rhoads Kinder, PhD, assistant professor in the UAMS College of Medicine Department of Obstetrics and Gynecology. "It's compliant with Android, iPad, and more."

Learn On Demand (LOD), a product developed under the UAMS Center for Distance Health (CDH), allows users to track all their educational hours

Dr. Julie Meaux

John Jefferson, PhD

and credits earned inside or outside the program. The site also is compliant with the CE requirements for all three national accrediting organizations for physicians, nurses, and pharmacists. Among the other health professions to which LOD is approved to offer continuing education are registered dietitians, case managers, lactation consultants, physical therapists, respiratory therapists, and emergency medical technicians.

Although online service is directed at providing continuing education first to Arkansas healthcare providers, it will be available for anyone else to use for a fee. An LOD user outside Arkansas can pay on the website for a class and begin taking it right away.

The UAMS CDH for several years has been offering continuing education classes through live videoconferencing.

LOD is important to UAMS' long-term goal of ensuring healthcare professionals statewide have equal access to educational tools. By using the site to maintain their skill sets, a physician, nurse or pharmacist in a rural part of Arkansas can be just as capable of delivering the same high-quality healthcare to their patients as their counterparts in urban areas.

The creation of LOD began in June 2012. Kesha James, an instructional development specialist in the Center for Distance Health who has worked on the site and service since then, said one of the major challenges was finding a system that would do everything they wanted it to do. Ultimately, a system and software provided by CE City was chosen.

In 2014, the Center for Distance Health plans to add a patient portal to LOD that will allow, for example, a pregnant mother with diabetes to receive video instruction in how to manage both her diabetes and her pregnancy.

Funding for LOD was secured through a grant from the Health Resources and Service Administration in the U.S. Department of Health and Human Services and from the UAMS Center for Distance Health.

ADH Recognizes World AIDS Day

The Arkansas Department of Health (ADH) STI/HIV/Hepatitis C/TB Section took a moment recently to recognize World AIDS Day on the front steps of the Arkansas Department of Health in Little Rock. Along with local health advocates, partners, and colleagues at the Arkansas Department of Health, the STI/HIV/Hepatitis C/TB Section released 83 biodegradable balloons to commemorate each individual who has lost their lives to AIDS in Arkansas.

World AIDS Day is an opportunity for people worldwide to unite in the fight against HIV, show their support for people living with HIV, and to commemorate people who have died. According to the ADH STI/HIV/Hepatitis C/TB Section, there are approximately 5,000 individuals living with HIV in Arkansas.

Knowing your status and getting treated for HIV is the best way to ensure that you are protecting your health and that of others. The Arkansas Department of Health STI/HIV/Hepatitis C/TB Section encourages Arkansans to visit www.KnowNowAR.com for information about confidential screening for HIV and other STDs.

For more information about testing call the STI/HIV/Hepatitis C/TB Section at 501-661-2408.

Jefferson to Lead New Physical Therapy Program

The University of Arkansas for Medical Sciences (UAMS) has named John Jefferson, PhD, to direct the physical therapy education program under development for its UAMS Northwest regional campus in Fayetteville. The UAMS physical therapy program will begin with 26 students and plans to add 26 a year for the three-year program to earn a doctor of physical therapy (DPT). As program director, Jefferson will be responsible for development of curriculum, policy, faculty recruitment and attaining accreditation.

Jefferson, who started at UAMS full time Jan. 1, brings more than two decades' experience as a physical therapy educator as well as time spent in curriculum and program development. The UAMS physical therapy program, to be a part of its College of Health Professions, is working toward provisional accreditation and hopes to enroll its first students in 2015.

Jefferson previously served as an associate professor in the Department of Physical Therapy at the University of South Alabama in Mobile, Ala. He joined the faculty at the University of South Alabama in 1994 following stints on the physical therapy faculty at Dalhouise University and the University of Alberta, both in Canada.

He received his doctorate in orthopaedic and sports science in 2010 from the Rocky Mountain University of Health Professions in Utah. In 1987, he earned a master's degree in biomechanics from the University of Waterloo in Canada. He received a bachelor's degree in physical therapy in 1980 from the University of Toronto in Canada.

Jefferson is a member of the American Physical Therapy Association. He is a member of the International Association for the Study of Pain. He was a founding member of the Physiotherapy Foundation of Canada.

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Endowed Chair Will Further Cancer Research

A $1 million donation to the University of Arkansas for Medical Sciences (UAMS) will be used to further cancer research and honor a longtime physician. The donor asked to remain anonymous. The donation was presented to the UAMS Winthrop P. Rockefeller Cancer Institute to establish the Laura F. Hutchins, MD Distinguished Chair for the Division of Hematology/Oncology. Proceeds from the Cancer Institute's 2012 Gala for Life fundraiser and private donations provided about $500,000 in additional funding for the chair.

UAMS Chancellor Dan Rahn, MD, said the donation will bring hope to many patients in Arkansas and beyond, adding, "It is gifts such as these that enable UAMS to stay at the forefront of medical treatment and research."

An endowed distinguished chair is established with gifts of at least $1.5 million. The chairholder, to be named later, will use the interest proceeds for research, teaching or service activities.

After graduating from the UAMS College of Medicine, Hutchins completed her internship, residency, and a fellowship in hematology/oncology at UAMS. She joined the faculty of the UAMS College of Medicine in 1983.

Hutchins has treated thousands of cancer patients throughout her career, with a focus on breast cancer, melanoma and brain cancer. Her extensive research background focuses primarily on breast cancer and melanoma, and she has been nationally recognized for her work in developing technology to support physicians, scientists and patients involved in clinical trials research.

Hutchins holds the Virginia Clinton Kelley Endowed Chair for Clinical Breast Cancer Research. She is a professor of medicine in the College of Medicine's Division of Hematology/Oncology, where she also served as division director from 1998 until September 2013.

In addition, Hutchins has served as director of clinical research at the Winthrop P. Rockefeller Cancer Institute since 1998 and is the recipient of numerous clinical, teaching and research honors and awards.

Healthcare Journal of Little Rock Launches Debut Issue

HJLR launch party at Wright, Lindsey & Jennings with Smith Hartley, E. Lee Lowther III, Hayden W. Shurgar, Heather Allmendinger, and Dianne Hartley.

UAMS Opens Adult Allergy & Immunology Clinic

The University of Arkansas for Medical Sciences (UAMS) recently opened an allergy & immunology clinic specializing in treating adults with asthma, seasonal allergies, food allergies, chronic hives, drug allergies, stinging insect allergies, and immune system deficiencies.

Matthew Bell, MD, and Joshua Kennedy, MD, assistant professors in the Division of Allergy and Immunology in the College of Medicine, will be leading the clinic. They are both board certified in allergy and immunology.

This new clinic is open Tuesdays from 8 a.m. to noon and Fridays from 8 a.m. to 4:30 p.m. It is located on the first floor of the UAMS Outpatient Center. Patients do not need a referral.

