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Chad Rodgers, MD

AMS 2020-21 President

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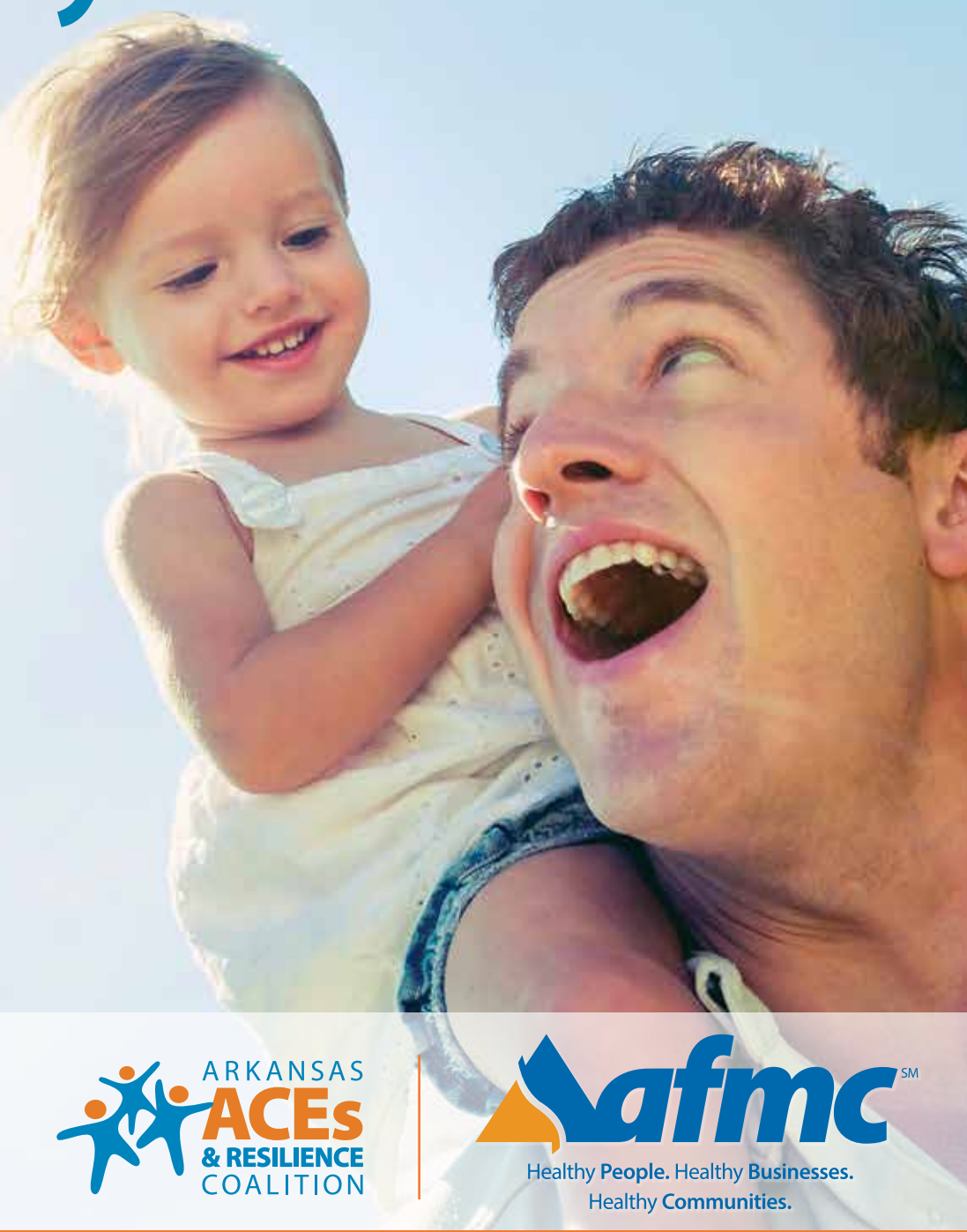

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Behind the Scenes: The Society at Work During a Pandemic

BY **DAVID WROTEN[1] & CASEY PENN**
[1]EXECUTIVE VICE PRESIDENT

From the first executive order that Arkansas's Governor, Asa Hutchinson, issued in March, the Arkansas Medical Society has been instrumental in supporting physicians and their patients. From assembling and distributing a COVID-19 update on an almost daily basis to running a full-scale side effort distributing personal protective equipment (PPE) to clinics across the state, AMS staff and leadership have been working in uncommon ways to provide for the needs of members and non-members alike. Let me offer you a rare, behind-the-scenes picture of what it has been like at the Society since mid-March.

COVID-19 Updates

The Society has worked daily to put pertinent information in front of members. AMS has shared information on all the various directives as they have gone out statewide and has provided links to information on billing, financial assistance, best practices, and so much more.

Meetings With Stakeholders

Our meetings with interested stakeholders and legislators have led to several initiatives. For instance, we requested that our state's insurance department issue directives suspending insurance practices such as prior authorizations, audits, and similar things that take up a clinic's valuable resources during a time when we need everyone focused on caring for patients.

During a conversation with the governor, I stuck my neck out just a little bit and said, "If you'll just help us out, we'll get it to them."

Protecting Telemedicine Legislative Efforts

The first order by Gov. Hutchinson relaxed the telemedicine law requirement that you had to have either an in-person or a face-to-face audio-visual visit with a patient to establish a doctor-patient relationship. That opened the door for people to establish that relationship through nothing but a telephone. After reviewing a draft of the executive order, the AMS was successful in getting the governor to change the order to include a requirement to have access to a patient's medical records *from a physician*. In other words, you could not just have the patient fill out an online health questionnaire and then use that to establish the doctor-patient relationship. That is not good medicine.

Reimbursement Provisions, Relaxing Liability Fears

Once the first Arkansas case was diagnosed, it was like someone turned off the lights. Patients stopped going to their doctor and began putting off care that they needed. The governor's office was encouraging people to stay home, and they did. On the other hand, clinics did not have testing capabilities and did not want patients coming in. So, AMS staff immediately reached out to all the state's carriers, and within 10 days, all of them agreed to pay for telephone-only visits at the same rate as in-person visits. We did this so that – particularly during the early days of the pandemic – established patients would not have to come to the office. This helped patients to continue receiving needed care and it helped physicians to keep their doors open. At the same time, we understood the concern and uncertainty of treating patients under these circumstances. AMS and other health care organizations requested help from the governor, and he issued an executive order providing liability protections for the state's health care professionals.

PPE Machine

The biggest thing we have been involved in during the pandemic has been addressing the need for PPE. Calls started coming in stating that physicians could no longer order the protective equipment needed. The supply lines were overwhelmed with worldwide requests. On top of that, Arkansas was not getting all it expected from the national stockpile of PPE, and what it was getting was going to first responders, hospitals, nursing homes and other hot spots. Again, AMS reached out to Gov. Hutchinson asking for assistance. The governor had announced that he would buy $30 million worth of PPE, and then that number went up to $70 million. During a Saturday morning phone call, he agreed to allot a percentage of those purchases to our state's medical practices. During a conversation with the governor, I stuck my neck out just a little bit and said, "If you'll just help us out, we'll get it to them."

From that point forward, we became PPE distributors. That is what your AMS staff has focused on for the past four weeks. A PPE request form was added to the COVID-19 Update and to the AMS website.

We asked others to spread the word, too, because one of the promises we made was that we would not limit this to members only. Under

the circumstances, that just would not have been the right thing to do. But since supplies are limited, AMS efforts have been focused only on medical clinics. So, if the clinic is staffed by member or non-member physicians or nurse practitioners, they have been provided PPE. There are currently 455 clinics with requests.

