Job Shadowing for Pre-Med Students
Hendrix College Program a Win-Win for Students and Physicians
Breastfeeding is natural. It’s the healthiest choice. But it is not always easy. Education and support — before, during and after the hospital stay — can increase success.

You can make it happen. Talk to new and expectant mothers about the benefits of breastfeeding. Refer them to resources like the Arkansas Breastfeeding Helpline at 1-800-445-6175. Order or download educational materials for mothers and health care providers at www.afmc.org/tools. And find out more at www.afmc.org/breastfeeding.

A small investment of your time can make a big difference in Arkansas’ future health. And theirs.
ON THE COVER

Job Shadowing for Pre-Med Students

Hendrix College Program a Win-Win for Students and Physicians

WHAT HAVE WE DONE FOR YOU LATELY?

DAVID WROTN, EXECUTIVE VICE PRESIDENT

COMMENTS

ROBERT HOPKINS, MD AND RONALD BALDWIN, MD

A Closer Look at Quality

Winner of the ASAE Excellence in Communications Award

36

30

34

SCIENTIFIC ARTICLE

Squamous Cell Carcinoma of Pancreas: Mystery and Facts

By Saikiran Raghavapuram, Arjun Vaid, Rayburn F. Rego

CASE STUDY

Stress Ulcer Prophylaxis use in the Intensive care Unit before and after House Staff Education

By Nikhil Meena, MD, FCCP; Marcus Costner, Pharm D, Manish Joshi, MD, FCCP

38

42

45

A Rare Presentation of Massive Right Atrial Myxoma Causing Constitutional Symptoms: A 20 Year Follow-Up

Alan X You; Evan S. Cohen, MD

Join us to stay updated on health care news in Arkansas.


© Copyright 2015 by the Arkansas Medical Society.
www.ArkMed.org

THE JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY

Volume 112 • Number 3  August 2015
I’m going to attempt to explain in the next few issues of The Journal, some of the legislation passed by your Arkansas Medical Society during the 90th Arkansas General Assembly. Many of these new laws will become effective during July of 2015.

This first new statute was the result of AMS members finding themselves financially at risk under private insurer episodes of care, specifically for perinatal episodes and total knee/hip replacements, where their average cost per episode was impacted primarily by the hospital’s reimbursement contract with the carrier.

Act 902 – To Limit Financial Penalties on Physicians in Alternative Payment Systems. In many alternative payment models such as “episodes of care,” physicians accept some of the responsibility for the quality and cost of care they provide. These systems are designed to hold physicians accountable for cost variations that are within their control. The incentives are designed to reward those who deliver high quality care while reducing unnecessary or avoidable costs such as the use of antibiotics for upper respiratory infections. On the other hand, physicians whose costs exceed a predetermined threshold are at some financial risk for part of that variation.

However, some costs are not within the physician’s control, such as the reimbursement contract between a carrier and a hospital. A physician practicing at hospital A (with a high reimbursement rate) whose practice patterns, lengths of stay, utilization of tests, etc. are identical to the physician at hospital B (with a lower or average reimbursement rate), will easily have a higher average cost due to the higher hospital reimbursement rate and potentially be on the hook for financial risk.

Physicians seem willing to participate in these alternative payment models as long as they are fair and support quality medical care. AMS believes that to be fair, physicians should not be penalized for costs that are not within their control. Physicians are normally not privy to hospital reimbursement contracts and have no way of knowing which hospital has lower rates; very little flexibility exists, particularly in rural Arkansas, to pick and choose which hospital you practice in (unless you want to move to another town); and physicians employed by a hospital, for all practical purposes will have to put their patients in the employer hospital regardless of their costs.

With the help of State Senator Missy Irvin, AMS introduced and passed what became Act 902. The essence of the statute comes down to a single paragraph: a health care payor…..when determining gain-sharing or risk-sharing for a physician, shall not attribute….any costs that are a result of variations in the …payor’s freely negotiated contract pricing with other persons or entities outside the physician’s practice if including the costs reduces a physician’s gain-sharing or increases a physician’s risk-sharing amount.

Contrary to what is being said by some of our Arkansas health insurers, Act 902 does not prevent them from participating in alternative payment models or pilots where physicians accept responsibility for some or all of the cost of care. Act 902 simply means that the carrier needs to make an adjustment to the physician’s cost of care to comply with the language stated in the preceding paragraph.

NEXT MONTH….Act 1106 – Prior Authorization Transparency Act
Professionalism Under Strain

ROBERT HOPKINS, MD AND RONALD BALDWIN, MD (ASSOC. PROF. OF PEDIATRICS)

A recent article in the wall street journal (Juhar, S), discusses the fact that many physicians are feeling a sense of discontent, loss of professional idealism and a perceived loss of status. There is a widespread anxiety regarding the future of medicine and the healthcare delivery system (Mackenzie, et al). There are many potential causes including the burden of increasing paperwork, rising professional liability premiums, and greater accountability at the same time as there is diminished autonomy and expectations from the public regarding healthcare and a delivery system which often does not meet the needs of the patient or the physician.

How can physicians address this disillusionment and dissatisfaction? Is this a loss of professionalism? If so, how do we define and reclaim professionalism? In antiquity, these were established by the Hippocratic Oath and a number of other codes of conduct.

Ultimately, the concepts of cultural, philosophical, and moral value were incorporated in teaching and practicing medicine. It became imperative to address the reason for practicing medicine — the care of patients and putting them first — emphasizing the real significance of answering the call to practice the art of medicine.

The core of this call is a system of professional ethics upon which are based the principles of patient care. Integrity of the individual physician is a requirement. Behaviors based in morality are codified in the Hippocratic Oath, including its modern interpretation. This is expanded in the chapter on medical professionalism to emphasize the importance of the welfare of patients, patient autonomy, and social justice. Such codes instruct us both on what we should do and on what kind of physician we should be in order to carry out our obligations to patients and society (Mackenzie, et al). This is our social contract and it is the beginning of a system of medical professionalism.

The social contract is dependent on understanding such virtues as compassion, trustworthiness, conscientiousness, discernment and integrity. These characteristic traits are associated with clinical competence, communication skills, beneficence, non-maleficence and justice. They guide our conduct and reveal other traits such as excellence, humanism altruism, and accountability.