"We want to offer solutions to patients with everyday allergies as well as more complicated allergic disorders and immune system deficiencies," Bell said. "We want to be an allergy & immunology referral center for patients around the state."

"We can offer the resources of an academic medical center, including cutting-edge technology and new research," Kennedy said.

The clinic will provide a variety of services from skin testing to lung function testing. With allergen skin testing, patients will have answers within 15 minutes to better help direct their medical care. This clinic will also benefit patients already at UAMS who may need testing for allergies to certain medications.

Bell and Kennedy both received their medical degree and completed residencies in internal medicine and pediatrics at UAMS. They also see pediatric patients at Arkansas Children's Hospital.

Arkansas Tobacco Free Advocates Recognized by National Group

Two Arkansas photographers were honored in a national tobacco prevention photography contest hosted by Countertobacco.org. Countertobacco.org is a comprehensive resource for groups working to challenge tobacco at point of sale.

Ashley Richter, a tobacco free advocate attend-

Joshua Kennedy, MD, and Matthew Bell, MD.

ing North Arkansas College, was a winner in the Youth Appeal category with a photo of an electronic cigarette advertisement adjacent to candies at a convenience store counter. An Honorable Mention in the same category was awarded to J.R. Few of Marion County. His photo shows a product placement of flavored cigars next to bubble gum and candy. Photos like these, showing nicotine products and ads in close proximity to candy and food, can send a hidden message that these items are harmless and normal, says the group.

Counter Tobacco is dedicated to providing tools and resources to counteract retail tobacco product marketing. The photo contest and image gallery are designed to expose the tactics used by the tobacco industry, helping to educate communities and especially youth, about the dangers of these marketing strategies. Educating and shining a light on the industry's tactics is critical to building awareness and sparking policy change, said Counter Tobacco.org.

The Arkansas Tobacco Prevention and Cessation Program can be reached at (501) 661-2953, 4815 W. Markham Street, Slot 3, Little Rock, AR 72205. The Arkansas Department of Health offers free counseling for tobacco addiction at 1-800-QUIT-NOW.

To see all winning photos visit this link: http://www.countertobacco.org/news/2013/11/13/2013-photo-contest-winners-announcement.

Photos like these, showing nicotine products and ads in close proximity to candy and food, can send a hidden message that these items are harmless and normal.

UAMS Receives Approval to Offer PT Degree

Approval to begin educating physical therapy students at the University of Arkansas for Medical Sciences (UAMS) at its northwest Arkansas campus has been given by the Coordinating Board of the Arkansas Department of Higher Education. The approval means UAMS can move forward in the process to create the doctoral program, which will be in its College of Health Professions. The program, which must become accredited before it can accept students, plans to admit students in 2015.

A needs assessment done in 2011 showed there were 300 openings for physical therapists across the state, and by 2016 there will be 800 unfilled positions. That's more than can be filled by the three existing physical therapy education programs at other universities in the state.

Douglas Murphy, PhD, dean of the College of Health Professions, said the UAMS program will begin with 26 students and plans to add 26 a year for the three-year program to earn a doctor of physical therapy (DPT).

The Higher Education Coordinating Board, meeting in Harrison, voted to approve the program for the UAMS Northwest campus. The program will be funded by philanthropic gifts, student tuition, grants, and clinical revenue.

For more information about the program, call the College of Health Professions at 501-686-5730. ■

Quality in Healthcare

Isn't Possible Without Coverage to Provide Access

Less than a year ago, Arkansas made history when a bipartisan effort from a Democratic governor and a Republican legislative majority passed what was coined the "Medicaid private option." This expansion of Medicaid eligibility opens up the chance for an estimated 250,000 low-income citizens, many working hard, to obtain a private insurance policy.

As we approach the February 2014 legislative budget session, in which a three-fourths majority vote will be needed to retain funding for the coverage, there is an inescapable fact that needs wide expression – quality healthcare begins with the coverage needed to afford access to the healthcare professionals of our state.

Prior to the passage of the private option in Arkansas, Medicaid coverage was not only restricted to the very poor, but also only to those adults with children with household incomes at less than 20 percent of poverty or those both disabled as well as very poor. This left many hardworking people without coverage, with insurance priced beyond their means and small employers who could not provide the coverage many of us take for granted.

In a brief historical note, the GOP had not controlled either house of the Arkansas Legislature since the Civil War Reconstruction of the 1870s. At the time, most Democrats were former Confederate soldiers whose citizenship had yet to be restored. We can fast forward to the election of 2012, when the GOP captured both the Senate and the House for the first time in 140 years. One

Ray Hanley is President and CEO, Arkansas Foundation for Medical Care

Without the private option, it's notable who would be denied any insurance coverage – essentially families earning less than $23,500 or individuals earning less than $11,500 a year.

local journalist gave no better than 5 percent odds that Arkansas would pass the Medicaid expansion. Personally, I was giving the chances at least 25 percent odds at the time. GOP legislative leadership, innovative DHS leadership, and a skilled Democratic governor found a way to overcome the odds and create the private option, under which the state would use federal Medicaid funds to pay for a private plan those eligible would select on the insurance exchange. At this writing, states as diverse as Pennsylvania and Iowa are looking at emulating the Arkansas model.

"Cashiers from the IGA grocer, clerks from the dollar store, workers at the local lock factory, call-center agents, laid-off coalminers, KFC cooks" all were signing up for coverage, according to a recent story in *The Washington Post*. The quote was about Kentucky, the only other Southern state besides Arkansas to expand coverage, but it could easily describe what is happening here.

It becomes easier to localize the private option's impact in the state when looking at last fall's county by county projection of those who will gain coverage, which was compiled by Arkansas Advocates for Children and Families. In Pulaski County, an estimated 25,000 of our citizens, almost a thousand people down in Chicot County, more than 5,000 in Saline County, more than 7,000 in Faulkner County, and almost 4,000 in Lonoke County are expected to get coverage, many for the first time.

Without the private option, it's notable who would be denied any insurance coverage – essentially families earning less than $23,500 or individuals earning less than $11,500 a year. Under the Affordable Care Act, people below those income levels qualify for no assistance to cover insurance UNLESS their state expands Medicaid. We all know such people and encounter them every day as they serve our food, care for our children, and wait on us in the shops and stores across Arkansas. Because of the private option that came from bipartisan leadership, these people will be able to see a doctor, fill a prescription or pay their local hospital for care if they need it.

They will have the coverage to access quality, appropriate local healthcare without resorting to the ER when they are so sick they have no other options. Their value to their employer goes up, as does the ability to provide for their families.

As we look to the coming legislative budget session when Arkansas will keep, or potentially defund, the private option, it bears repeating: Quality healthcare is not possible without access to care, and that access is extremely hard to have without healthcare coverage the private option opens up to many of our low-income, hardworking people. ■

Yearly Flu Vaccination

of Healthcare Personnel Protects Patients, Employees, and Facility Operations

Each year thousands of Arkansas residents are stricken with the flu. Many of these people are treated at hospitals and, unfortunately, some people die from what could have been a preventable disease.