To date, there have been four major shipments of PPE totaling more than 600,000 pieces. With each shipment, our delivery methods have evolved. The Arkansas Department of Emergency Management has been our primary partner in this effort. They agreed to mail out the first shipment for AMS. When round two came in, we took to the road. After renting three 16' Penske trucks, we drove to Warren, Arkadelphia, Alma, Springdale, Jonesboro and Mountain Home – basically areas around the state where clinic staff could drive 1.5 hours or less to get to us. Clinics were alerted by email and all they had to do was show up. Over a week's time, we dispersed it all. By the third round, which was smaller at 50-60,000 pieces, we were emailing clinics and giving them the option to either pick it up or pay for postage and have us mail it to them. For many clinics, paying for the postage was well worth it to avoid spending 1.5 hours each way to pick up the supplies.

Hopefully, the supply of PPE will catch up with the demand. But for now, if the state keeps bringing it in, AMS will keep distributing it.

Thank you, AMS Staff & Board of Trustees

Your AMS staff – I cannot brag on them enough for what they have accomplished over the past couple of months. It is a large-scale effort to sort, pack, and distribute the PPE. Most of the staff has been able to work in the office with two, sometimes three, working remotely. Fortunately, the AMS office is laid out in a way that we are not on top of each other, so it is easy to keep some distance. Then keeping the COVID-19 Update relevant to AMS members is sometimes a challenge. The intent was to make that a weekly update, but for most of the time, it has been necessary to push one out daily.

It seems inappropriate to celebrate and give each other a pat on the back during a time like this, but at the same time, I'm extremely proud of how the Society – its elected physicians, members, and staff – has stepped up to meet this challenge. In the face of a pandemic that is taking lives away from all of us, the Society has been and continues to work tirelessly to address the needs of physicians across the state.

Thank You to Health Care Workers

The ones we really should be bragging on, however, are the individual physicians and other health care workers of our state. The Arkansas Medical Society is so grateful to those working the front lines. In a public service announcement that aired on television and social media outlets statewide, the AMS Board of Trustees expressed this sentiment: "They touch lives. Listen to hearts. They're risking their health to preserve ours. To everyone who works in our state's clinics and hospitals, thank you doesn't say enough. Then again, it says everything."

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BY CASEY L. PENN

Chad Rodgers, MD

AMS 2020-21 President

A Lifelong Arkansan

Chad Rodgers, MD, likes to say that he was born into medicine – and born to live in Little Rock, Arkansas. "I have pretty much lived my life inside a five-mile radius," joked Rodgers, who resided outside the state only once, during his undergraduate years at Baylor University in Waco, Texas. "I love Little Rock, and I've made my life here."

His love for the practice of medicine was inherited as well according to Rodgers, who spent plenty of time around it as a child. He explains, "My father, Charles 'Shot' Rodgers, is a retired family physician. While he made rounds, or was working in the ER, I used to hang out in the Baptist doctors' lounge. Also, we were always going to AMS and AAFP meetings around the state. I met a lot of wonderful doctors through my father."

Rodgers admired his father's passion – and compassion – and from an early age, sought to emulate them by choosing a healing profession. "Initially, I thought about the ministry," he recalled, "but medicine turned out to be the best fit."

Upon starting UAMS College of Medicine, Dr. Rodgers planned to follow his father into family medicine. After all, he had already met many mentors who were family docs. In the end, however, he chose pediatrics. "I know my dad was a little disappointed when I went into pediatrics, but once in rotations, I loved working with the kids. Adults complain too much. Kids get sick, but most of the time, the fever breaks and they pop right back. Also, I've always had a passion for preventative medicine. Hopefully, I can intervene early in my patients' lives and encourage healthy behaviors and thereby prevent long-term bad health behaviors that lead to chronic disease."

Other areas of interest for the young medical student included dermatology, orthopedics, and pediatric psychiatry. "Early on, I had a pediatric psychiatrist encourage me to go into psychiatry. I did not really think it was something I wanted to do, but now … 20 years into practice, I do a lot of behavioral and mental health. All those interests have helped me to be a better doctor."

Dr. Rodgers completed UAMS Medical School in 1998 and completed his pediatric internship and residency at UAMS/ACH. Following that, he spent one year as chief resident before joining Little Rock Pediatric Clinic in 2002. "I do a lot of well-baby visits/preventive checkups, sick visits, and adolescent health and mental health visits as well," he said. "It has been a very rewarding career, and I have loved watching my 'babies' I have taken care of grow up into adults."

After practicing full-time for many years, he has moved to a part-time schedule. "I work half-days Monday – Friday. "During my practice, I have developed interests in child advocacy, health literacy, child development, population health, social determinants of health, and most recently, the impact of childhood trauma, Adverse Childhood Experiences, and resilience. The learning never ends …"

His love for learning led Dr. Rodgers to take on the position of chief medical officer for the Arkansas Foundation for Medical Care. After first serving on the AFMC Board, he began as CMO in 2015 and has enjoyed being part of the team. "This diverse team of professionals has taught me a lot. They are committed to quality, and there is a real science to the process," said Dr. Rodgers. "I enjoy seeing patients in the exam room, but to contribute to larger health care improvements, I needed to get out of the exam room. I love the work that we're doing at AFMC. It's about constantly improving, it's intellectually stimulating, and it also involves creative thinking."

At AFMC, Dr. Rodgers has enjoyed being involved in various quality improvement projects related to Arkansas Medicaid. "When I first came on, we were finishing up an Alcohol Use Disorder (AUD) project," he recalled. "Doing pediatrics, I had stored my adult medicine away, but due to aging parents and my work at AFMC, I had to freshen up on my adult medicine knowledge. I often have to call my colleagues in various specialties to ask, 'This is the standard of medicine now? Really cool. Okay, we'll work on it.'"

Most rewarding to him thus far has been AFMC's work on Long Acting Reversible Contraception (LARC). "Women who complete college before child bearing are more successful financially and able to provide better care for themselves and their children," he said. "It can break a cycle of poverty for many people. Giving young women and men starting college the information they needed to postpone child bearing until they were ready was very rewarding to me.

"I obviously love kids, and moms are incredibly important to their well-being. We most recently worked on the Maternal Morbidity and Mortality project to help educate health care providers and first responders about signs to watch for and ask about after pregnancy. This included some educational materials for new moms about what to watch for, when to call their doctor, and when to go to the hospital."

A Product of Many Mentors

From the physicians he met as a young man to the colleagues that surround him today as he advocates for medicine, Dr. Rodgers has learned from many mentors throughout his life. "My dad was obviously influential, and family doctors like Mike Moody, Joe Stallings, Bill Dedman, and many others encouraged me and were very supportive. In the pediatric world, Gordon Schutze, Stacie Jones, Richard Jacobs, Mary Aitken, Tony Johnson, Gary Wheeler, Betty Lowe, too many to name ... all were great influences and always full of encouragement."

These and other influences helped steer Dr. Rodgers to the Arkansas Medical Society and to organized medicine in general. "My father taught me early on, 'if you're not at the table, you are on the menu.' I was also hyperaware of the time my dad spent at the Capitol with AMS advocating for health care and patients. He obviously loved it, but it was also a great sacrifice that meant time away from his practice – and the monetary loss that comes with that – and time away from his family. It was what he showed me growing up that made me want to be a member of a greater good.

"I joined AMS as a medical student in 1995 and have served in some capacity ever since. I also worked with Carla Coleman at the Arkansas chapter of the American Academy of Family Physicians during the summers from age 12 to age 22. I did some 'nuts and bolts' work helping her get ready for an annual meeting, but it also gave me a lot of exposure to organized medicine. I learned so much and developed a great appreciation for doctors who stepped up and took leadership roles as thought leaders, problem solvers, compassionate doctors, and just great humans. All of them made sacrifices just to show up and be present. Who wouldn't want to be a part of that?"

He's been a successful part of organized medicine in his own right, according to his colleagues. "Chad is one of the most selfless persons I've known," said Dr. Wheeler, who has worked alongside Rodgers in organized medicine outlets such as AMS, AAP, and AFMC.

"I enjoy seeing patients in the exam room, but to contribute to larger health care improvements, I needed to get out of the exam room. I love the work that we're doing at AFMC. It's about constantly improving, it's intellectually stimulating, and it also involves creative thinking."