And yet, there are at least twenty definitions which purport to describe professionalism beyond this social contract. Friedson describes it as a set of institutions which permit the members of an occupation to make a living while controlling their own work. This implies a specialized body of knowledge and an ability to oversee and self-regulate. (Mackenzie, et al). However, it does not address the more complex societal responsibilities of the physician or healthcare providers.

Professionalism is more than a list of behaviors. It is a belief system which has motivational force and from which are developed character traits which serve as standards of performance and conduct by which compliance, monitoring, and enforcement can be made (Wynia, et al). This is the basis upon which physicians and medical organizations can unite, create and keep shared promises of health care delivery — the social contract.

A belief system (philosophy) such as this will promote technical standards as well as the shared ethical values; a dialog can then develop based on ideas and ideals which may define the best way to organize and deliver health care. In that process, the profession (promise) about what the public and individual patients can expect from physicians and healthcare providers is bound to trustworthiness and commitment to patient care (leach et al).

But, what makes a good promise? Promises are vulnerable (leach et al). Well understood is the fact that, unfortunately, promises are not always kept. Unprofessional behavior, manipulation or intimidation in public, private and academic arenas do occur. There must be a system which allows for transparency, disclosure, apology and redesign of policy and procedure for repair and reinstatement of unkept promises.

Medical education has a primarily competency-based focus with measurable assessments of learners and their acquisition of skills. How the qualities of professionalism and being a “good physician” are instilled requires a different approach. How physician roles shape future physicians is based on an understanding of identity formation. Although not a new concept, it does focus on how medical competency and professional identity develop congruently and allows us to evaluate the difference in “doing the physician’s work” and “being a physician” (Selinger, et al). Individual identity develops in stages over time, experience. And exposure and professional identity develops within that context. Personal systems of value and judgment occur with significant transitions in social interaction. Social constructs (roles) and behavioral manifestations (competencies), though not synonymous, develop concordantly and complement one another in the process of becoming a physician. Explicit and implicit learning, social exposure, experience, and role modeling are all necessary components of the process of identity formation.

As assessment drives learning, we must in our evaluation of learners rigorously assess procedural skills, judgment and commitment to patients to inspire learning, influence values, and professional identity, reinforce competence and ultimately reassure the public (Cooke, et al).

Medicine as a profession is a calling, not a business. There is, to be sure, the business of medicine, and to the extent that it can facilitate professional health care delivery, it has purpose. As practitioners caring for and being committed to our individual patients we need to maintain an openness and commitment to our social contract. We can live the promise of our profession and enjoy what it means to be a member of a noble profession. When that is accomplished, the disillusionment and disappointment disappear.
It would be intimidating to think about going to medical school without this experience,” said Ty Spradley, 21, in reference to the Hendrix College Alumni/Student Pre-med Shadowing Program. “The firsthand knowledge I gained from this program was tremendous.”

Both Ty and his brother, Ples, have taken advantage of the program, which pairs pre-med students from the Conway campus with working physicians of various specialties. Currently available to any Hendrix College pre-medical student, the shadowing program is a service that developed, initially, from a conversation and a good idea.

Hendrix Development Coordinator, Julie Janos, spoke a few years back with a group of Hendrix alumni that happened to include AMS member Hayden Franks, MD. “We were looking for a way to help Hendrix students who were applying to medical school connect with physicians in Arkansas who are alumni of Hendrix College,” recalled Dr. Franks, a member of the Hendrix Board of Trustees. “Our thought was that a shadowing program would be a good way for Hendrix Pre-med students to get exposure to different fields of medicine with help from alumni practicing in those fields. The idea also represented a way to help alumni physicians reconnect with their alma mater.”

Excited about the possibilities, Dr. Franks stepped in to get involved. Since the program began in 2012, he has acted as its medical director. Now, three years after its inception, Dr. Franks expresses pride in a program that he believes is filling a need in Arkansas’ medical community. “I hope that physicians who are Hendrix alumni will see this article and be inspired to participate in our program,” he said. “Also, I hope that Arkansas physicians who are alumni of other colleges and universities will read this and jump in to help their institutions offer similar programs.”

Also involved closely in the creation and ongoing coordination of the shadowing program is Leigh Lassiter-Counts, director of Career Discovery and Internships at Hendrix. “The program is a partnership between the Hendrix Career Discovery Office and the Development Office,” said Lassiter-Counts, who works with Dr. Franks each year to get the program rolling. Together, they create and distribute personalized recruitment letters outlining the program for prospective students and participating alumni. “My role

---

**Job Shadowing for Pre-Med Students**

*Hendrix College Program a Win-Win for Students and Physicians*

by CASEY L. PENN
is getting the mailing out, receiving the information back from physicians, and organizing information by location and specialty. I then match the students with physician volunteers and communicate those matches to both groups. I couldn’t do this without the help of our development office.”

Once the program is advertised to students, Lassiter-Counts provides training to prepare the participants. The training covers workplace norms that college students may not yet have been exposed to like how to act professionally while shadowing, how to reach out to the physician to set up the shadowing day, and understanding HIPAA.

Ples Spradley, one year ahead of his younger brother Ty, participated in the program every year since its inception before graduating this past May with two degrees – Biochemistry/Molecular Biology and Spanish. (He will attend medical school at UAMS beginning this fall.) Ples credits the Hendrix program with solidifying his choice to pursue a career in medicine. By following a different doctor and specialty each year, he learned something new from each experience. “Shadowing confirmed that medicine is a field that requires constant learning. That is exciting to me,” said Ples, who followed physicians in dermatology, cosmetic surgery and cardiology. “In each experience, I noticed the caring nature of the physicians during interactions with patients and witnessed relief and comfort on patients’ faces when they received good news from their doctor. The common theme was an intellectual, challenging environment with caring people who make meaningful differences in the lives of patients.”

More specifically, the program opened his eyes to characteristics unique to each specialty. “I observed differences in terms of patient consultations, typical procedures, and daily regimen,” he said. “I am more knowledgeable about these medical specialties [now] and will use this information as I begin to think about my own future area of medicine.”

Pre-med student Taylor Bennett is entering her senior year at Hendrix. Originally from Quitman, Ark., her participation in the program raised her confidence level. “The program allowed me to experience the medical field as it truly is. At times, I wondered if I was competent enough to become a doctor,” said Bennett. “By shadowing, I received advice that encouraged me never to give up and gained reassurance in my decision to continue with a future in this field.