Despite the recognized benefits of yearly influenza (flu) vaccinations the Centers for Disease Control and Prevention (CDC) reports that vaccination among healthcare professionals (HCP) remains low. To protect HCP and their patients, the Advisory Committee on Immunization Practices (ACIP) recommends that all HCP be vaccinated against flu each flu season. These recommendations apply to all HCP, including those in acute care hospitals, nursing homes, skilled nursing facilities, physician's offices, urgent care centers, and outpatient clinics, as well as to those who provide home healthcare and emergency medical services.

There is strong evidence that unvaccinated healthcare workers are a risk to their patients and co-workers. The flu virus is spread through coughing or sneezing and by touching virus laden surfaces (like a door knob) and then touching the nose or mouth. The best way to prevent the influenza infection is by getting a flu vaccine each year. Although any healthcare worker with flu-like symptoms should be encouraged to remain at home, staying at home when you are sick is NOT enough to effectively protect patients and coworkers. Those infected with the influenza virus are contagious to others even before developing symptoms of flu. In fact, up to half of those infected with flu may not have any symptoms at all.

Over the last 50 years, flu vaccines have been shown to be safe and effective. Approximately 100 million doses of influenza vaccine are used in the United States each year. These flu vaccines have an excellent safety record. The flu vaccine cannot give you the flu–this is an "old wives' tale" that needs to be put to rest. If you contract the

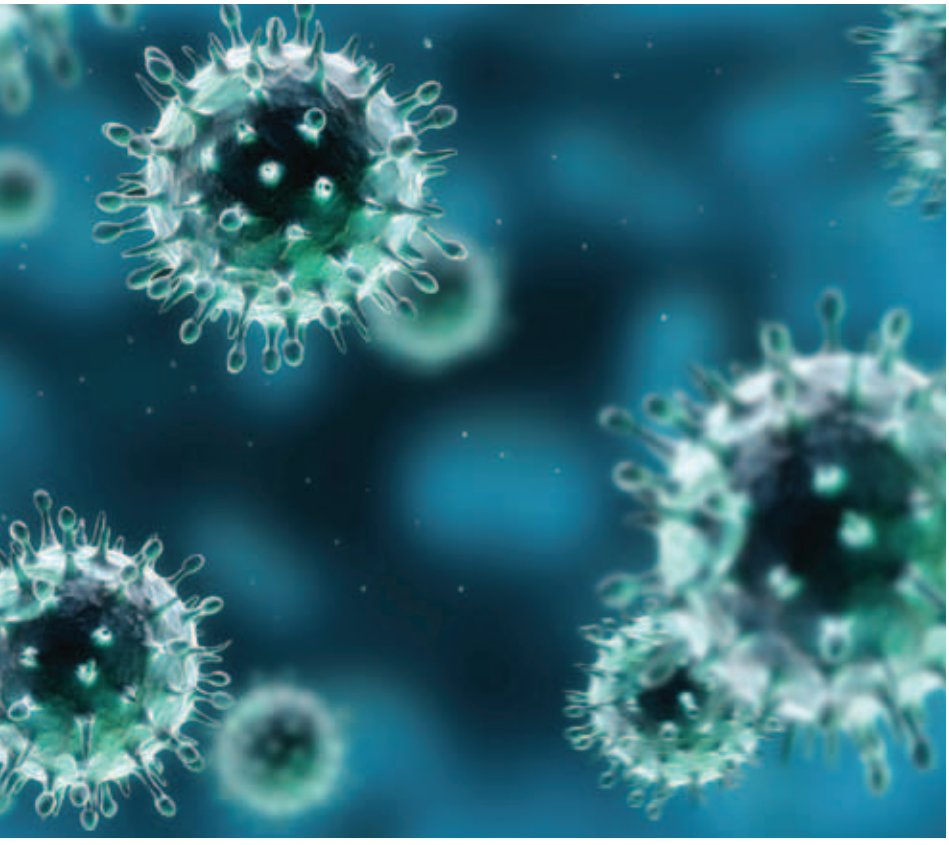
Nathaniel Smith is Director and State Health Officer, Arkansas Department of Health

flu shortly after receiving the vaccine, you were already infected with the virus. In this instance, the vaccine can actually provide some protection and might possibly result in a less severe case of flu. Moreover, there are very few medical reasons not to get the flu vaccine. These include life-threatening reactions such as anaphylaxis to a previous dose of flu vaccine or Guillain-Barre syndrome. There is now an egg free influenza vaccine that can be safely administered to those with serious egg allergy.

Flu vaccination for HCP not only protects patients from exposure to the flu, but also decreases HCP absenteeism and healthcare costs associated with ill personnel. Ensuring high HCP vaccination coverage each season requires organized efforts by healthcare facilities. Comprehensive, work-site intervention strategies that include education, promotion, and easy access to vaccination at no cost can increase HCP vaccination coverage. Revisions in personnel policies can be used to increase vaccination coverage during each flu season.

Many healthcare organizations, including the Arkansas Department of Health, require staff to be vaccinated against the flu each season. Those who cannot receive the flu vaccine for medical reasons are required to wear a face mask throughout flu season to protect patients and other staff from potential exposure. Some healthcare facilities have taken a slightly different approach in requiring all staff to wear face masks during flu season UNLESS they are vaccinated against the flu. These policies are functionally equivalent, but the second approach emphasizes the patient safety aspect and gives staff the freedom to choose how to achieve the goal of patient protection from flu.

"Many healthcare organizations, including the Arkansas Department of Health, require staff to be vaccinated against the flu each season."



To optimize vaccine coverage among HCP, flu vaccine should be offered throughout flu season, even after flu activity has been documented in the community. In the U.S., seasonal flu activity can increase as early as October or November, but flu activity typically reaches its peak in January and lasts through early March. Although the timing of flu activity can vary by region, vaccine administered after November is still likely to be beneficial. Peak antibody protection is achieved approximately two weeks after vaccination. Arkansas is in the midst of the current flu season, so getting vaccinated now is still highly recommended.

I hope you will join me in helping to protect our fellow Arkansans as well as ourselves this flu season. This is above all a patient safety issue. If we want all Arkansans to be protected from the flu, healthcare professionals will have to "walk the talk." ■

By Joseph W. Thompson, MD, MPH

Inside Arkansas's Private Option

The Arkansas 89th General Assembly did something extraordinarily good for the health and economic wellbeing of Arkansans when they passed the Health Care Independence Act.

This highly innovative, bipartisan legislation assures that our most financially vulnerable citizens will have access to the health care coverage they need. Importantly, it does so in a way that provides a fiscal benefit to our state and strengthens our overall initiative to create a higher quality, sustainable health care system. However, success of the program is dependent on continued funding authorization during the upcoming fiscal session.