– Dr. Chad Rodgers

"Whether it is for his patients, for an advocacy issue, for a political candidate, or for a friend, he gives until there is nothing left."

James Hunt, MD, first witnessed Dr. Rodgers at work while Rodgers was serving as chief resident of pediatrics at Arkansas Children's Hospital. Hunt was a medical student at the time and recalls, "Even in the crush and attendant fatigue of hectic clinical schedules and patient care, managing resident assignments, and shepherding wide-eyed and worried medical students, Chad seemed to be having fun. That simple sign in Chad's presence was powerful and calming for everyone around him."

Years later, Dr. Hunt has been pleased to keep up with Dr. Rodgers' career thus far. "I'm not known as an excitable type, but I'm near giddy that he's our AMS president," he said. "A subtle brilliance of Chad is that he early on recognized the value of using his growing community involvement and his medical expertise to improve health education and health wellness among Arkansas's kids—and then invested himself in growing that value at multiple levels of need including social and legislative."

Committed to Organize Medicine

Dr. Rodgers gets nostalgic and a bit sad at times thinking about organized medicine of the past and how it compares with today. "In the old days, there was more camaraderie," he said. "I saw those doctors work hard, but they also had a lot of fun and enjoyed the social events, dinners, and dancing. We have lost that a little bit."

Nostalgia aside, Dr. Rodgers feels nothing but praise for the Society, which has been a professional home for him. "When there are things I want to work on, talk about, and think about, I look to the Society. We have an incredible staff who do not get recognized enough for the work

At-A-Glance: Dr. Chad Rodgers

- Board-certified Pediatrician
- Partner/Physician at Little Rock Pediatric Clinic
- Staff Physician, Baptist Medical Center
- Chief Medical Officer, Arkansas Foundation for Medical Care

Current and Former Affiliations

- Alpha Omega Alpha
- American Medical Association
- Arkansas Academy of Pediatrics (National and State)
- Arkansas Advocates for Children and Families
- Arkansas Birth Defects Monitoring Program
- Arkansas Early Childhood Commission
- Arkansas Foundation for Medical Care
- Arkansas Medical Society
- Arkansas Newborn Screen Subcommittee
- Children's Tumor Foundation
- Easter Seals Arkansas
- Just Communities of Arkansas
- Pulaski County Medical Society
- Reach Out and Read
- Women and Children First

Professional Awards

- M. Jocelyn Elders Award for Excellence in Community Service (2000-2001)
- HIPPY Champion for Children Award (2010)
- Arkansas Campaign for Grade-level Reading, Volunteer Pacesetter of the Year Award (2013)
- Former Winner, Best of the Best Award, runner up, "Best Pediatrician" in Central Arkansas
- Former Winner, About You Magazine, "Best Pediatrician" in Central Arkansas
- Arkansas Children's Hospital, Dr. Tom Ed Townsend Award (2015)

Hobbies/Outside Interests

"I think work has become my hobby! I do enjoy travel A LOT, but that's all been put on hold. My husband and I tend to be over-involved in the community. We love entertaining. Eric is a good cook, and I'm good at setting up and mixing drinks. I love pottery and love to read when I can. We take walks with our labs. We have enjoyed becoming grandparents and all that entails. My step-daughter just completed nursing school (with honors!), and we are very proud of her. She has given us Adalyn, 4, and Lucas, 2. We don't see them enough, but we will pretty much put anything on hold to spend time with them and our family."

Best Advice to Share

"The late Dr. Mike Moody said it best: 'Do what you love, and you'll never work a day in your life. I think that's pretty good advice."

they do so quietly behind the scenes. So often, I have called to get input from them. They're a trusted source of valuable information for members and, truthfully, anyone that calls them."

Dr. Rodgers is a past Board member and is currently serving on the AMS Executive Committee.

This year, he steps into the role of 2020-2021 AMS president. In that role, he initially had some areas of focus in mind, but in the current pandemic, has learned to focus on the issues of the day, whatever those are. "I was going to focus in on physicians and self-care," he said. "I need to work on it personally and have been spending a lot of time talking about the need for health care providers to care for themselves. However, since COVID-19 came along, I have seen nothing but health care professionals putting the care of their patients above themselves. It's just in our DNA. I've had the honor of knowing a lot of AMS presidents over the years. Many times, I have heard the same from them. They may have had an idea of what they *wanted* to work on, but then *Any Willing Provider* came along, or *Tort Reform*, the *Affordable Care Act, health care coverage expansion,* and so on.

"Our goals as a Society are a moving target – one that we must keep chasing even as it changes daily. I see my job as president not to represent my agenda but the agenda of the society and the issues of today and tomorrow."

Due to COVID-19, the Society's annual membership meeting was cancelled. However, Dr. Rodgers will be celebrated during a presidential gala to be announced for a later date.

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BY **CASEY L. PENN**

Coping Amidst COVID-19

Clinics Continue Care Through Sudden Change

RANDY WALKER, MD CLINIC STAFF

PHOTO CREDIT K.A.E. PHOTOGRAPHY, RANDY WALKER, MD CLINIC

In *normal* times, variables such as physician specialties, patient demographics, location, staff, and technology affect a medical practice and its delivery of care. So, during a health crisis, it stands to reason that clinics would respond in unique ways. Across Arkansas, physicians and clinics have made innovative adjustments to continue delivering care during the COVID-19 pandemic. Amid their individual survival strategies, they all share a united drive: doing whatever it takes to help patients regardless of situational circumstances.

From those working in family medicine to those working in our state's prison system, the pandemic's challenges have run the gamut. "This feels like first day of med school all over again: it's information overload and a continual reminder of 'first do no harm,'" said Nannette L. Vowell MD, sharing her sentiments from her work inside one of the state's COVID-19 hot spots. Vowell is the medical director of the Ouachita River Correctional Unit Special Needs Hospital. "It's been quite the new experience for me, this pandemic in prison. There's been limited space to isolate, too much transferring of patients due to hospital status, and a vulnerable population due to our special needs unit. Meanwhile, I personally have a father at home with cancer and a mother at home with COPD."

Similar experiences abound as physicians and clinic staff put their personal challenges aside to care for patients and address the tasks at hand as best they can. This month, we reached out to two different clinics to see how COVID-19 has directly affected each. Their stories are diverse and undoubtedly relatable to physicians and health professionals statewide.

Interventional Pain Management Clinic Experiences Swift Change to MOD

Solo practitioner John Swicegood, MD, found himself challenged just to stay afloat and maintain the livelihoods of his patients, his staff, and himself as coronavirus drastically changed his clinic's day-to-day routine without any warning.

From Advanced Interventional Pain & Diagnostics of Western Arkansas in Fort Smith, Dr. Swicegood evaluates and treats complex spine and musculoskeletal disorders with minimally invasive diagnosing and therapeutic modalities. He is board certified in anesthesiology and pain management, an interventional pain fellow, and a diplomat of the American Board of Interventional Pain Physicians. Assisted by three registered nurses and three additional support staff, Dr. Swicegood and his clinic see up to 5,000 patient encounters annually. His patients, mostly elderly, are primarily failed-operative or non-operative chronic-care patients.

Admitting that COVID-19 has been professionally and personally overwhelming, Dr. Swicegood and his staff have been in survival mode since closing their doors for five weeks during the worst of the pandemic. Since reopening on April 27, the clinic has been using telehealth with many patients. Those who must be seen in person are brought in with the recommended safeguards in place, such as masks, face shields, and temperature tests.

Throughout the pandemic, Dr. Swicegood has worked to keep up with and understand the state's directives, implement telemedicine technology, and maintain accounts receivable amidst an initially very low patient load and continuing overhead. He attended webinars, applied for loans and grants, and watched his accounts receivable dwindle. "Even though I received a SBA loan and a stimulus payment, without generating A/R, it was unlikely that I could make payrolls into June," he said. "The clinic had to get back on its

feet. If closed much longer, those expenses that don't stop would have overtaken us."