“Becoming a physician will not be easy, but I have learned that I am not only capable of reaching my peak, but ready to keep climbing the mountain until I get to my destination. I can only hope that one day I will become the Hendrix alumni physician who helps guide another future Hendrix College student.”

Lassiter-Counts takes special care to match students with appropriate physicians in the program. In-state students typically work with physicians...
cians from their hometown area – alumni from all four corners of the state as well as those in central Arkansas have volunteered for the program. Out-of-state students are normally assigned to central Arkansas doctors. “Many times, students shadow over a winter, spring or summer break, so the hometown matches have worked out well,” explained Lassiter-Counts. “In addition, we don’t want to overburden our Conway and Little Rock physicians with a flood of students.”

In the first year of the program, Lassiter-Counts matched 32 physicians with 51 students. That rate has remained steady, with 55 students and 40 physicians being involved this past spring. Since the program began, as many as 54 participating physicians have served as shadowing mentors.

“We always welcome more to sign up. Some of our more generous volunteers will host five to eight students a semester. It would be great to spread those out a little more,” she said. Thrilled by the success of the program, Lassiter-Counts called it a win-win and hopes, like Dr. Franks, to watch it continue to grow. “Hendrix attracts a large number of pre-med students each year, and we have a great track record of acceptances to medical schools all over the country.”

The program has achieved a number of goals for the college, indicated Lassiter-Counts. “It is allowing alumni physicians to reconnect with their alma mater in a tangible way,” she said. “In turn, the program is helping Hendrix College to create stronger, more experienced applicants for professional schools in health.”

Lassiter-Counts would love to see the program eventually expand to other high enrollment areas such as Dallas and Memphis or other pre-professional areas such as law.

Board certified in dermatology, Dr. Franks has hosted 10 students through the program, giving them opportunities to shadow at both his Little Rock and Texarkana locations. “In my practice, I focus on teaching by exposing the students to patients and then discussing their disease process, diagnosis, and treatment algorithms,” explained Dr. Franks. “The students have been fantastic. They have witnessed firsthand the practice of dermatology. They have been exposed to hundreds of patients, assisted in numerous surgeries and procedures, and, by the end of their rotation through our clinic, are performing at the level of a medical intern. I think this experience has helped them immensely.”

Rob Emery, MD, a urologist in Batesville, is also active in the program. His daughter, Kate Emery, is also participating in the program, as a senior pre-med student at Hendrix. From the unique perspective of seeing the program from both sides, Dr. Emery feels that shadowing is rewarding to all involved. He said, “Not only does the program give students an opportunity to interact and network with physicians from their hometown areas, it also gives physicians a chance to meet someone from their alma mater who shares an interest in medicine. A future colleague, if you will.

“This program has exposed Kate to aspects of medicine that I was not able to provide for her. No matter what job an undergraduate may be interested in, shadowing someone in that occupation is extremely valuable.”

So far, pre-med students in the program have shadowed physicians working in cardiology, cosmetic surgery, dermatology, urology, and many other specialties. The door is open for involvement by physicians and health care professionals (Hendrix alumni) from any practice or specialty. To learn more about Hendrix’ shadowing program, contact Dr. Franks at haydenfranks@me.com or Leigh Lassiter-Counts at Lassiter-counts@hendrix.edu or 501-450-1439.

Hayden Franks, MD, has hosted 10 students through the Hendrix College alumni/Student Pre-med Shadowing Program.
AMS Benefits, Inc.

Created by the Arkansas Medical Society to deliver quality insurance coverage to Arkansas physicians, their families and their practices.

Providing the protection you need to focus on your patients.

Coverage Includes

- Group Health
- Individual Health
- Group Disability
- Individual Disability
- Health Savings Account Plans
- Business Overhead
- Life Insurance
- Dental Insurance
- Vision Insurance

Comprehensive Insurance. Custom made for you.
www.ArkMed.org/AMSBenefits
800.542.1058 | Agency NPN# 1650351
CASE REPORT:

A 31-year-old, Caucasian female with stage II A intraductal breast carcinoma was admitted to the hospital for chemotherapy induced oral mucositis and febrile neutropenia. She was receiving neo-adjuvant chemotherapy through a right subclavian infusion port. At admission she was hemodynamically stable and physical examination did not reveal a source of infection. She was started on empiric antibiotic therapy after necessary cultures were obtained. The following day, she developed acute onset shortness of breath. On examination, she was tachypneic and tachycardic. A dusky cyanosis of the face extending down to the neck and upper chest, peri-orbital edema and facial swelling were also noted. Upper body cyanosis worsened with recumbency. Over the ensuing minutes, she complained of severe headache and had a brief syncopal episode. She remained hemodynamically stable and alert throughout the course. An emergent contrasted CT scan of the chest revealed an occlusive thrombus within the superior vena cava (SVC) and within the distal portions of the right brachiocephalic and internal jugular veins extending in to the right atrium. The thrombus in the right atrium measured 3.2 x 2.1 cm (Figure 1). The tip of the infusion port was embedded within the SVC thrombus. Anticoagulation with intravenous heparin was initiated and the patient was transferred to the intensive care unit. Cardiothoracic surgery and interventional radiology were consulted for assistance. Catheter guided thrombolysis was considered to be risky due to the high clot burden in the right atrium and the potential risk of clot dislodgement and embolization to the pulmonary arterial system on catheter manipulation. Open surgical thrombectomy was also felt to impose a prohibitive risk of embolism, stroke and potential death. Meanwhile the patient continued to have worsening headaches and cyanosis and developed rapidly worsening blurring of vision. Due to the high risk of other approaches, systemic thrombolysis was initiated. Heparin infusion was stopped and intravenous infusion of 100mg of tissue plasminogen activator (t-PA) was given over 2 hours with dramatic improvement in vision, upper

“The Scalpel or the Needle for Superior Vena Cava syndrome?”

By Deepak Chandra, MD; Naga Venkata K. Pothineni, MD; Nikhil Meena, MD FCCP
From the Department of Medicine, University of Arkansas for Medical Sciences and Central Arkansas Veterans Hospital System, Little Rock, AR.

