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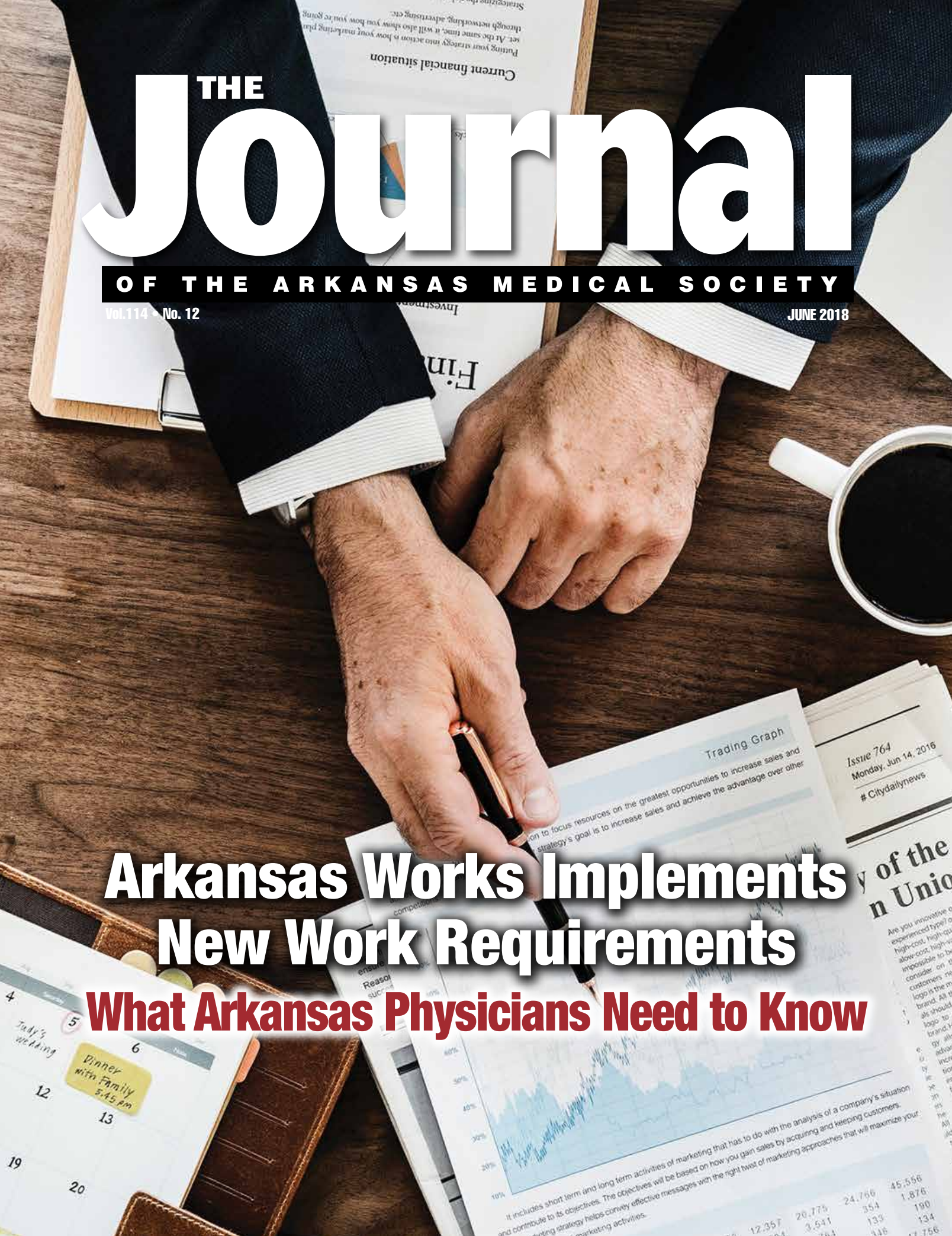

Arkansas Works Implements New Work Requirements

What Arkansas Physicians Need to Know

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by CASEY L. PENN

ON THE COVER

Arkansas Works Implements New Work Requirements

What Arkansas Physicians Need to Know

Winner of the ASAE Excellence in Communications Award

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IABC arkansas BRONZE QUILL AWARD WINNER excellence Feature Articles

WHAT HAVE WE DONE FOR YOU LATELY?