Even while the clinic was closed, the work did not stop. Nurses took turns coming in to check messages and take care of refills, deliveries, and other critical tasks. The front office staff came in for a few hours each week to do things like update cancellations, post payments, check mail, and make deposits. The clinic staff ordered PPE as they could find it, shopped for wipes and cleansers, utilized telemedicine as best they could, and saw a few in-person patients on an emergency basis.

Telemedicine at first proved a challenge for the clinic staff, which was used to a much more hands-on approach. "In a practice where the physical exam is an integral part of initial and ongoing treatment of patients, the current pandemic has presented extreme challenges. We try to do a complete assessment of the patient – an ongoing assessment as pain can be complex, multifactorial, and ever-changing," explained Dr. Swicegood. "When a patient comes in, our staff is trained to validate and to develop a bond so that the patient experience is familiar and welcoming rather than institutional."

JOHN SWICEGOOD, MD

In addition to distance being a factor, the clinic's technology just wasn't there. "We were poorly prepared," he shared. "I immediately began working to educate myself on everything required for telemedicine. On that note, I must commend David Wroten and the Society staff for being so proactive. They stepped up with information on coding, directions to help with implementation, and later, PPE. By about the fourth week, we began to get good results, and we've worked our way from three to four telehealth visits per day to around 10."

Professional burnout was a real threat for Dr. Swicegood, who felt responsible for his team. "I'm committed to these people. I was concerned about their health insurance. They have families and children. You can't just furlough somebody and leave them no health insurance," he said. "You can't just say, 'oh, go get unemployment. You'll be fine.' This was the thing that weighed on me the most."

The doctor's burden didn't end when the clinic started assuming some regularity. "I still have trepidation about it. We don't feel the virus is understood, we don't see promising treatments, we don't have a vaccine, and we look for a resurgence in the fall. I see this going on for quite some time. I wonder if the clinic can survive the additional cost and reduced patient load. If we have a new wave of COVID-19, every patient I have is a high-risk patient. As long as we don't get our practice interrupted again, I think we'll make it."

Clinic employees are continuing to pull together, assured Office Manager Cindy Swicegood, who runs the office with positivity. "We are all like family here, and we understand each other," she said. "We are strong and determined."

Clinic Meets Patients Where They Are

Although Randy Walker, MD, never felt his practice was threatened with extinction during this pandemic, he and his clinic in DeQueen met plenty of challenges and fought to conquer them in an area of the state that lost its hospital in February of 2019.

Dr. Walker is a board-certified family medicine physician there and with help from three nurse practitioners, he usually sees around 90-100 patients each day. To bridge the area's gap in care, the clinic was already keeping extended hours (seven days a week) with an on-call nurse in place for emergencies. In addition, they had already established relationships with other area clinics and had some telemedicine options in place.

Office Manager Angie Walker explains how the clinic went into overdrive at the onset of COVID-19.

"I don't think we've seen as dramatic a hit as some clinics have," said Angie. "At the beginning, we had a day or two where we were throwing a little bit of extra equipment in place, but really, we adjusted pretty quick. We took on the mindset of, 'okay we're going to make sure patients know that we're here, we're going to take advantage of getting their wellness visits done, and we're going to do whatever it takes to care for our patients.'"

Reaching out to patients was already somewhat routine for the Comprehensive Primary Care Initiative Clinic, but as the pandemic hit, the staff took things up a notch. Angie explained,

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A CLOSER LOOK AT QUALITY

Looking Closer at HIPAA and Your SRA

MOLLIE MCCAMMON, RHIA, CHP

The Health Information Portability and Accountability Act (HIPAA) has been around since the late 1990s, but employees come and go and there is an ongoing need for basic HIPAA training. Many HIPAA conversations generate even more questions so let's get some answers.

Who must follow HIPAA rules?

According to HIPAA security standard §164.302, covered entities (CE) and business associates (BA) of every CE.

What defines a covered entity?

HIPAA defines CEs as a practice or individual that is a: health plan, including private health insurance companies, health maintenance organizations, employer-sponsored health plans or government programs: Medicare, Medicaid or Veteran's Administration; a health care clearinghouse that processes nonstandard health information to conform to the required standards for data content or format on behalf of others; or a health care provider who transmits any health information in electronic form related to a transaction for which the U.S. Department of Health and Human Services (HHS) has adopted a standard (§164.104)

What is a transaction?

HHS makes and implements HIPAA rules and identifies certain standard transactions for the electronic exchange of health care data. These transactions include: Payment and remittance advice (information exchange between two parties to carry out financial payment, usually by electronic funds transfer; and details from the plan to the provider of specific services covered such as adjustments, copays and secondary plans); Claims and encounter information (submitting a claim to obtain payment or reporting a health care encounter to the plan if there is no direct claim); Claims status (provider and payer communication about a health claim, including provider inquiry about claim status and payer's response); Eligibility (inquiries between a provider and a plan about patient's insurance coverage including copays and deductibles); Referrals and authorizations (obtaining approval and preauthorization for health care; received before performing specialist visits, tests or procedures); Coordination of benefits (provider communication with a plan to determine payment responsibilities for claims or payment information when patient is covered by multiple health plans; payer determination on which insurer(s) covers patient care costs and order of claim payments); Enrollment and disenrollment (communication between insurer and health plan to establish or terminate patient coverage); Premium payment (health plan initiates transfer of patient premiums, providing plans with payment detail information such as payroll deductions).

More detail on transactions at www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/TransactionsOverview. If your clinic, office or organization provide health care services and perform any of the above transactions, HIPAA considers you a CE.

Still uncertain if you are a CE under HIPAA?

The Centers for Medicare and Medicaid Services' website provides a guidance tool, based on your answers to specific questions, at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/Downloads/CoveredEntitiesChart20160617.pdf.

Are we required to have an SRA if we do not participate in MIPS Promoting Interoperability or Medicaid PT (formerly meaningful use)?

HIPAA security standard §164.308(a) requires all CEs and their BAs to perform an SRA — a security risk analysis. Security standards for SRAs include implementing policies and procedures to prevent, detect, contain and correct security violations. §164.308 (a)(1)(i) Security Management Process; conducting an accurate and thorough assessment of potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (e-PHI) held by the CE or BA (§164.308 (a)(1)(ii)(A) Risk Analysis Required; implementing security measures to reduce risks and vulnerabilities to a reasonable and appropriate level. (§164.308 (a)(1)(ii)(B) Risk Management Required; and reviewing and updating documentation periodically in response to environmental or operational changes affecting e-PHI security. §164.316(b)(2)(iii) Policies, procedures and documentation requirements.

What are the penalties for not conducting an SRA?

Penalties can be very expensive as well as damaging to your reputation. Patients can file lack of privacy complaints with the federal Office for Civil Rights (OCR), that enforces HIPAA rules and investigates complaints. When you know of a PHI breach, you must report it through the HIPAA portal. OCR will investigate your practice and look at the steps you took to isolate, correct and prevent the breach from reoccurring. When OCR investigates, you are required to provide your SRA's documentation of your review of all systems and places where PHI lives and the protections you have in place. OCR will look for risks you identified, and steps taken to remedy and protect your information. OCR can ask for the most recent SRA, past years' assessments, the last six years of SRAs and risk analysis documentation.

A recent example of an investigation after a breach was reported by a small gastroenterology practice in Utah. The provider filed a breach report with OCR stating that their electronic health records (EHR) company, a BA, was blocking them from accessing its e-PHI through the EHR. After the OCR investigated and performed a HIPAA compliance review of the provider, they identified these deficiencies: Security risk analysis had never been conducted; a failure to implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level. Provider had failed to implement policies and procedures to prevent, detect, contain and correct security violations (known as HIPAA policies). Provider did not have a BA agreement with the EHR company, although they had been working together since 2013

OCR assessed a monitored two-year action plan and a $100,000 civil money penalty for the deficiencies. Updates on future breaches on this website: https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

Where are details about performing an SRA?