The absence of coverage and underinsurance among Arkansans has led to high uncompensated care costs for Arkansas health care providers and is a leading cause of personal bankruptcy in the U.S. Those without health care coverage often avoid or delay seeking treatment, resulting in even higher medical costs and more serious illnesses, even death. High uninsurance rates have contributed to maldistribution of our health care workforce, with providers avoiding setting up shop in areas where there is a greater likelihood of not being paid for their services.

Development of the Health Care Independence Act, "Private Option"

Faced with the U.S. Supreme Court's June 2012 ruling allowing states to decide whether or not to extend Medicaid benefits to their citizens who qualify under the Patient Protection and Affordable Care Act (PPACA) expansion, Arkansas legislators had some politically-charged decisions to make. Understandably, many found the idea of expanding an already unsustainable public program unacceptable. Equally unacceptable was denying Arkansans the opportunity to secure health care benefits so long out of reach and thus perpetuating our position at the bottom of nearly every national health ranking. Rather than refusing the opportunity to improve our health care system as did some of the states (the negative consequences of which are now emerging), a unique, bipartisan proposal was crafted. Arkansas will use federal Medicaid funding to provide health care benefits to individuals eligible under the PPACA expansion via private insurance plans offered through the new Health Insurance Marketplace. Commonly known as the "Private Option," the Health Care Independence Act and its accompanying appropriation was passed by the required three-fourths majority vote in both the Arkansas House and Senate, and signed into law by Governor Mike Beebe on April 23, 2013.

Joe Thompson is Arkansas Surgeon General and
Director, Arkansas Center for Health Improvement

General Overview

The Act calls on the Arkansas Department of Human Services (DHS) to explore program design options that reform Arkansas Medicaid so that it becomes a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program using competitive and value-based purchasing to:

- maximize the available service options;
- promote accountability, personal responsibility, and transparency;
- encourage and reward healthy outcomes and responsible choices; and
- promote efficiencies that will deliver value to taxpayers.

Arkansas DHS has secured approval of a waiver demonstration application submitted to the U.S. Department of Health and Human Services specifically designed to implement the Act's requirements.

Rationale for Expanding Health Care through the Act

Expanding the existing state Medicaid program to nearly all individuals with incomes at or below 138 percent of the federal poverty level (FPL), as set out in the PPACA, would have presented several challenges for Arkansas. First, the newly eligible adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35 percent of adults will experience a change in eligibility within six months of their eligibility determination. The Private Option provides continuity, reducing coverage gaps and disruptive changes in benefits, provider networks, premiums, and cost-sharing. In addition, expanding the traditional Medicaid program would have increased program population by nearly 40 percent. The state's existing network of participating fee-for-service Medicaid providers is already at capacity. As a result, Arkansas would have been faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to care. Instead, the Health Care Independence Act relies upon private provider networks at private insurance reimbursement rates.

In short, absent the federal waiver to implement the Act, a traditional Medicaid expansion based on the existing Medicaid delivery system would have perpetuated an inadequately coordinated approach to patient care. While reforms associated with the Arkansas Payment Improvement Initiative (www.paymentinitiative.org) are designed to address the quality and cost of care in Medicaid and the private market, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults who will enroll through the expansion.

Funding & Cost

The Act allows the program to continue for the duration of the waiver but is contingent upon annual appropriations by the Arkansas General Assembly. The waiver has been approved by U.S. DHHS for 2014–2016. The costs of the program are shared by the federal government, beginning with the federal government paying 100 percent of the cost through 2016, with the state's share of the cost gradually increasing to 10 percent in 2020 and beyond.

In a comparison of options for extending health insurance coverage to low-income Arkansans, the impact of the Health Care Independence Act on the state and federal budgets were estimated as follows.

State Budget:

State general revenue obligations will be reduced by approximately $40 million per year due to avoided uncompensated care.

State spending will increase by $47 million in FY15 with 100% federal support and $275 million in FY20 at 10% state/90% federal match requirement for the expansion population.

Additional premium tax revenue over the first 10 years of the Private Option will generate $436 million.

The net impact on the state budget is a favorable $670 million over 10 years. This estimated net impact freed up state funds and allowed legislators to implement tax cuts in other areas.

Federal Budget:

The federal government will benefit from approximately $1.1 billion per year in new taxes and Medicare payment reductions.

The increase in federal costs for expansion and ongoing Medicaid is projected at $1.59 billion in FY15 and $2.35 billion in FY20.

The net impact on the federal budget approaches neutrality over 10 years (not including economic stimulant effects).

Private Plans Available to Arkansans

The Act requires the state to take an integrated and market-based approach to covering low-income Arkansans by offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.

An early benefit of this approach can be found in the number of private insurance companies offering plans across the state through the Health Insurance Marketplace and the interest it has generated from additional carriers not currently doing business in the state. Arkansans living in each region of the state will have a choice of plans from at least two companies. In comparison, neighboring Mississippi, a state choosing not to participate in the expansion, had 36 counties without a single plan offered through its marketplace and has only two participating insurance companies.

Arkansas's Health Care Independence Program Waiver Demonstration Proposal

By using premium assistance to purchase qualified health plans through the Health Insurance Marketplace, Arkansas will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality-improvement efforts. Further, it is expected that by providing a source of payment to an estimated 250,000 currently uninsured Arkansans, an economic impetus will be created that will lead to an increase in the availability of health care providers, particularly in currently underserved counties. In fact, a recent study sponsored by the Arkansas Center for Health Improvement and conducted by the RAND Corporation indicated that full implementation of expanded coverage under the PPACA would result in a $550 million annual increase in Arkansas's gross domestic product and the creation of 6,200 jobs, with the majority of this impact accruing to rural Arkansas where the uninsured rates are relatively higher.

"All Payer" Health Care Reform

Arkansas's integrated health system improvement initiatives are considered to be at the forefront of innovation providing a model that other states are considering as they too struggle with needed reform. Importantly, as premium assistance is used to meet the needs of Arkansans through the Private Option, the state is considerate of the cost implications of such an expansion. With this in mind, policymakers incorporated delivery system reforms into the Health Care Independence Act requiring that, beginning in 2015, health insurance carriers offering plans through the Health Insurance Marketplace participate in the Arkansas Payment Improvement Initiative. This includes implementation of patient-centered medical home strategies which will accelerate the efficiencies and potential cost savings associated with those efforts and will increase the number of Arkansans who benefit from enhanced care coordination, access, and quality of care that are expected to follow from these activities.

The Road Ahead

Tens of thousands of Arkansans were helped by a bipartisan solution uniquely suited to meet the needs of Arkansans. Each year the Arkansas General Assembly must pass annual appropriations to continue funding the Health Care Independence Program, requiring 75 percent of the vote in both the House and the Senate. As the fiscal session approaches, I urge our legislators to continue this good work so desperately needed to improve health, save lives, and provide a competitive economic environment for our state. ■

HOSPITAL Rounds

HOSPITAL NEWS & INFORMATION

HOSPITAL ROUNDS

Japanese Neurosurgeon and Residents Visit ANI

The Arkansas Neuroscience Institute (ANI) at St. Vincent Infirmary recently hosted neurosurgeons from Japan to train with ANI director and world-renowned neurosurgeon Ali Krisht, MD, FASC. Kentaro Mori, MD, PhD, Professor and Chairman of the Department of Neurosurgery for the National Defense Medical College Saitama, Japan and three neurosurgeon colleagues traveled to ANI to learn advanced techniques in neurosurgery.