Excessive Prescribing – Regulation 2.4

DAVID WROTEN
EXECUTIVE VICE PRESIDENT

I attended the Arkansas State Medical Board's public hearing on "excessive prescribing," April 5, 2018. One thing was apparent; either patients are being terribly misled by someone or many physicians are misinterpreting the implications of the rule.

Regulation 2.4 lists many of the offenses for which a physician can be found guilty of "ignorant malpractice." One of those offenses is excessive prescribing. After many years of being challenged by attorneys on what exactly constitutes *excessive*, the Board is attempting to adopt language that would define *excessive* as it relates to controlled substances and specifically opioids.

Patient after patient stepped up to testify before the Board that their physician had told them that the Board's proposed rule meant they could no longer write prescriptions for narcotics. Others testified that their physician, in anticipation of the rule, had cut them back by 50-75% of the amounts they had previously been taking. Most cited fear of Board reprisal as the motivating factor behind their physician's actions. Now, just to be clear, these were patients whose medical conditions appeared to be so severe that without adequate pain control, they could not function as productive citizens. These were patients that had been on opioids for 10, 15, and 20 years. There was the gentleman whose encounter with an 18-wheeler, followed by years of multiple surgeries, left him nearly incapacitated. With his prescription opioids, however, he was able to function again and work to support his family. Now that his physician had reduced his prescription, he was struggling to function and afraid of losing his job and his family.

There are a few facts to keep in mind. The State Medical Board's proposed rule on excessive prescribing does not limit the quantity, dosage, or number of days that a physician prescribes. It does not create a system of witch hunts whereby the Board simply goes out looking for physicians to punish.

What it does say is that if you write a prescription for any drug in any amount without detailed justification documented in the medical record, it can be considered excessive. That is and always has been the case. For opioids, if you prescribe a quantity or dosage that exceeds a specified amount, you must have adequate documentation to support that prescribing. If the Board receives a complaint on a physician for overprescribing, which is nothing new, part of the investigation will be to review their records to determine whether or not the physician complied with the documentation requirements and provisions of the rule. Those specified levels are, greater than or equal to 50 morphine milligram equivalents (MME) per day for chronic pain and seven days for acute pain.

What must be documented for chronic pain (exceeding 50 MME per day)? Objective findings, specific reasons to exceed 50 MME, options for alternative pain management including those that have been tried and failed, an assessment of the potential for abuse and/or diversion, that the patient is being seen at least once every three months, regular drug screens, pain management contract, etc. For acute pain, initial prescriptions written for a quantity that exceeds seven days, the physician must have a detailed documented reason or rationale for exceeding the seven days and any subsequent prescriptions must be medically justified as detailed in the medical record.

Furthermore, *excessive* does not apply to prescriptions written for patients in hospice, active cancer treatment, palliative care, end-of-life care, nursing homes, assisted living, or while in an inpatient setting or emergency department.

The rule must still be approved by the Legislative Council of the General Assembly and will not likely become effective until summer. For a full reading of the rule — and to dispel any other rumors — please visit the Arkansas State Medical Board website, www.armedicalboard.org, Look under "Forms and Publications" and then click on "Proposed Amendments to Regulation 2." AMS

THE Journal
OF THE ARKANSAS MEDICAL SOCIETY

Issam Makhoul, MD

COMMENTARY

Black and White

At age 45, Mrs. S. saw the first white spots on her arms and legs. She ignored them in the beginning; however, when they did not go away and started spreading to larger areas of her skin, she talked to her doctor. He looked undisturbed by her skin and said, "Do not worry, this is vitiligo," and stopped. She asked, "Is it going to go back to normal?" Without looking at her again he said, "Rarely does it happen; at least I have never seen it."