HIPAA does not specify the exact elements of an SRA but outlines the risk analysis process to include: Evaluate the likelihood and impact of potential risks to e-PHI; implement appropriate security measures to address risks identified in the risk analysis; document security measures and rationale for adopting them; and maintain continuous, reasonable and appropriate security protections.

Risk analysis should be an ongoing process. CEs should regularly review its systems that track access to e-PHI and detect security incidents, periodically evaluate the effectiveness of security measures and regularly re-evaluate potential risks to e-PHI. https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

Who can help with an SRA?

SRAs can be performed internally with help from your IT support or outsourced to a third party. Various companies provide this service, including AFMC. Visit afmc.org or contact the SRA team at SRA@afmc.org; 501-906-7511.

Some providers find that alternating methods from one year to the next provides a fresh look at risk analysis. Here is a free tool at the HealthIT.gov website: https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

If you provide health care services and bill electronically for your services, you are a CE. You are required to perform an annual SRA. SRA documentation will help if you are investigated for a patient complaint or experience a security-breach incident. SRAs can keep you out of the news and save you from expensive fines. ▲

Mrs. McCammon is AFMC's HIPAA privacy and security policy analyst.

"We immediately pulled a list of patients 60 and older [and] patients who had diabetes, CHF, Asthma, and other co-morbid conditions and began calling to reassure them and get a head start on medication refills and preventative care.

"We've been doing telemedicine for about two years, but it was mostly Dr. Walker. When this happened, we immediately adjusted his schedule to include more telemedicine and we carved out a couple of hours a day where our nurse practitioners are doing nothing but home visits and telemedicine. It's been extremely successful. Patients are appreciative and excited that they don't have to come into the office. They can do a lot of things online. We went from five to 10 telemedicine visits per month to 25 a day."

The clinic has continued to see patients as well, after first screening them first by phone. If patients need to come in who have COVID-19 signs or symptoms, they go into a separate, dedicated area of the clinic.

Angie expects the clinic to emerge with some improvements in place. "For instance, the swap to telehealth has been a help to Dr. Walker," she said. "We've been doing half-day of in-person visits and half-day of telemedicine, and on Wednesdays, it's all telemedicine. I think that alone took some stress off him. We added one more nurse practitioner a few weeks ago, which reduced his burden even more. Also, he was used to rounding in nursing homes every Thursday, but since they went into lockdown, we've gone to iPads and Facetime, so we are seeing those patients from a distance."

To help patients through this process, the clinic has been all about "meeting patients where they are," stressed Dr. Walker. "Patient outreach now is key because they're scared to come in, they're scared to go to the ER, they're scared to call the ambulance, so the more that you can explain to them up front the better," he said. "Like, with us having a split area in the clinic, patients can absolutely come into the clinic. We also set up a tent area up front so that patients can have scheduled labs. We don't want to miss out on the work they've been doing on A1Cs and cholesterols. They can pull up and call us, and we can send out a nurse to draw their labs. We're also doing home visits for patients who maybe would not meet the criteria for being homebound, but it's where they're comfortable.

"We purchased a couple of iPads so that if we have patients who simply can't navigate our system, we'll send a nurse out with an iPad. She's there with the patient in the home, doing what I need done and relaying that back to me, or sometimes just teaching patients how to use their own technology to access our system. I was surprised at the amount of people that we have over 65 that have been able to navigate this and love it. They're used to Facetime chat with their grandkids and such, and this is one more related thing. It was funny, the other day I had a patient who joked, 'this is the closest I've ever been to Dr. Walker. He was one inch from my screen.' "

That's not to say that the clinic hasn't taken a loss or suffered some burnout. They have seen reimbursement decreases and an overall revenue decrease, according to Angie, "We are not willing to furlough staff, though we did have to bring some outsourcing in-house to make up the difference."

To guard against burnout, the clinic enacted small supports for the staff. "On the first of March, we started catering all food in so that our staff doesn't have a financial burden to go out for lunch, but they also don't have to be out in public in scrubs. It allows them to go into the kitchen or out back and just take a breather," said Angie. "We've sent some staff members home with pay just because there was a day there when it was clear that some were worn out. You've got employees that are giving 150%, and they're just wearing out. You send them home for a day with pay and sometimes that's all it takes."

AMS Steps Up to Support Physicians

As COVID-19 began to take hold in Arkansas, the Arkansas Medical Society began working to enable the state's physicians and other health care workers to continue safely caring for patients. From developing a COVID-19 update on an almost daily basis to protecting past telemedicine legislative efforts, the AMS staff has worked in many areas to provide for the needs of members and non-members alike.

AMS efforts as a liaison to Arkansas Governor Asa Hutchinson kept past telemedicine safeguards in place even as restrictions were relaxed on requirements for establishing professional relationships. And as telephone-only visits were opened with certain restrictions for the good of the patients, AMS was instrumental in ensuring reimbursement for those visits from insurance carriers. "If we're opening the door to telephone-only visits, then we have a problem because our telemedicine statute does not require insurance carriers to pay for audio-only telephone," explained AMS Executive Vice President David Wroten. "So, we reached out to the state's carriers, and within 10 days, all of them agreed to pay for telephone-only visits at the same rate as in-person visits. We did this so that – particularly during the early days of this pandemic – established patients wouldn't *have* to come to the office … the governor's office was encouraging people to stay home. This was an important thing to the clinics. It was like you turned on a light switch and patients stopped going to their doctor and began putting off care that they needed. This helped patients and it helped physicians to keep their doors open."

Perhaps the biggest thing that AMS has been involved in during the pandemic has been filling a need for personal protective equipment. Between March and May, the Society distributed over 600,000 pieces of PPE to clinics around the state who could not order it themselves because it wasn't available. (For photos and videos of the PPE road show, visit the AMS Facebook page - @arkmedsoc.)

"I can't begin to describe how proud I am of our medical society staff for the hard work and dedication they've exhibited during these past couple of month," said Wroten. "That said, the ones we really must be bragging on are the health care workers of our state. The Arkansas Medical Society is so grateful to those working the front lines. Listen to hearts. They're risking their health to preserve ours. To everyone who works in our state's clinics and hospitals, thank you doesn't say enough. Then again, it says everything.'"

For more on The Society's response to COVID-19 for the benefit of members and non-member health care professionals around the state, see David Wroten's commentary, page 4.

RANDY WALKER, MD

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BY ANIL KOPPARAPU MD[1]; DIANE JARRETT EDD[1]; GITANJALI BAJAJ MD[2]; SHASHANK KRALETI MD[1]
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Iatrogenic Cervicothoracic Subcutaneous Emphysema, Pneumomediastinum Following a Dental Treatment Procedure

ABSTRACT

Background: Subcutaneous emphysema and pneumomediastinum are commonly caused by traumatic injury or iatrogenic injury such as a surgical procedure of the respiratory and alimentary tracts. It can be caused by the infections from gas-foaming bacteria or during dental procedures while using high-speed air turbine drills and/or laser therapy, or spontaneously.

Case summary: A 66-year-old female presented with cervicothoracic subcutaneous emphysema, pneumomediastinum that occurred during a dental procedure involving a high-speed air turbine drill and laser therapy.

Conclusion: Surgical procedures in the oral cavity can lead to the development of emphysema and pneumomediastinum, especially when air turbine dental drills and/or lasers are used. Treatment is usually supportive care. Clinicians must recognize these conditions early to avoid life-threatening complications.

KEYWORDS

Cervicothoracic emphysema, Pneumomediastinum, dental procedures, dental high-speed air turbine drill, dental laser treatment, Tooth extraction

Early recognition of this condition is essential in preventing life-threating complications such as airway obstruction, sudden cardiac arrest, and respiratory failure.