The team observed Krisht perform two surgeries in their two day visit to ANI. Mori, who is also a visiting professor at Juntendo University in Tokyo, said he requested the visit with Krisht because of his interest in skull base surgery and Krisht's expertise and reputation for excellent outcomes in skull base surgery. Krisht is rated among the top one percent of neurosurgeons in the country by Castle Connolly Medical, Ltd, a research and information company established to help people find the best healthcare by providing information to identify the top doctors in their own communities.

ANI has a mission of sharing knowledge to enhance education and Krisht said training international neurosurgeons is one way ANI can transfer their expertise to the patients of Arkansas and the world. Mori said many surgeons don't share their expertise, unlike Krisht who shares information by not only allowing surgeons and residents to observe, but also by conducting seminars and by publishing in medical journals.

"By observing Dr. Krisht we learned new techniques, tips, and strategies. We learn much more by observing him than we can learn from text books or video or DVD," said Mori. "His small tips and techniques make a big difference." Mori also said while instruments in Japan are good, those used by Krisht at St. Vincent Infirmary are superior and he will try to make those same instruments available in Japan.

During this international educational event, Mori and his team rounded with Krisht. Mori says the diligent hands-on attention and care ANI provides to their patients serves as a model of excellence for the world of neuroscience.

This is not the first time Mori has visited ANI. In 2012 he attended an international brain tumor seminar at ANI. He says he will teach what he has learned from Krisht to Japanese residents as soon as he returns to Japan.

UAMS Offers New Brain Tumor Procedure

A nationally renowned neurosurgeon at the University of Arkansas for Medical Sciences (UAMS) is the first in the state to use a minimally invasive, breakthrough brain tumor removal procedure using a tube-like tool and sophisticated three-dimensional imagery in two successful surgeries.

The cutting-edge surgery uses a new BrainPath tube, advanced imaging of tracts in the brain and a computerized brain navigation system, which allows UAMS physicians to navigate the brain to target and suction out deep-seated brain tumors, abscesses and hemorrhages that could not be reached with as little disruption of tissue with traditional techniques. The surgery removes deeply located tumors in the brain considered difficult to safely access, such as glioblastoma multiforme (GBMs) and metastatic cancerous brain tumors.

John D. Day, MD, chair of the Department of Neurosurgery in the UAMS College of Medicine, who has performed this new surgery twice at UAMS with success — once for a malignant tumor and once for an abscess — says the new port neurosurgery is a promising development in allowing brain tumor removal with a minimum of injury to normal surrounding brain tissue.

"The procedure is the closest that we can get to a precisely targeted, flawless surgery for deep brain tumors," Day said. "We are able to get to tumors in a much safer way that will put patients at less risk of brain damage and will preserve critical brain structures and tracts."

Along with the Brain Path device, the Myriad, a thin, tubular three-in-one device (scissors, suction and blunt dissector) designed by NICO, is used to remove hard-to-reach tumors through the narrow corridor. The device can be used on multiple procedures and does not use heat, so there is less risk to surrounding tissue.

The many benefits of the breakthrough procedure, which creates a small, dime-size channel through the brain, include a faster recovery time, minimal internal and external scarring, less trauma to the brain and nerves, and few side effects and complications post-surgery, Day said.

John D. Day, MD

Day underwent extensive training in March in order to perform the surgery and says there are only about 50 neurosurgeons in the United States currently equipped to use the new devices.

Baptist Health to Partner with Hot Spring Med Ctr.

Baptist Health began a long-term lease agreement with Hot Spring County Medical Center in Malvern, on Jan. 1. The hospital is now named Baptist Health Medical Center-Hot Spring County and is Baptist Health's eighth hospital. Hot Spring County Medical Center first invited Baptist Health to consider partnership options over a year ago.

Hot Spring County Medical Center is a community-based hospital with approximately 360 employees and is licensed for 72 acute-care beds. Hot Spring County Medical Center has been owned and operated by Hot Spring County since it opened in 1923. Baptist Health is the state's only Arkansas-based, locally owned and managed, not-for-profit, and faith-based healthcare organization.

Sixteen Hospitals Receive ADMC Incentive Payments

Arkansas Medicaid and the Arkansas Foundation for Medical Care (AFMC) have released $2,020,609 in performance bonus payments to 16 Arkansas hospitals as part of the Inpatient Quality Incentive

(IQI) program. This is the seventh year that IQI has presented the incentive payments to hospitals.

This year, IQI recognized hospitals that showed improvement in care coordination, obstetrics, and prevention of venous thromboembolism, or blood clots in the veins. Hospitals were required to meet specific goals for at least 80 percent of eligible measures, including offering treatment for tobacco use and reducing the number of elective early deliveries. The measures were selected by the IQI advisory board, AFMC and Arkansas Medicaid.

IQI offers performance bonus payments to hospitals that improve the quality of patient care according to the Arkansas Medicaid Program's clinical priorities. The priorities are based on clinical data, including research, best clinical practices and emerging health care evidence.

Since the IQI program began in 2007, Arkansas Medicaid has awarded a total of $28.4 million to hospitals that have participated in the program and successfully improved care. Over the last six years, clinical priorities have included pneumonia, heart failure, surgical infection prevention, venous thromboembolism prevention, obstetrics, and transitions of care for Arkansas Medicaid patients.

The Arkansas Hospital Association, Arkansas Medicaid and AFMC worked together to develop the IQI program, which has earned national attention for its innovative involvement with the healthcare community. This program reflects a growing movement toward rewarding hospitals for commitment to quality and providing evidence-based care to their patients.

St. Vincent Named Blue Distinction Center +

Arkansas Blue Cross and Blue Shield has named St. Vincent Infirmary in Little Rock a Blue Distinction Center+ for Cardiac Care for excellence in patient safety and outcomes, developed with input from the medical community, and also for meeting core measures that address consumers' needs for affordable healthcare.

The Blue Distinction Centers for Specialty Care® program recognizes hospitals across the country that have a proven track record for delivering better results – including fewer complications

East End Baby Remembered with Floragraph

UAMS reported that volunteers helped put the finishing flower materials on a floragraph portrait to be featured in the 2014 Rose Parade on the Donate Life Float. The floragraph, one of 81 from across the nation, is in memory of Elijah "Eli" McGinley, a baby from East End, Ark., who became a tissue donor.

Eli and his twin brother Walker were born Aug. 3, 2009. Eli died five days later. His aortic valve saved a 2-day-old girl in Maine. The Arkansas Regional Organ Recovery Agency (ARORA) chose to honor Eli in this year's float. A floragraph is a portrait created with floral materials.

Eli's parents, Jesse and Jodie McGinley; UAMS staff and volunteers; and ARORA staff were on hand for the completion of the portrait.