ABSTRACT

Acute Superior Vena Cava (SVC) syndrome from thrombosis is an increasingly recognized complication of intravascular devices. We present a 31 year old woman with an infusion port placed for chemotherapy who developed acute SVC obstruction. A computerized tomograph (CT) of chest revealed an occlusive thrombus within the SVC extending into the right atrium. Catheter-guided thrombolysis and surgical thrombectomy were felt to impose prohibitive risks. Worsening symptoms led to the use of systemic thrombolysis with tissue plasminogen activator (t-PA) leading to dramatic improvement in symptoms. A repeat CT, revealed a reduction of the right atrial thrombus and SVC occlusion had resolved.

Figure 1: CT scan showing occlusive thrombus within the Superior Vena Cava (SVC) with the tip of the infusion port embedded within it and Right Atrial (RA) thrombus.
The underlying etiology. The most useful diagnostic obstruction is about 6 months but varies widely with estimated life expectancy among patients with SVC syndrome. The degree of obstruction and speed of onset. The severity of symptoms will depend on the heart of this uptick. It has been reported that up to 42% of patients with central venous catheters will develop catheter related thrombosis and up to 14% develop SVC syndrome.

Obstruction of the SVC causes a rise in venous pressures with resultant swelling and cyanosis of the head, neck, face and arms. Patients may complain of cough, hoarseness, dyspnea, stridor or dysphagia from edema in the larynx and pharynx. The laryngeal edema or coma from cerebral edema may result in death. The severity of symptoms will depend on degree of obstruction and speed of onset. The estimated life expectancy among patients with SVC obstruction is about 6 months but varies widely with the underlying etiology. The most useful diagnostic imaging modality, to diagnose SVC syndrome is contrast enhanced CT of the chest. Clinical history and CT images will clinch the diagnosis and the possible etiology. Further invasive testing such as bronchoscopy or mediastinoscopy may be necessary to obtain a tissue diagnosis. If surgery or stent placement is planned, venography may be necessary.

Management of SVC syndrome is twofold: treatment of the underlying etiology and symptomatic relief. Head elevation, glucocorticoids and loop diuretics have been tried to provide symptomatic relief, though there is paucity of data to support any of these measures. There have been no randomized controlled studies that have investigated different therapeutic approaches for central venous catheter thrombosis. Thrombolytic therapy followed by anticoagulation is the recommended therapy in acute thrombosis. Gray et al published a large series of cases in 1991 where systemic t-PA was successfully used for treatment of acute SVC syndrome. They also observed that thrombolysis was most effective for patients with venous catheters, possibly because, thrombosis was detected earlier and the thrombolytic agent could be delivered directly into the thrombus via the catheter. Dağdelen recently reported successful use of systemic tissue plasminogen activator (t-PA) for thrombolysis in a patient who developed SVC syndrome, from thrombosis of a subclavian vein port. With development of interventional radiology techniques, catheter directed thrombolysis is the preferred treatment modality. Open surgical thrombectomy and venoplasty are other strategies that have also reported success in SVC thrombosis. Intravascular stents are used as definitive therapy and for palliation.

Acute SVC syndrome from thrombosis, though rare, is increasingly seen, as a complication of use of intravascular devices. Currently catheter guided thrombolysis is the mainstay of treatment. However, due to the high risk of clot dislodgement and risk of surgical approaches, systemic thrombolysis was successfully used in our patient. In addition, systemic thrombolysis could be used for acute central venous thrombosis at centers that do not have immediate access to catheter guided thrombolysis or surgical thrombectomy. This case highlights the safety of this approach and can potentially be useful for management of acute thrombotic SVC syndrome.

REFERENCES:
Patient Centered Medical Home Quality Assurance — Validation

Providing high quality, effective health care has become a priority in today’s expanding health care industry. It benefits patients as well as providers and health care facilities. The Patient-Centered Medical Home (PCMH) program of the Arkansas Payment Improvement Initiative (APII) seeks to achieve the triple aim of improving the health of Arkansas Medicaid beneficiaries, enhancing the patient experience of care, and reducing or controlling the cost of care. The PCMH program’s design necessitates a strong quality assurance program to ensure the program’s integrity and encourage real practice transformation for the benefit of Arkansas Medicaid beneficiaries. The purpose and primary focus of the PCMH Quality Assurance (QA) program is to ensure practices adhere to the program’s principles by monitoring and reviewing self-reported data, placing practices in a remediation plan if program requirements are not met, and providing continuous education about the PCMH program.

TRACING ACTIVITIES
AND METRICS

To maintain practice support and shared savings incentive payments, participating providers must complete PCMH activities and metrics. Table 1 is a list of each activity and the non claims-based metric tracked for practice support.

Further details and deadlines are in the PCMH Manual, located on the APII website at www.paymentinitiative.org under the PCMH section.

The first step in completing the activities is attesting that the activities and the non claims-based metrics have been completed. Attesting involves entering self-reported data into the Arkansas Health Information Network (AHIN) provider portal prior to designated deadlines for each activity and metric. The PCMH QA team will be responsible for validating the self-reported information.

VALIDATION OF ACTIVITIES
AND METRICS

It is important to validate the activities and metrics to ensure that self-reported data is accurate and uphold the program’s principles. A QA specialist will schedule and conduct an online validation visit at each PCMH to review supporting documentation for each activity and non claims-based metric. Based on criteria established by the QA team and approved by Arkansas Medicaid’s Division of Medical Services (DMS), the QA specialist determines if the supporting documentation is sufficient to be accepted as evidence, and that the activities and non claims-based metrics are complete and meet all program requirements.

If a QA specialist determines that the supporting documentation is insufficient to meet program requirements, the practice will receive notification from the PCMH QA team. The practice will be given time to remediate its activity or metric performance. Typically, a practice must remediate activity performance prior to the end of the first full quarter after the practice receives a notice that the target was not met. For the non claims-based metric that does not meet the target, practices will have until the end of the second full quarter after the date the practice received notice that the target was not met to remediate its performance. If, at the end of the remediation period, a practice fails to meet the required target for practice support, the QA team will refer the practice to DMS for additional action. DMS can suspend the practice from the PCMH program. In order to meet PCMH program requirements, practices are encouraged to seek the assistance of a practice transformation vendor or an AFMC provider representative.