INTRODUCTION

Subcutaneous emphysema is defined as presence of air or gas underneath the skin. Pneumomediastinum is defined as air or gas in the mediastinum.[1] These are uncommon conditions that occurs when air leaks from any part of lung or airways in to the skin and the mediastinum. Subcutaneous emphysema is appreciated by a palpable crepitus on physical exam, [2] usually diagnosed by conventional chest x-rays; however, non-contrast CT of the chest is more sensitive if only low levels of air accumulate. Usually, supportive care with rest, antibiotics, and analgesia is adequate.

CASE REPORT

A 66-year-old female presented to the emergency department with sudden onset of chest pain and neck pain with swelling on both sides of the neck. This occurred while she was undergoing a prolonged dental treatment in which her dentist used a high-speed air turbine dental drill and laser equipment. She underwent right lower dental bridge removal over the second premolar, first and second molar teeth, and gingivectomy during her dental procedure. She had a history of hypertension, hyperlipidemia, insomnia, and anxiety. She did not have any pre-existing lung disease or chest problems. Her medications included trazodone, simvastatin, cholestyramine, aspirin, and duloxetine. She denied history of smoking, alcohol intake, or recreational drug use. Vital parameters revealed a heart rate of 71 beats per minute, blood pressure of 157/76 mmHg, a respiratory rate of 18 breaths per minute, with a peripheral capillary oxygen saturation of 100% on room air and a temperature of 97.9^{0}F. Physical examination revealed swelling and crepitation over both sides of the neck, the right shoulder, and the right chest wall. Oral examination revealed no significant wounds or lacerations. No signs of hematoma were noticed. Her heart sounds and breath sounds were normal. Labs showed mildly elevated white blood cell count (13.48 K/uL). All other cell counts, renal function tests, troponin, and Electrocardiogram were normal. Chest x-ray showed extensive subcutaneous air within the bilateral neck spaces, anterior chest wall, and pneumomediastinum (Figure 1, 2). CT scan of neck, chest revealed extensive subcutaneous air within the bilateral neck spaces, anterior chest wall, mediastinum and small volume bilateral apical pneumothorax. No radiological findings of rib fractures or organ rupture or mediastinitis were noted. She was started on prophylactic broad-spectrum antibiotics, vancomycin, and piperacillin-tazobactam and was admitted to the family medicine team for further management. Her symptoms started to improve within 24 hours, and she was discharged to home on oral clindamycin. Her symptoms completely resolved in one week.

DISCUSSION

Subcutaneous emphysema and pneumomediastinum are commonly caused by traumatic injury or iatrogenic injury such as any surgical procedure of the respiratory and alimentary tracts.[1] It can be caused by the infections from gas-foaming bacteria or during dental procedures while using high-speed air turbine drills and/or laser therapy or spontaneously.[2] Air compression and laser use during dental procedures can cause air to be forced down into the mediastinum. The roots of the first, second, and third molars communicate directly with the sublingual and submandibular spaces, that are communicated to mediastinum thru pterygomanidular, parapharyngeal, and retropharyngeal spaces.[1]

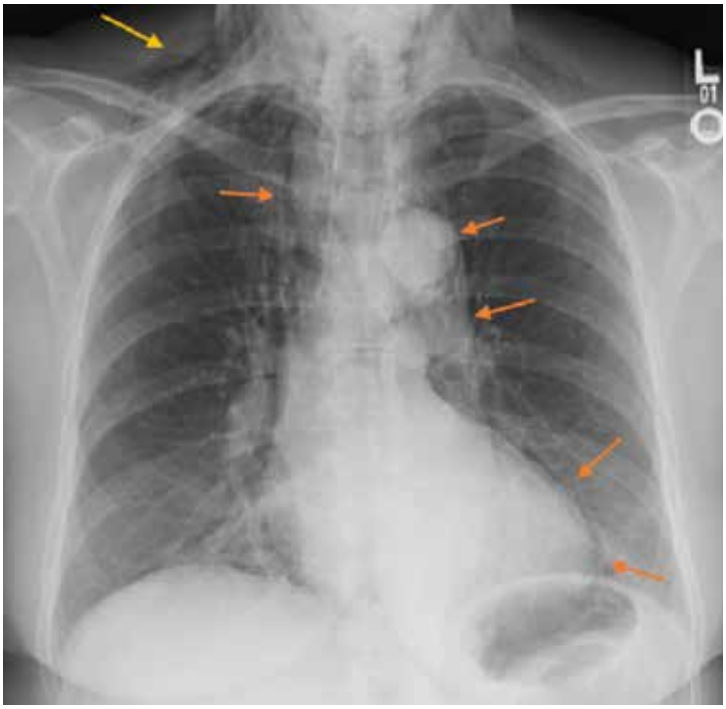

FIGURE 1: CHEST X RAY SHOWS THE AIR DISSECTING ALONG THE FACIAL PLANES OF NECK (YELLOW ARROW) AND AIR ALONG LEFT SIDE OF HEART BORDER (ORANGE ARROWS).

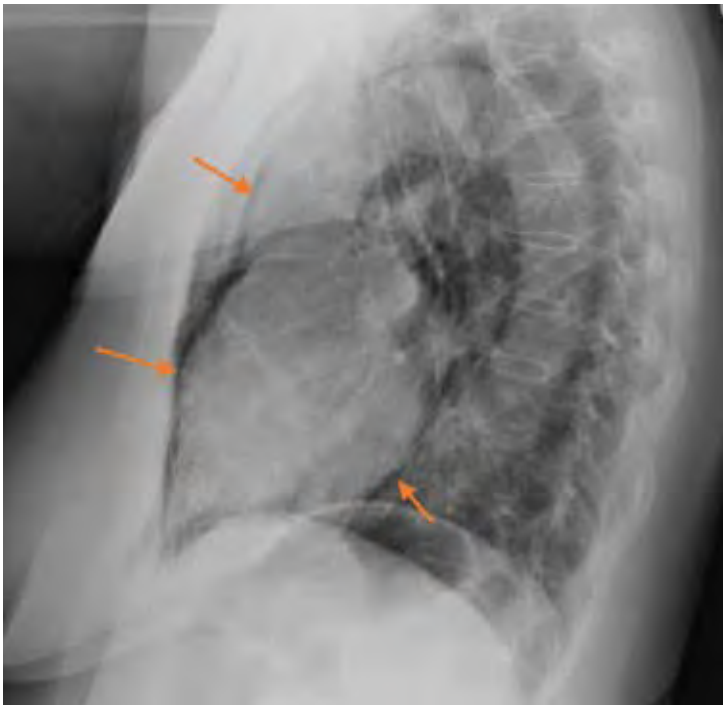

FIGURE 2: CHEST X-RAY SHOWS THE AIR OUTLINING THE MEDIASTINAL CONTOURS, INCLUDING CONTOURS OF THE MEDIASTINAL VESSELS (SUPERIOR VENA CAVA, AORTA AND PULMONARY ARTERY) AND HEART (ORANGE ARROWS).

Patients with subcutaneous emphysema show marked swelling and discomfort where air has penetrated tissues. The pathognomonic sign of subcutaneous emphysema is crepitus on palpation.[3,4,5] A radiographic examination of the patient should be conducted as soon as subcutaneous emphysema is detected to confirm the diagnosis and to determine the extent and location of the emphysema.[6,7,8]

The differential diagnosis for patients presenting with chest pain, neck pain, swelling or discomfort after a dental procedure includes local allergic reactions, anaphylaxis, angioedema, pneumothorax, expanding hematoma, or infection in the facial planes of the neck and chest. Patients with clinically significant subcutaneous emphysema and pneumomediastinum should be admitted for further management and should be monitored closely. Treatment of uncomplicated subcutaneous emphysema and pneumomediastinum is supportive and consists of analgesia, rest, antibiotics and avoidance of maneuvers that increase intrathoracic pressure such as Valsalva or forced expiration. Most cases resolve spontaneously in seven to 10 days.[9] Delay in diagnosis and treatment of pneumomediastinum can lead to complications like tension pneumothorax, cerebral air embolism and death.[9] Surgical intervention may be necessary if the patient develops hemodynamic compromise or respiratory failure.