▲ Walker McGinley, 4, puts finishing touches on Eli's floragraph. Eli's image is one of 81 featured in the 2014 Rose Donate Life Rose Parade Float on Jan. 1, 2014.

and readmissions – than hospitals without these recognitions. Blue Distinction Centers+ meet the same quality criteria as Blue Distinction Centers, but are further recognized for their expertise and efficiency in delivering high quality care that is more affordable for patients.

Since 2006, consumers, medical providers, and employers have relied on the Blue Distinction program to identify hospitals delivering quality care in Bariatric Surgery, Cardiac Care, Complex and Rare Cancers, Knee and Hip Replacements, Spine Surgery, and Transplants. The Blue Distinction Centers for Specialty Care program was recently expanded to include new cost efficiency measures, as well as more robust quality measures focused on improved patient health and safety.

"This Blue Distinction reflects the efforts each and every day of a highly skilled and compassionate team of physicians, nurses, and other healthcare professionals who truly put the patient first," said Peter D. Banko, President and CEO St. Vincent Health System. "Now, more than ever, value is the forefront of any healthcare discussion."

The cardiologists and cardiovascular surgeons who joined together with St. Vincent to form the Jack Stephens Heart Institute did so to set a new and higher standard for the quality of heart care in Arkansas. St. Vincent has four physician-led Quality Monitoring committees and is an active participant in two national Quality Data Collection Databases to measure and demonstrate commitment to this effort.

For more information about the Blue Distinction Program visit www.bcbs.com/bluedistinction.

Baptist Purchases Land for Conway Medical Center

Baptist Health has purchased approximately 37 acres to construct a wholly owned and operated medical center in Conway to serve the growing healthcare needs of Faulkner and surrounding counties.

Baptist Health is collaborating with more than 30 Conway-based physicians to develop and open the new medical center in Conway to be operated as a not-for-profit, faith-based community hospital providing comprehensive clinical services.

Dr. Benjamin Dodge of Conway is chairman of a steering committee of nine physicians representing over 30 local physicians who for several years have sought a collaborative alignment to benefit the long term outlook of healthcare in Central Arkansas.

Cynthia Brown, RN

This new hospital facility will address the healthcare needs of Faulkner County and surrounding areas, which have experienced unprecedented population growth over the past 10 years. Baptist Health Medical Center-Conway will employ approximately 425 healthcare professionals and staff and be led by an experienced leadership team working closely with local physicians committed to improving the health of the community. A local full-service hospital will also enhance the potential for the area's economic growth by contributing to an increase in local employment and providing state-of-the-art healthcare services that help attract new businesses.

The proposed 200,000-square-foot hospital is projected to open in 2016 and will be located along the west side of Interstate 40 near Exit 126 in Conway. The facility is expected to provide 100 beds, seven operating rooms, and a Level III trauma-center emergency room. The two year construction project is expected to generate approximately 250 jobs.

Brown to Lead UAMS Infusion Clinics

Cynthia Brown, RN, has been named director of the Infusion/Ancillary Services Division at the University of Arkansas for Medical Sciences (UAMS). She supervises the UAMS Winthrop P. Rockefeller Cancer Institute's two infusion clinics and blood draw areas in the Cancer Institute and Outpatient Center.

Brown completed her bachelor of science in nursing degree from the UAMS College of Nursing, where she is working toward her master's degree.

Her nursing career began in the UAMS neonatal intensive care unit, followed by stints in home health and family practice. For the past 15 years, Brown has concentrated on oncology nursing, having served in various positions including director of inpatient hematology/oncology at Arkansas Children's Hospital and chief nursing officer at St. Vincent Rehabilitation Hospital.

While at Arkansas Children's Hospital, Brown received the Care, Love and Hope Award.

Baptist Health Expands eICU® care to White River

White River Medical Center recently partnered with Baptist Health eICU care to give their patients an additional team of critical care specialists who will watch over them 24/7. With a simple press of a button by the physicians or nurses at White River Medical Center, the staff will be instantly joined at their patient's bedside by Baptist Health's experienced critical care team in Little Rock.

The eICU care team includes physicians and nurses specialized in critical care and trained to execute predefined plans or intervene in emergencies when a patient's attending physician cannot be immediately present.

Each critical-care room with eICU technology is equipped with a camera, microphone, and speaker that enable staff in the control center to communicate with caregivers and the patient in real time. The two-way video and "cockpit-like sensors" of this advanced telemedicine technology enables the eICU care staff to detect even the slightest change in the patient's condition and communicate more effectively with the bedside team to reduce the time between problem identification and intervention.

Staffed round-the-clock, every day of the year, the Baptist Health eICU care command center and its staff help rural hospitals like White River Medical Center provide state-of-the-art intensive care

to its sickest patients.

Typically, eICU technology is used in emergency departments, surgical ICUs (including kidney transplants), trauma ICUs, cardiac surgery (including heart transplants and artificial hearts), medical ICUs, coronary care units, surgical step-downs, extended care hospitals, and progressive care units. Hospitals across the country using eICU technology with critical care specialists have seen reductions in complications, reductions in mortality, and better outcomes for patients.

Not only was Baptist Health the first in the state to use eICU technology back in 2005, but the healthcare system was the first in the region to implement its use in patient care and among the first 20 healthcare systems in the country to have a command center.

UAMS Seeks Alliances for Care Close to Home

In an effort to promote best care closest to home, the University of Arkansas for Medical Sciences (UAMS) has established a center that will look for partnerships, and collaborations in underserved areas to assist with routine care and provide access to specialty care.

The newly created Center for Healthcare Enhancement and Development will explore ways for UAMS to support and work with hospitals and clinics throughout the state to provide better health care for Arkansans.

Tim Hill, formerly director of the UAMS Rural Hospital Program and UAMS Center for Rural Health, leads the new center along with associate directors Justin Hunt, MD, and Mark Jansen, MD

Hill said the center has facilitated a partnership with the South Arkansas Ear, Nose & Throat Clinic in Pine Bluff operated by Stephen Shorts, MD, to enable the clinic to serve more patients

UAMS ear, nose and throat surgeons Jennings Boyette, MD, and Angela Paddack, MD, will each practice one day a week at Shorts' clinic. Boyette and Paddack also will each perform surgery one day a week at Jefferson Regional Medical Center in Pine Bluff as part of the arrangement.

Hill said ideas for partnerships exist across the state, including the use of telemedicine to bring specialty care to areas that lack those services.

In another venture, UAMS will assist White River Health System in Batesville by treating many of its radiation oncology patients for several months in Little Rock while the Batesville hospital installs new technology and equipment.

Baptist Health Holds Health Insurance Fair

With the deadline to sign up for health insurance through the affordable healthcare act looming, Baptist Health hosted two free health insurance fairs to provide professional assistance to those who have unanswered questions or who would like help navigating the online tools.