OBSERVATIONS AND VALIDATION RESULTS

During the first round of activity validation, the QA team discovered...
that most practices faced challenges in providing Arkansas Medicaid beneficiaries with 24-hour, seven-days-a-week access to care. Practices are required to provide beneficiaries with access to a live voice (an employee of the practice or an answering service) when calling the office after regular business hours. Several practices asked the caller to leave an answering machine message and the call would be returned the next morning. The use of an answering machine is acceptable if the machine can immediately page an on-call medical professional 24/7. The purpose of the 24/7 access to care activity is to ensure beneficiaries are provided with instructions, from a live person, to treat emergency and non-emergency conditions after regular business hours. With the help of additional education and guidance, noncompliant practices were able to remediate their performance and successfully complete this activity. After the remediation period, results of the six-month validation indicated that 96 percent of PCMHs completed and passed the activities.

During the validation period, the QA team received valuable feedback and positive comments about the PCMH program from providers and practice staff. One provider stated, “The PCMH program does cause more work, but it will be better for everybody once the processes get into the flow.” Another provider said, “We’re already doing things for Medicare and five-star standards, so we just expanded things to include our Medicaid patients. We were already doing most of the required activities.”

FUTURE PLANS

During the next phase of the PCMH program, providers are required to once again complete the non claims-based metric by the end of the performance period on Dec. 31, 2015. Practices will also be required to complete the activities, with deadlines of 12, 18 and 24 months, for the practice to continue receiving practice support. The same validation process will occur for future activities as it did for the six-month activities. Once practices have attested to completing the respective activities and non claims-based metric, the QA team will begin the validation process.

In the coming year, the PCMH QA program requirements for activities and metrics, including the care plan metric, will be revised as necessary to ensure continuous improvement of Arkansas Medicaid beneficiaries’ health outcomes. Providers are encouraged to carefully review activity and metric targets for 2015. The targets have changed so participating practices can continue improving the quality of beneficiaries’ health care. Updates to the program will be on the APII website at www.paymentinitiative.org under the PCMH section. Information on a webinar and frequently asked questions relating to care plans is available on the APII website and under the PCMH QA section at afmc.org. The PCMH team will continue to support practices by offering educational sessions regarding changing program requirements.

Ms. Fedor is manager of PCMH Quality Assurance for the Arkansas Foundation for Medical Care.

### TABLE 1. Tracked activities and non claims-based metrics for practice support

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>NON CLAIMS-BASED METRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Identify top 10% of high-priority beneficiaries.</td>
<td>A. Percentage of high-priority beneficiaries whose medical record has a care plan that includes:</td>
</tr>
<tr>
<td>B. Assess operations of practice and opportunities to improve.</td>
<td>1. Documentation of beneficiary’s current problem</td>
</tr>
<tr>
<td>C. Develop and record strategies to implement care coordination and practice transformation.</td>
<td>2. Plan that integrates contributions from health care team and beneficiary</td>
</tr>
<tr>
<td>D. Identify and reduce medical neighborhood barriers to coordinated care at the practice level.</td>
<td>3. Instructions for follow-up</td>
</tr>
<tr>
<td>E. Make available 24/7 access to care.</td>
<td>4. Assessment of progress to date</td>
</tr>
<tr>
<td>F. Track same-day appointment requests.</td>
<td>Care plan must be updated at least twice within a 12-month period.</td>
</tr>
<tr>
<td>G. Establish processes that result in contact with beneficiaries who have not received preventive care.</td>
<td></td>
</tr>
<tr>
<td>H. Complete a short survey related to beneficiaries’ ability to receive timely care.</td>
<td></td>
</tr>
<tr>
<td>I. Invest in health care technology or tools that support practice transformation.</td>
<td></td>
</tr>
<tr>
<td>J. Join SHARE and be able to access inpatient discharge and transfer information.</td>
<td></td>
</tr>
<tr>
<td>K. Incorporate e-prescribing into practice workflows.</td>
<td></td>
</tr>
<tr>
<td>L. Use electronic health records (EHR) for care coordination.</td>
<td></td>
</tr>
<tr>
<td>M. Demonstrate ability to extract clinical data from EHRs.</td>
<td></td>
</tr>
</tbody>
</table>

Ms. Fedor is manager of PCMH Quality Assurance for the Arkansas Foundation for Medical Care.
Stress Ulcer Prophylaxis use in the Intensive care Unit before and after House Staff Education

By Nikhil Meena, MD, FCCP1 Marcus Costner, Pharm D2 Manish Joshi, MD FCCP3

1 From the Department of Medicine, University of Arkansas for Medical Sciences and Central Arkansas Veterans Hospital System, Little Rock
2 From the Department of Pharmacy, Central Arkansas Veterans Hospital System, Little Rock

Abstract

PURPOSE: We hypothesize that stress ulcer prophylaxis with acid suppressant medications (ASM) is overused and educating house-staff will decrease this.

METHODS: Retrospective chart review in two six-month phases. House staff was educated prior to phase II. Rates of SUP were calculated for ICU stay, medicine floor, and at discharge.

RESULTS: There were 625 ICU admissions. Analysis was done on 106 and 118 patients in each phase. SUP use decreased from 62% to 37% in patients with no indications (p value <0.01).

CONCLUSION: Education can have a significant impact on the appropriate use of medications. Even after this significant decrease, rates of inappropriate usage could be considered unacceptable.

KEYWORDS:
Peptic ulcer disease, acid suppressive medications, house staff

ABBREVIATIONS:
ICU: Medical Intensive Care Unit
ASM: Acid Suppressive Medications
SUP: Stress Ulcer Prophylaxis

Introduction

Acid suppressive medications (ASM) for stress ulcer prophylaxis (SUP) are widely prescribed for ICU patients at risk for stress-related gastrointestinal bleeding. The Surviving Sepsis Campaign advocates SUP for patients with severe sepsis, noting that many patients have major risk factors (mechanical ventilation or coagulopathy) for stress ulcer bleeding. While SUP is indicated for some ICU patients, there is not a universal need for SUP, and there have been reports of overuse of SUP in both ICU and non-ICU settings. Failure of appropriate therapy occurs in two ways; there is over-prescription for patients admitted to the hospital, and there is failure to stop SUP after acute-care indications have resolved. In one study 31.0% of patients who had not been on ASM prior to ICU admission were discharged on ASM despite having no new identifiable indication for ongoing ASM therapy.

Our study was aimed to evaluate (a) SUP use at our institution and (b) impact of house staff education on said use. We hypothesized that SUP is prescribed more often than indicated and that house staff education would decrease rate of over-prescription.

Methods

This was a retrospective chart review performed after Institutional Review Board approval had been obtained. The goal was to evaluate how a teaching intervention affected the prescribing of SUP. We specifically looked at the admitting diagnosis, presence of indications for SUP, time of initiation of SUP, and discontinuation of SUP.