CONCLUSION

This case report of a patient who developed extensive cervicothoracic subcutaneous emphysema, pneumomediastinum while undergoing a dental procedure highlights the possible complications associated with high-speed air turbine dental drills and laser therapy. Early recognition of this condition is essential in preventing life-threating complications such as airway obstruction, sudden cardiac arrest, and respiratory failure.

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BY **LAURA HAYWOOD**

PPE ROAD SHOW

The Arkansas Medical Society, in conjunction with Governor Asa Hutchinson and the Department of Emergency Management, brought critical personal protective equipment (PPE) to medical clinics around the state during the COVID-19 pandemic.

In March, Governor Asa Hutchinson allocated $75 million dollars for the purchase of PPE and ventilators for health care professionals and first responders treating COVID-19, and AMS was instrumental in securing a portion of these purchases for medical clinics.

The AMS PPE Road Show was no small endeavor for the AMS, with almost 600,000 pieces of PPE distributed between April and June. Supplies were allocated based on the counties and cities with existing or growing COVID-19 cases. On April 21, PPE trucks stopped in Warren and Arkadelphia, and on April 22, trucks made stops in Alma, Springdale, Mountain Home, and Jonesboro. Additonal shipments arrived in May and June, and the AMS staff shipped over 700 boxes of PPE to 333 clinics in need.

Here's what a few PPE recipients had to say:

- We were very excited when AMS said they have PPE for our clinic. I had some patients who were scared to come to the clinic. With this PPE, I was able to see them and be protected and make sure COVID-19 doesn't spread. – Olabode Olumofin, MD, MPH, First US Clinic PA, Pine Bluff.
- We were able to open up our lab services back up to thyroid patients who needed to get their levels checked. – Hannah Manus, Harmony Health Clinic, Little Rock.
- We are so thankful and grateful for the PPE. These are going to help us do our jobs and take care of our patients. – Sheryl Spieldenner, Daugherty & Daugherty Medical Clinic, Jacksonville.
- Thank You for the supplies...it has allowed us to protect our patients and staff. – Karen Connelley, Connelley Medical Clinic, Monticello.

Helping Arkansas physicians and their practices get the PPE they need to take care of their patients has been one of our top prorities during COVID-19, and we are proud to be able to serve you during this time.









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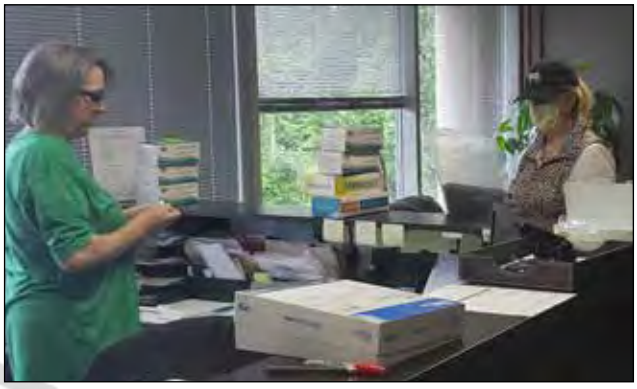
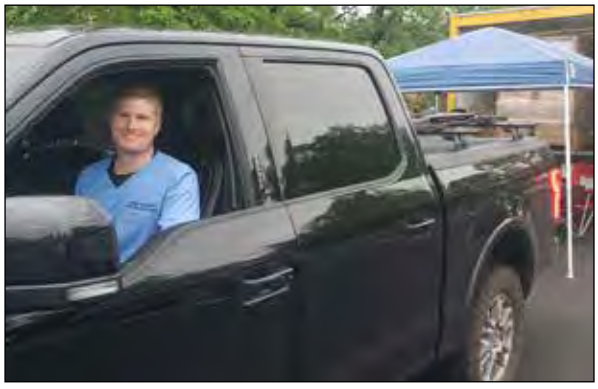


BY ZACHARY RENFRO, MD[1]; LEONARD N. MUKASA, MD[1,2]; JOSEPH BATES, MD[1,2]; VIRGINIA MATURINO, MD[1]; NAVEEN PATIL, MD[1,2]
ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK[1], UAMS[2]

A Plan for Elimination of Tuberculosis in Arkansas: It's Past Time

Arkansas has developed a plan for elimination of tuberculosis (TB) by 2040. The physician is central in the implementation strategy of this plan. The incidence of TB in Arkansas has dramatically decreased from 848 per million persons in 1953 to 26 per million persons in 2018, largely due to the efforts of the TB program at the Arkansas Department of Health (ADH) and physicians across the state (ADH, 2018). Despite this remarkable decline, TB remains a major cause of suffering and death in the state, and is a substantial public health issue. The ADH is committed to eliminating TB from Arkansas. Elimination is defined as a case rate of 1 case per million people. Most cases of active TB in Arkansas do not arise from recent transmission, but rather as a result of longstanding latent tuberculosis infection (LTBI) which progresses to active disease in 10-15% of those infected. (Lee, 2016) There are an estimated 90,000-100,000 people with LTBI in Arkansas, the majority of whom are not tested and are unaware of their infection status. Recent modeling suggests that at the current rate of decline, TB won't be eliminated from the U.S. or Arkansas by the end of the 21st century. In order to change this, there needs to be implementation of new and bold strategies to attack TB disease by addressing the large reservoir of people with LTBI who are at the highest risk of progressing to TB disease.

To best use limited resources, limit the number of false positives, and reduce unnecessary follow-up and treatment; screening for LTBI should be focused in epidemiologically determined high-risk groups. These groups include:

Contacts to active TB cases

1. Non-U.S. born residents
2. People with diabetes mellitus
3. People who are HIV positive
4. Birth cohort prior to 1951 (pre-TB antibiotic era)
5. People taking TNF-α antagonists
6. People on chemotherapy
7. People in high congregate settings such as prison, homeless shelters, and long-term care facilities.

This strategy will only work when the clinician at the frontline becomes a champion for TB screening. How can physicians join this noble cause and contribute to the fight against TB? Physicians can help by ensuring that patients at high risk for TB receive at least a baseline screening for TB and by documenting screening results in patients' medical records. Then, report all positive TB tests to your county's local health unit in a timely manner so that further evaluation can begin as soon as possible.

Today we have the ability to rapidly diagnose LTBI and TB. When identified, we have highly efficacious medication regimens for both LTBI and TB, including a short course, three-month regimen for LTBI. In short, we have the capability to eliminate TB and with it the associated pain, suffering, and loss. Physicians, nurses, and public health officials all have a role to play in achieving this goal. It's our job to *Think TB.* Clinicians' roles are integral to the elimination of TB from our state. The Arkansas Department of Health thanks you for your dedication to this cause and the people we serve.