Representatives from Medical Advocacy Services for Healthcare (MASH), Inc., were on hand to provide assistance during the insurance fairs at the Little Rock and North Little Rock hospital campuses. The events were open to anyone who didn't currently have insurance or would not have health insurance coverage in 2014 unless they signed up for insurance through the government's healthcare market.

Donation to Support New Breast Center Site, Cancer Procedures Facility

A $1 million gift from Stuart Cobb of Little Rock puts the University of Arkansas for Medical Sciences (UAMS) Winthrop P. Rockefeller Cancer Institute one step closer to completing its new breast center and cancer procedures facility. The gift will support construction and services of the facility, which will be located on the third floor of the Cancer Institute at UAMS.

"Stuart Cobb has a longstanding and special connection to the Cancer Institute. Her generous donation will ensure that Arkansans have access to the most advanced facility for mammography and other essential outpatient cancer-related procedures for many years to come," said UAMS Chancellor Dan Rahn, MD.

Upon completion, the UAMS Breast Center will move from its current location in the Outpatient Center to the Cancer Institute's third floor. In addition to its all-digital mammography equipment, the center provides a full range of breast imaging and diagnostic services, including ultrasound, MRI and biopsy.

Stuart Cobb

"Stuart Cobb's generosity will help us create a warm, comfortable and spacious area for the Breast Center, hopefully alleviating some of the anxiety that people experience when undergoing medical exams and procedures. We're very grateful for her gift and what it will provide the women of Arkansas," said UAMS Cancer Institute Director Peter Emanuel, MD.

The facility also will house equipment for bone marrow biopsy, an essential procedure for patients with blood cancers, as well as CT scanners, interventional oncology services, and other radiologic procedures.

A charter member of the Cancer Institute Auxiliary, Cobb was instrumental in establishing the Cancer Institute's gift shop, which now serves as one of the organization's primary fundraising projects. All sales at the gift shop directly benefit support services for patients.

Cobb served as auxiliary president in 1991-1992, was named Volunteer of the Year in 1996 and co-chaired the Cooks Tour fundraising event in 1998. She continues to serve as an auxiliary board member and volunteer on many projects, in addition to serving on the Winthrop P. Rockefeller Cancer Institute Foundation Fund Board.

She also previously served as president of the Junior League of Little Rock and co-chair of Arkansas' Race for the Cure. In 1993, Cobb was named a Community Service Award recipient from the Arkansas Department of Human Services. She was the wife of the late Jim Cobb of Little Rock.

HOSPITAL ROUNDS

Grant to Fund Obstetric Simulation Lab

St. Vincent Foundation was the recent recipient of a grant from The Blue & You Foundation for a Healthier Arkansas. The Blue & You Foundation awarded grants to 42 health improvement programs in Arkansas. St. Vincent Foundation received $62,422.

The grant to St. Vincent Foundation will be used for medical professional education by establishing a new obstetric simulation lab for resident nurses to hone their technical skills and for continuing education of nursing and support staff at St. Vincent Health System to ensure the best care of 1,800 to 2,500 patients giving birth and receiving pre-natal and peri-natal care at St. Vincent. St. Vincent will purchase a SimMom and delivery bed for the lab. SimMom is an advanced full body interactive birthing simulator. It will provide functions that are required in the birthing process to train nurses in obstetric skills.

Arkansas Blue Cross and Blue Shield established the Blue & You Foundation in 2001 as a charitable foundation to promote better health in Arkansas. The Blue & You Foundation awards grants annually to non-profit or governmental organizations and programs that positively affect the health of Arkansans. In its 12 years of operation, the Blue & You Foundation has awarded nearly $19 million to 423 health improvement programs in Arkansas.

Arkansas Heart Hospital Offers ILUMIEN

Arkansas Heart Hospital is the only publically accessible hospital in central Arkansas now offering St. Jude Medical's ILUMIEN PCI Optimization System as a treatment option for patients suffering from coronary artery disease (CAD). The ILUMIEN system is the first and only integrated diagnostic technology that combines optical coherence tomography (OCT) and fractional flow reserve (FFR) technologies on one platform.

Using the combined ILUMIEN system, physicians at Arkansas Heart Hospital gain advanced physiological and anatomical insights that can improve the diagnosis and treatment of CAD.

Patients with coronary artery disease experience decreased oxygen delivery to the heart due to plaque or cholesterol build-up inside arteries. Dr. Ian Cawich, an interventional cardiologist at Arkansas Heart Hospital was the first to use ILUMIEN at the hospital.

"The key to optimizing treatment of coronary artery disease is knowing which blockage needs treatment and how to treat it," said Dr. Cawich. "The ILUMIEN system allows me to have the information I need in one place and helps me accurately diagnose and optimize therapy for my patients."

With the integration of these two technologies, Arkansas Heart Hospital physicians can identify the precise measurement and dimensions of culprit narrowings responsible for obstructing blood flow to a patient's' heart, as well as determine vessel size and structure.

Foundation Funds Security Enhancements

Security enhancements to the Women's and Children's Unit at Baptist Health Medical Center-Stuttgart (BHMC-S) were recently completed thanks to funds raised by the Stuttgart Memorial Hospital Foundation. Both the nursery and labor and delivery areas within the Women's and Children's Unit now have security cameras and electronically controlled access using security badges that when scanned automatically unlock and open the doors to the unit.

Funding for this project came from the 15th annual foundation dinner event, "Steak Soiree," held back in October last year at the Grand Prairie Center. Approximately 220 people attended and $34,000 was raised from ticket sales and sponsorships. The steaks were grilled by the reigning World Championship Steak Cook-off winning team from Magnolia. This year's Steak Soiree was held again at the Grand Prairie Center on Nov. 5 with feature guest speaker, Larry Lacewell, former Dallas Cowboys director of scouting. ■

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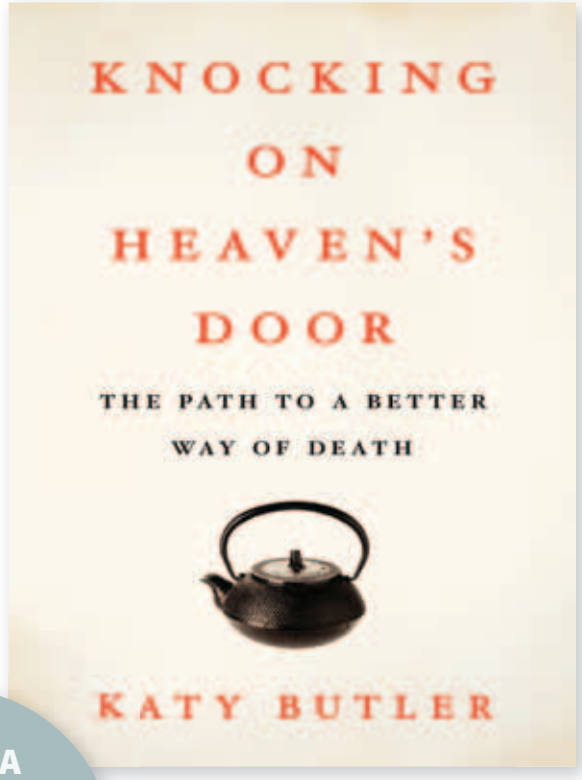


by **Katy Butler**
c.2013, Scribner

Your mind's made up.