Study design:

The study was conducted in two phases. Phase I comprised of data collection for patients admitted to the ICU between July 1, 2009 and December 31, 2009. All house staff in the ICU during phase II completed a pre-rotation questionnaire followed by a dedicated didactic session on SUP. Phase II was conducted from January 1, 2010 to June 30, 2010.

Exclusion criteria

Patients on ASM prior to admission, patients admitted to the ICU with indications that required ASM not as prophylaxis but as therapy (i.e. gastrointestinal bleeding), and patients who died within 24 hours of admission were all excluded.

Results

A total of 626 patients were admitted to the Central Arkansas Veteran Hospital Systems (CAVHS) ICU over the study interval. After application of the exclusion criteria, there were 106 study patients in phase I and 118 study patients in phase II. The largest reason for exclusion was ASM therapy prior to admission, which accounted for 84% of exclusions and 54% of patients accrued over the entire study.

Phase I

Overall, 75 (70%) of the 106 study patients admitted to ICU during phase I were started on ASM (see Table 2). When categorized by group, 20 patients had a group 1 (major) indication and 18 of them (95%) were started on SUP, 68 patients had a group 2 (minor) indication and 14 (78%) were started on SUP, and 68% were in group 3 (no indication) but 42 (68%) had been started on SUP regardless. Of the 106 study patients accrued during phase I, 99 improved enough to be discharged to the floor. Out of these patients 95 had no remaining indications for SUP, however 68 (69%) remained on ASMs.

Table 1 delineates literature-based major and minor indications for SUP in the ICU. Study patients were divided into 3 groups based on the presence of major or minor indications. Group one consisted of patients who had at least one major indication and who therefore definitely should receive SUP; group 2 consisted of patients with no major indication and ≥ 1 minor indication; and patients with no major or minor indication for SUP were placed into group 3.

Statistical analysis

Student’s t test was used to compare phase I with phase II, and p values were calculated where applicable.

Overall, 75 (70%) of the 106 study patients admitted to ICU during phase I were started on ASM (see Table 2). When categorized by group, 20 patients had a group 1 (major) indication and 18 of them (95%) were started on SUP, 68 patients had a group 2 (minor) indication and 14 (78%) were started on SUP, and 68% were in group 3 (no indication) but 42 (68%) had been started on SUP regardless. Of the 106 study patients accrued during phase I, 99 improved enough to be discharged to the floor. Out of these patients 95 had no remaining indications for SUP, however 68 (69%) remained on ASMs.
Ninety-two of the 99 patients who had been discharged to the floor were eventually discharged to home. Only one patient had a minor indication (high-dose steroids) for ASM, but 21 of the 92 (23%) were discharged on ASM therapy despite the lack of ongoing indication.

**Phase II**

Pretests about literature-based indications for starting and stopping SUP were completed by 46 house officers. While 42 (91%) reported that they were cognizant of the recommendations, only 6 (13%) knew when to stop therapy.

Of the 118 patients admitted to the ICU during phase II, SUP was started on 16/18 (89%) patients with group 1 indications, 13/19 (68%) group 2 patients, and 30/81 (37%) patients with no indication. Overall 50% of the phase II study patients were started on ASM. At discharge from the ICU, 37 (34%) remained on ASM despite no ongoing indication, and this number decreased to 16 (15%) at discharge from the hospital. Two patients were discharged home on ASM for peptic ulcer disease.

**Discussion**

Critically ill patients are at increased risk for stress-related gastric mucosal disease and subsequent bleeding as a result of both underlying disease and therapeutic interventions. Several clinical conditions and medications place patients at risk for stress-related gastric mucosal disease. In a multicenter observational study, Cook et al demonstrated that respiratory failure (mechanical ventilation for at least 48 hours) and coagulopathy were strong independent risk factors for stress-related mucosal bleeding. The frequency

<table>
<thead>
<tr>
<th>Major</th>
<th>Minor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical ventilation</td>
<td>Sepsis or severe hypotension&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Coagulopathy&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Acute Renal Failure&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Hepatic Failure&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Severe head or spinal cord trauma</td>
</tr>
<tr>
<td></td>
<td>History of gastrointestinal bleeding</td>
</tr>
<tr>
<td></td>
<td>Burns &gt; 35% of body surface</td>
</tr>
<tr>
<td></td>
<td>Major surgery &gt;4 hours</td>
</tr>
<tr>
<td></td>
<td>High-dose corticosteroids&lt;sup&gt;e&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup> International normalized ration >1.5, partial thromboplastin time >2 times upper limit of normal, platelets <50,000  
<sup>b</sup> Systolic blood pressure < 80 mmHg  
<sup>c</sup> Creatinine clearance < 40 ml/min or serum creatinine >2.8 mg/dL  
<sup>d</sup> Aspartate transferase > 500 U/L or total bilirubin > 8.8 mg/dL  
<sup>e</sup> Equivalent of 250 mg of hydrocortisone
of bleeding was 3.7% if one or both of these risk factors was present, whereas patients without either of these complications had a bleeding rate of only 0.1%.

SUP with ASM including sucralfate, H2 blockers, and proton pump inhibitors (PPIs) has been widely used in ICU patients at risk for stress-related gastric mucosal disease. The Surviving Sepsis Campaign advocates SUP for severe sepsis, noting that many septic patients have a major risk factor (mechanical ventilation or coagulopathy) for stress ulcer bleeding. Prophylaxis against stress ulcers, however, is expensive and may have adverse effects. There have been multiple reports of overuse of SUP in both ICU and non-ICU settings. Perhaps a greater issue arises when these medications are not discontinued later in the hospital course. In a study by Farrell et al., 31.0% of patients not on ASM prior to a hospital stay that began with an ICU admission were discharged on ASM despite having no identifiable indications at time of discharge.

In addition to the direct and indirect costs associated with these medications, these drugs have potential for adverse side-effects. PPIs have been linked with increased incidence of c. difficile infection, nosocomial pneumonias and, more recently, with increased adverse outcomes when combined with clopidogrel in patients with acute coronary syndrome. H2 blockers can cause thrombocytopenia and ICU delirium.