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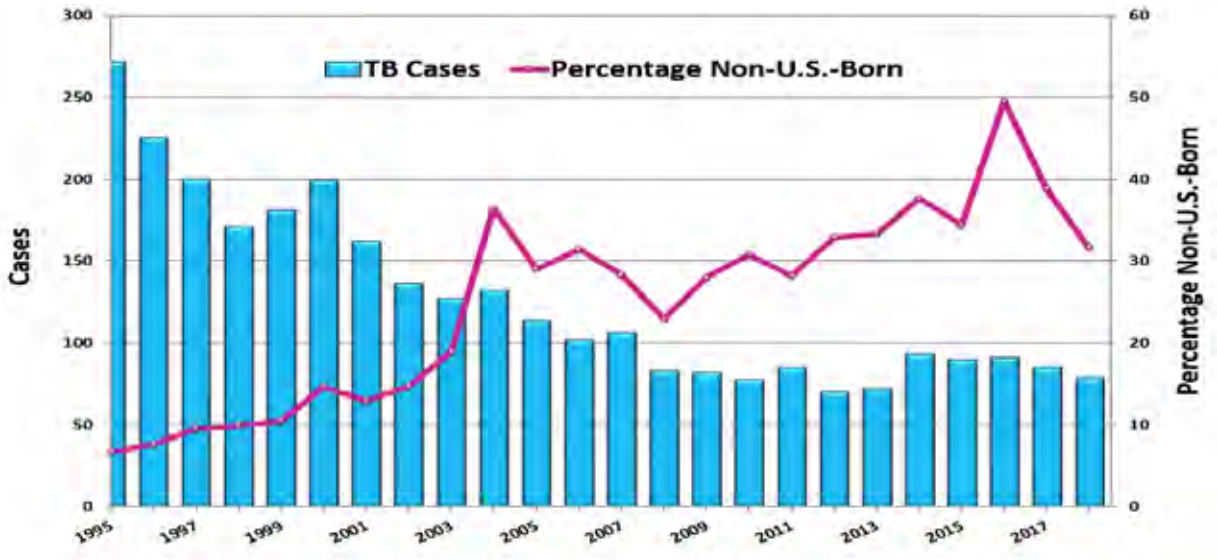

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AR License #100112594

DOCBOOKMD TRANSITIONS TO MEDICI CONNECT

DocbookMD has transitioned to Medici Connect, and AMS members have an exclusive, free membership to use this communications app. Medici Connect combines the previous features of DocbookMD with new upgrades that include telemedicine.

Users will now be able to send HIPAA-compliant voice, video, and text messages to both patients and colleagues and have access to eReferrals, group messaging, and a network of AMS doctors. The account also comes with the availability to communicate from your Android or iPhone device or the web and a signed Business Associate Agreement.

If you had a Docbook account, you will be receiving an email with instructions on how to create your Medici Connect account. This email will include a personalized link that gives you a quicker registration process. If you did not receive an email, you can visit their website and create an account (https://app.medici.md/#/auth/register).

If you are a current member and do not have a Docbook account, contact us at ams@arkmed.org and we will add you to our network.

Medici Connect is a $300 yearly value that we provide for our members as an exclusive benefit. If you are not an AMS member, but would like to join our Medici Connect network, visit https://www.arkmed.org/membership/join-renew/ to become a member.

WELCOME TO THE AMS COMMUNITY

The following physicians have joined AMS in March, April and May 2020.

Dennis Beck, MD
Jonesboro

Sean Baker, DO
Fort Smith

Rodrigo Cayme, MD
Little Rock

James O. Davis, MD
Little Rock

John Faircloth, DO
Jonesboro

Renea Henderson, DO
Rogers

Gerren Hobby, MD
Jonesboro

James Hoffmann, MD
Pine Bluff

Meera Gangadharan, MD
Little Rock

John Jayroe, MD
Little Rock

Allison Johnson, MD
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Little Rock

Navin Kilambi, MD
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Matthew Kincade, MD
Bentonville

Emmanuel MacDonald, MD
Jonesboro

Navin Mangroo, DO
Jonesboro

William Mays, MD
Memphis, TN

Ana Michunovich, DO
Jonesboro

Cynthia Morgan, MD
Pettigrew

John Mounsey, MD
Little Rock

Michael North, MD
Searcy

Ikemefuna Onyekwelu, MD
Little Rock

Arpit Patel, MD
Little Rock

Kristine Patterson, MD
Little Rock

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David Spiro, MD
Little Rock

Charles Stearns, MD
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Tomoko Tanaka, MD
Little Rock

Katherine Patel, MD
Little Rock

Cory Vaughn, MD
Springdale

Brock Warford, MD
Hot Springs

Steven Williams, MD
Blytheville

Ramon Ylanan, MD
Fayetteville

Do you know other physicians who are not a members? We encourage you to reach out to your peers and tell them what the Arkansas Medical Society means to you and why they should join you.

IMPROVING HEALTH CARE IN ARKANSAS REQUIRES A SPECIAL PROCEDURE - JOINING US. VISIT ARKMED.ORG TO JOIN TODAY.

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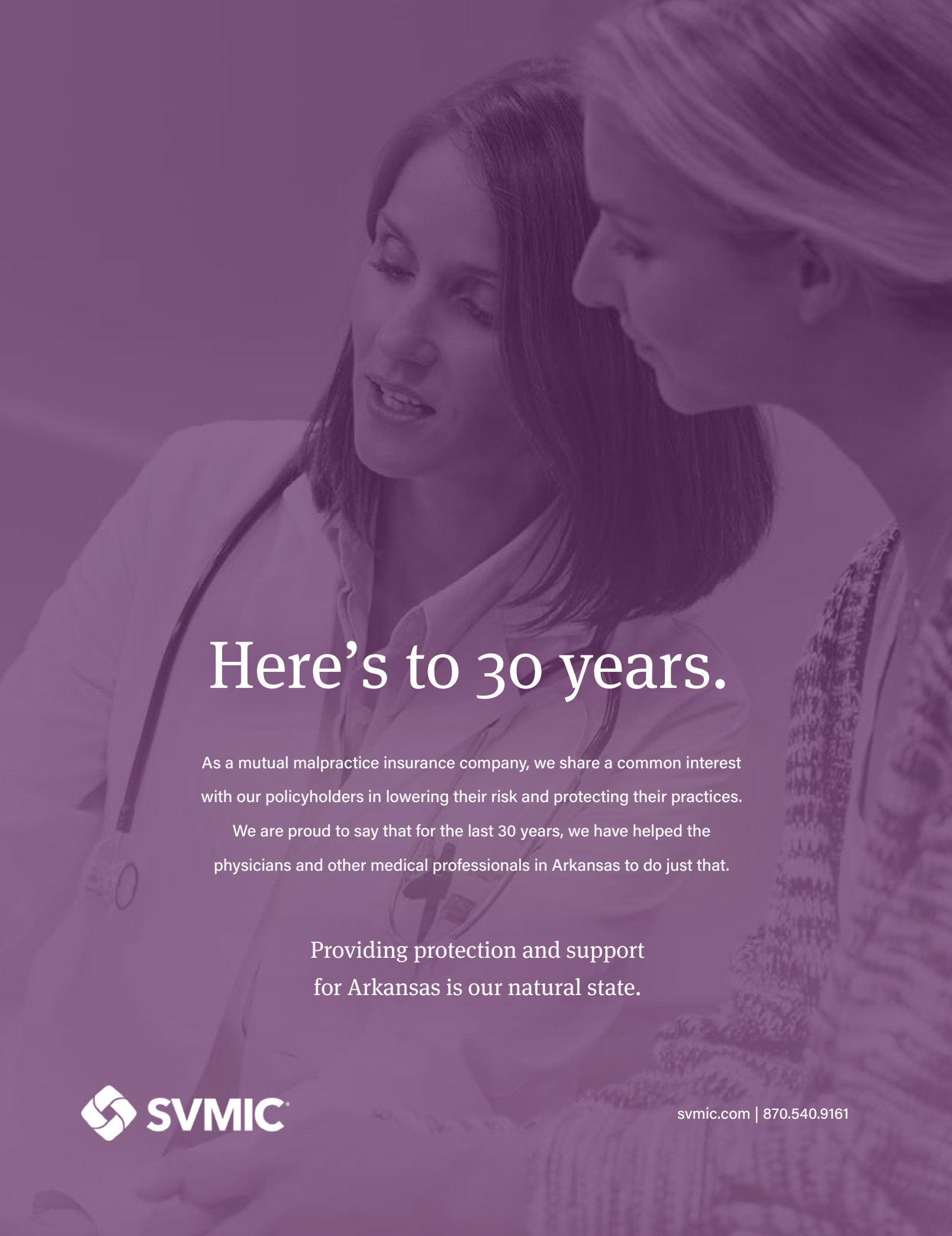

Here's to 30 years.

As a mutual malpractice insurance company, we share a common interest with our policyholders in lowering their risk and protecting their practices. We are proud to say that for the last 30 years, we have helped the physicians and other medical professionals in Arkansas to do just that.

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