There's no going back once you've made a choice between Door Number One or Door Number Two. You're not a waffler, you weighed pros and cons, and you're confident you picked correctly. Or not.

Indeed, the worst part about making a decision can be the regret that's possible at the end of the choice. And in the new book "Knocking on Heaven's Door" by Katy Butler, a seemingly no-brainer decision tears a family apart.

Jeff Butler cheated death many times.

As a child, he narrowly missed dying in a car accident. In World War II, he lost an arm, but not his life. And in November 2001, at age 79, he suffered a stroke that nearly killed him. A year later, he received a pacemaker.

And that, says his daughter Katy, kept him alive but didn't "prevent his slide into dementia, incontinence, near-muteness, misery, and helplessness."

Jeff and his wife Val were forward thinkers. He was a college professor. She was a perfectionist with fierce drive. They had been "in control of their lives, and they did not expect to lose control of their deaths."

But that's exactly what happened: as Jeff's health continued to decline, his abilities dwindled and his cognizance weakened – all of which he was aware. He indicated dismay at his diminished life and said that he'd "unfortunately" lived too long.

On the other side of the country, Katy Butler worried. She'd always been closer to her father than to her mother, but arguments and old hurts continued to sting. Still, she flew home to Connecticut to help because she was, after all, their daughter – statistically, the one who bore the brunt of parenting a parent.

But as Jeff's dementia worsened, so did Val's tolerance and her health. She was "stoic," but impatient, snappish, and exhausted, and only accepted outside help when she became overwhelmed. Butler says she knew her mother "clouted" her father, and shouted at him in frustrated anger.

By this time, Butler was convinced that the pacemaker her father had wasn't the medical miracle it was meant to be. And she learned that pacemakers could be turned off...

THIS IS A STUNNING BOOK, TRUTHFUL AND DIGNIFIED...

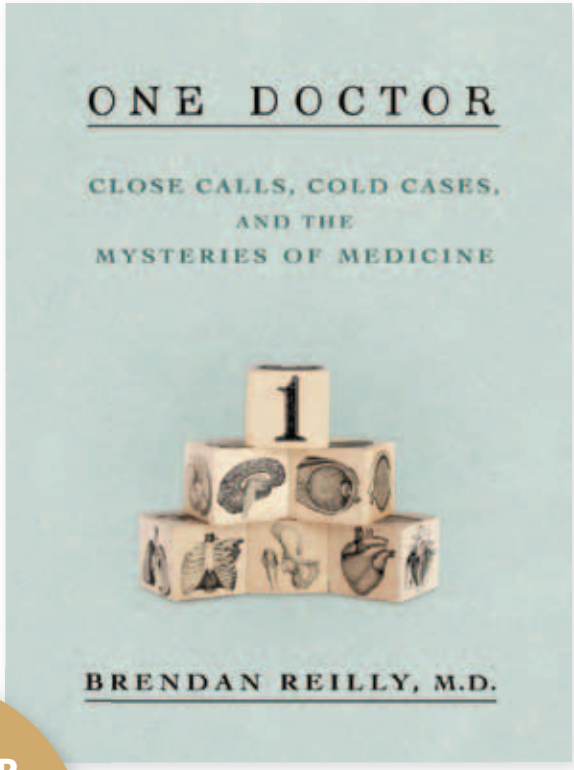
So much went through my mind as I read this beautiful, emotionally brutal book.

With sorrow, grace, and growing exasperation, author Katy Butler writes of her father's long, messy death; her mother's quiet, dignified passing; and the parallel story of how modern medicine, drug companies, and government rules promoted the former.

That's a lot of hard reading, made gentler with Butler's Buddhist values and serenity. And yet, it's not easy to avoid outrage as she points out the unfairness of aging, the cruelty of physical decline, and the knowledge that those – and the surety of caretaking – are somewhat inevitable for many Baby Boomers today.

This is a stunning book, truthful and dignified, and it could be a conversation-starter. If there's a need for that in your family – or if you only want to know what could await you – then read "Knocking on Heaven's Door." You won't regret it. ■

TERRI SCHLICHENMEYER IS **THE BOOKWORM**



by **Brendan Reilly, MD**
c.2013, Atria Books

You always hated taking tests.

Prepared or not, your hands sweated when faced with a test, and your stomach felt shaky. Whatever you'd learned, it flew from your head the second you sat down.

Today, it's the same in the hospital as it was in high school: you hate taking tests. But what other way does your doctor have of knowing what's wrong with you? In the new book "One Doctor" by Brendan Reilly, MD, you'll see that moth-eaten methods may beat modern.

"New York doctors don't work weekends."

That's what one of Brendan Reilly's patients claimed, surprised to see Reilly at her bedside on an early Saturday morning at New York's Presbyterian Hospital. He was there because he believes that the doctor who "knows you best" is the one who should assume the majority of the caregiving. That's not the way most medical centers work these days, but it's the way he prefers to practice medicine.

For Reilly, doing things the old-fashioned way is often better than technology, when making a proper diagnosis. Machines, he points out, can miss the smallest of symptoms: a non-dilated pupil, an errant reflex, a hidden blood clot, rare bacteria that mimics something else.

BROKEN UP INTO THIRDS, "ONE DOCTOR" IS A MIXED (MEDICAL) BAG.

"Diagnosing disease," he says, "has something to do with patterns." Good doctors – "grandmasters," he calls them – know how to recognize those patterns without "wasteful, redundant, or ineffective" medical intercession. Such recognition, near-intuition, and the ability to deal with a day when "doctoring feels like pinball" are talents he cultivates in his residents and students.

Even so, there are times when a doctor is stumped by a medical mystery that requires rapt attention and sleuthing skills. That's when it's mandatory to listen to a patient, the patients' ailing body, and one's own subconscious, as well as medical knowledge new and old. Such mysteries may result in instinctual reaction, and a cure. Other times, they might end with the surety that it's time to stop.

And on that, says Reilly, doctors "know about regret. But we don't talk about it. Ever."

Broken up into thirds, "One Doctor" is a mixed (medical) bag.

Author Brendan Reilly, MD starts his book in the wee hours of a typical on-service day in a busy New York hospital, and we're treated to a whirlwind of intriguing medical cases, AHA! moments, and solutions worthy of a Sherlockian novel. The end of that long day, and the cases of his own parents, are where Reilly wraps up.

I would have been more enthusiastic about this book, had that been the sum of it.

No, instead, the middle third here is taken up by the story of a couple that Reilly knew some 30 years ago, the care of which still resonates in his career. That was interesting at first, but I thought it became overly long.

And yet, I did enjoy this book, overall, and I think lovers of medical dramas will, too. If that's you, and you're maybe willing to skip bits that lose your interest, then "One Doctor" tests out well. ■

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