This study performed at a teaching institution demonstrated several findings. First, a large portion of patients (54%) admitted to the ICU setting were already being treated with ASM. This may be partially due to lack of discontinuance from prior admissions, a conclusion supported by the fact that both pre- and post-education about 20% of patients were discharged on ASM with no ongoing indication for that therapy. Second, even though practitioners felt confident in their knowledge base, usage of ASM was sub-optimal and a refresher course had a significant impact upon outcomes. In this study, high rates of SUP usage for patients with strong and intermediate indications for SUP were present both before and after education, but there was a marked decrease in inpatient usage for those patients with no clear indication (p < .001 both in the ICU and after discharge to the floor). This decrease in over-usage has implications with respect to both cost and adverse side-effects. Third, even the improvements in usage resulting from our educational interventions were inadequate; the goal for unnecessary interventions should be zero. Daily drug review and medicine reconciliation at time of patient transfers are paramount and need to be added to decrease unnecessary use.

In summary, our data suggest that appropriate use of SUP is teachable. Brief training had a significant impact upon in-hospital use. From another perspective, one could say that even this effective intervention was inadequate; even after training, inappropriate use persisted for about one in three inpatients and one in five patients upon discharge. Any inappropriate usage of a medication represents risk without benefit. The wide adoption of electronic records may contain a solution; drugs such as ASM could be tagged with educational bullets embedded in the prescribing pathway such that re-education and reconsideration were required on an ongoing basis. Our data support the need for a solution such as this.

References
For all the road blocks in life.

Let us help Pointe your family in the right direction.

When families become stressed by behavioral issues, they need a caring environment. Pinnacle Pointe is the largest child & adolescent behavioral care hospital in Arkansas.

Programs and Services:

- Acute Inpatient
- Residential Inpatient
- Outpatient
- School-Based

Pinnacle Pointe is the only Tricare-certified residential program in the state. Contact us for a free, confidential assessment.
Squamous Cell Carcinoma of Pancreas: Mystery and Facts

By: Saikiran Raghavapuram, Arjun Vaid, Rayburn F. Rego
University of Arkansas for the Medical Sciences, Little Rock, AR

KEYWORDS: Squamous cell cancer of pancreas, metastasis from other sites, poor prognosis.

ABSTRACT:
Squamous cell carcinoma of the pancreas is very rare as pancreas does not have any squamous cells. Only a few cases have been reported in the literature so far. We describe such a case where in the patient presented with painless jaundice. CT and EUS confirmed the pancreatic mass biopsy of which showed squamous cell cancer.

CASE:
A 76-year-old Caucasian male presented with weight loss, painless jaundice and abdominal pain. Labs were consistent with obstructive jaundice picture. CT revealed a 4.1 x 4.9 x 5.0 cm enhancing inhomogeneous malignant appearing mass in the head of the pancreas. Endoscopic ultrasound was performed which showed a 4 cm hypoechoic mass (Figure 1) in the head of the pancreas. Biopsy was performed and the histology showed moderately differentiated squamous cell carcinoma (Figure 2a) with no glandular differentiation and immunostaining was positive for CK 5/6 and p 63 (Figure 2b) confirming it as squamous cell cancer. CT scan of the body has not showed any other potential primary.

Pt had a biliary stent placed for the palliative purposes at the time of diagnosis with ERCP. The pt underwent PET CT which has not shown any metastasis outside pancreas. The pt was referred to surgery for the resection of tumor. He underwent biliary stent exchange 7 months later. His last CT abdomen pelvis after 10 months showed a substantial decrease in the size of tumor from 4.9 x 4.1 x 5 cm at the time of diagnosis to 1.7 x 1.5 cm. He was awaiting to be seen by surgery for the resection when he was seen for the last time.

DISCUSSION:
Pure pancreatic squamous cell cancer is very rare and has been described in 0.005% percentage of all exocrine pancreatic tumors.1,2 It is important to rule out more common conditions including metastasis to pancreas from other primaries where squamous cell cancer is common and also the possibility of a adenosquamous carcinoma. Different theories have been proposed for the origin of squamous cell cancers including squamous metaplasia of the ductal cells, differentiation of multi potent cell into squamous cells but exact origin is still controversial.1 CT imaging is extensively used as it can provide information not only regarding local or distant metastasis but also can provide information about the other primary sites from where metastasis to pancreas is common.5 Enhancement of tumor on contrast CT and tumor blush on angiography helps to differentiate squamous cell from the adenocarcinoma due to its rich vascularity.1,2 EUS guided biopsy is commonly employed.5 Sometimes esophagoduodenoscopy is used for the biopsy when the tumor invades the stomach.6 Biologically, it behaves similar to adenocarcinoma with local or distant metastasis at the time of diagnosis and carries a more grim prognosis than the adenocarcinoma. Median survival is 6-16 months. Surgical resection is curative but applicable only in a minority of patients as the tumor is widely metastatic almost all the time

There has been one case report where platinum based chemotherapy has been used for palliation and was able to achieve better quality of life when compared to other chemotherapy regimens.3
at the time of presentation. Chemotherapy including gemcitabine based regimens are commonly used but with variable success. There has been one case report where platinum based chemotherapy has been used for palliation and was able to achieve better quality of life when compared to other chemotherapy regimens.3

CONCLUSION:
Pancreatic squamous cell cancer is very rare but is quite interesting as its origin is still controversial. Imaging guided biopsies are commonly performed and immunostains are used for the exact diagnosis. Most important is to exclude metastasis from sites where squamous cell cancer can commonly occur. Prognosis is grim and its method of diagnosis and management does not differ much from other types of pancreatic malignancies.

REFERENCES:

Figure - 2(a): Hematoxylin and eosin staining of the biopsy specimen showing nests of squamous cells with atypia.

Figure-2(b): Immunostaining showing that the sample is positive for CK 5/6 and p63 confirming it as squamous cell carcinoma.

ICD-10-CM Coding Extravaganza “A Hands-on Approach”
September 2, 2015
IIAA Building
5000 North Shore Drive
North Little Rock
Registration: 8 am
Seminar: 8:30 am – 4:45 pm
A full day of “hands-on” ICD-10-CM training and education
Register online at www.arkmed.org

AMS Annual Insurance Conference Dates:
• Jonesboro: October 1, 2015
• Fayetteville: October 15, 2015
• Little Rock: October 21, 2015
• Little Rock: October 22, 2015
Locations and registration materials will be sent soon.
ATTENTION MEDICAID ELIGIBLE PROFESSIONALS

Don’t miss out!

AFMC is now offering 

no-cost assistance

to Medicaid eligible professionals* in Arkansas to achieve and sustain Meaningful Use.

2016 is the FINAL YEAR to begin participation in the Medicaid incentive program and earn the maximum incentive payment of $63,750!

*MDs and DOs, dentists, nurse practitioners and certified nurse midwives, physician assistants and other specialists as established by guidelines from the Centers for Medicare & Medicaid Services (CMS).

For more information about this program and our services, visit afmc.org/healthit or call 501-212-8616.
Primary tumors of the heart are rare. Approximately 70 percent of cardiac tumors are benign, and 30 percent malignant. Of the benign tumors, myxomas make up the majority, representing approximately 50 percent of all benign tumors. There have been less than 15 reported cases of a myxoma arising from the inferior vena cava. This present report represents a case of a rather large myxoma arising from the right atrial-inferior vena caval junction. Echocardiographic findings and surgical techniques are described.

Case Report
The patient is a 57-year-old male with several month history of generalized fatigue, 10 pound weight loss, and night sweats. Previous evaluation failed to find any specific problems other than tachycardia. He was admitted to the hospital because of progression of his symptoms. Echocardiography demonstrated a huge right atrial mass that was noted to prolapse through the tricuspid valve. At operation, cardiopulmonary bypass was established with venous return from a right-angled superior vena caval cannula and right femoral vein cannulation. With the aorta cross clamped, a generous right atriotomy was performed. A large tumor mass that measured 11 x 8 x 4 cm was found attached to the junction of the free wall of the right atrium and inferior vena cava by a small stalk. A portion of the tumor extended down into the inferior vena cava. The tumor was excised with a surgical margin ranging from 0.7 to 1.0 cm. Inspection of the other cardiac chambers did not reveal any other masses. Microscopic analysis was consistent with a myxoma. The patient's hospital course was uneventful and he was discharged on the fourth postoperative day. All of the patient's symptoms resolved postoperatively, and follow up echocardiograms have revealed no evidence of recurrence. Patient remains asymptomatic and continues to have an active lifestyle 20 years postoperatively.

Discussion
Myxomas are the most common primary tumors of the heart, with an estimated incidence of 0.5 per million population per year. Although they can arise from any cardiac chamber, 80 to 90 percent are found in the left atrium. As with left atrial myxomas, when right atrial myxomas occur, they primarily originate from the atrial septum. Very uncommonly do they have any involvement of the inferior vena cava or related structures. In fact, there have been only thirteen previously reported cases of a myxoma arising from the inferior vena cava, the junction of IVC and right atrium, or the eustachian valve. Involvement of the IVC is significant as it can lead to unusual symptoms at presentation and may necessitate alternative procedures during intra-operative treatment. Excision of the tumor in our patient did not require partial excision of the IVC and pericardial patching as the site of attachment was relatively small relative to tumor size due to the presence of a tumor stalk. However, such procedures may be required in tumors with greater involvement of the suprahepatic IVC.

Symptoms from cardiac tumors are highly variable and are usually from manifestations of acute or chronic obstruction of blood flow or from embolization. A majority of patients present with cardiovascular signs and symptoms such as valve obstruction, dyspnea, or cardiomegaly. Fatigue is the most common symptom overall with over 80 percent of patients reporting some degree of fatigue at initial presentation. Cerebral or pulmonary embolic events occur in roughly 20 percent of patients dependent upon size, fragility, and mobility of the tumor. Some patients uncommonly present with fever, weight loss, anemia, Raynaud's phe-
nomena, myalgias, and arthralgias. These constitutional symptoms are reported preoperatively in less than 15 percent of all patients with atrial myxoma and can sometimes be the only symptoms at initial presentation. Our patient’s symptoms of generalized fatigue, 10 pound weight loss, and night sweats at presentation gave no indication of a cardiac diagnosis. In fact, diagnosis of atrial myxoma in this patient was only made after thorough workup had ruled out more common causes of these general constitutional symptoms. These symptoms resolved completely upon surgical resection of the myxoma and have shown no signs of recurrence in the follow up period.

Echocardiography has proved to be the most appropriate screening and diagnostic imaging technique for most cardiac tumors. Though trans-thoracic echocardiography has high sensitivity for most tumors, transesophageal echocardiography may be necessary for tumors smaller than 5 mm or for distinguishing tumor from atrial thrombi. Magnetic resonance imaging and computed tomography can be used to provide alternative information on structural morphology of the tumor and adjacent cardiac morphology. Cardiac angiography, which has been used in the past for the diagnosis of these tumors, is rarely necessary in the diagnosis of myxomas. However, it is currently recommended that older patients undergo cardiac catheterization to rule out concomitant coronary artery disease.

A high index of suspicion for atrial myxoma should be had in patients with appropriate symptoms in high risk demographics, as diagnosis can be made easily and reliably with echocardiography. Furthermore, treatment by surgical excision is well tolerated with excellent results and a low rate of recurrence.

References
At First Security, we take great care of people. Why? Because First Security is only in Arkansas – and that means our customers are our friends and neighbors, too. So we make sure they get the latest in financial tools and products, all backed by friendly professionals and nearby convenience. If you take care of people here, First Security is here for you.
Multiple Tools for Arkansas Doctors

SVMIC is Uniquely Equipped to Help Arkansas Doctors Succeed

2, 560 Claims handled by SVMIC attorneys from inception in Arkansas to date; unmatched claims expertise working with local defense counsel in Arkansas helps defend your personal and professional reputation if the time comes.

25+ Years of experience as the premier medical professional liability carrier for Arkansas physicians & surgeons; more continuous years protecting doctors in Arkansas than anyone else.

31 Consecutive years SVMIC has maintained an “A” (Excellent) or better financial rating from A.M. Best; industry-leading financial stability means we will be here when you need us.

9 Number of physicians on the Arkansas Advisory Committee who review claims and make underwriting decisions for Arkansas doctors on behalf of SVMIC; local representation by 3 Arkansans on the SVMIC Board of Directors means the unique concerns and challenges of the state are well represented within SVMIC governance.

We have local representatives in Arkansas to serve your needs. Contact Sharon Theriot or Mandy Holmes at mkt@svmic.com or call 800.342.2239.

Follow us @SVMIC • www.svimic.com

SVMIC Mutual Interests. Mutually Insured.