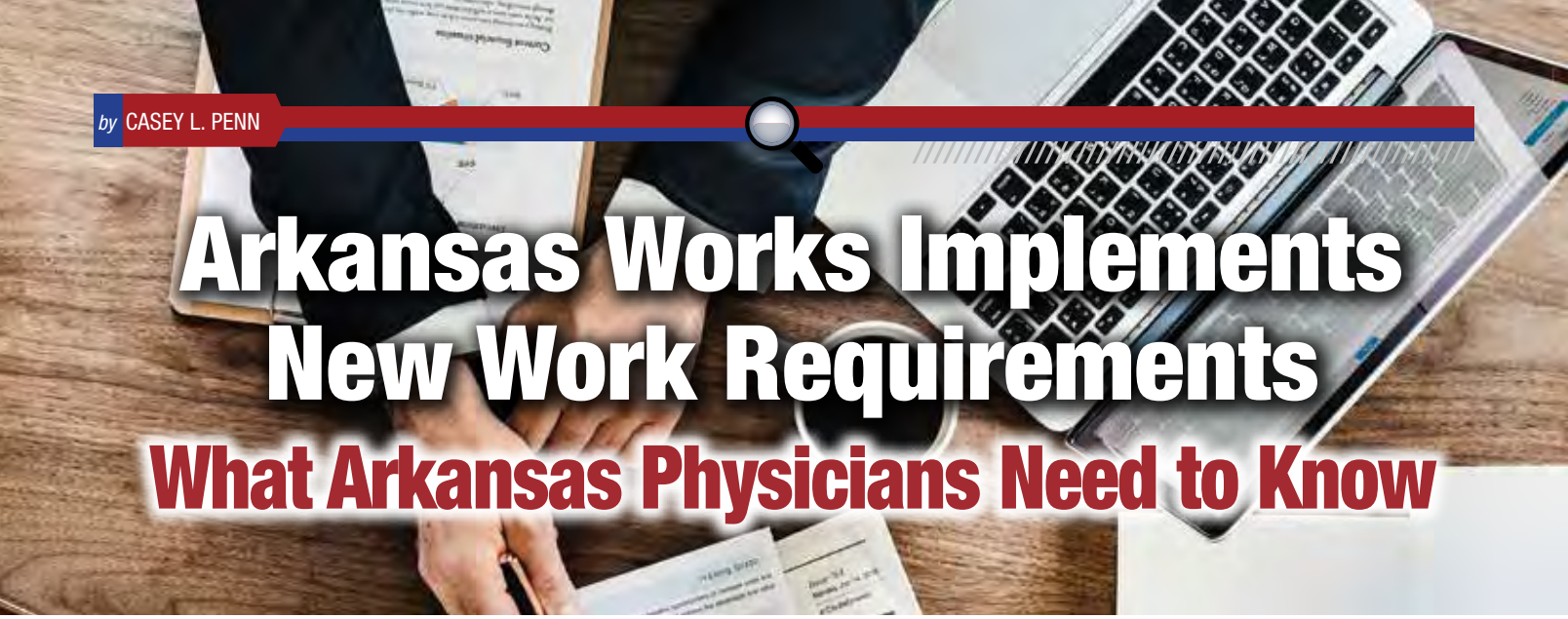
Over three years, her skin underwent a radical transformation from black to white. As this process was happening, her family and friends started withdrawing from her. Only her husband and children were sympathetic to her, to a point. One time she was stepping out of the bathroom into the hallway in the darkness of the night with only the moon rays from the nearby window lighted the hallway, when her husband, surprised by her presence, was startled. He collected himself and apologized to her. This was the prelude of many similar occurrences with other family members and friends.

In the beginning, she wore long pants, dark stockings, long skirts, and long sleeves to cover her whiteness. She felt ashamed. The last straw was when her face turned white. Cosmetic creams and makeup helped for a while, but it was so difficult to make it work any longer. She had to reveal her new face to the world. Now, it was her turn to be startled when looking in the mirror at herself every morning. She cried for days on end. Her doctor diagnosed her with depression and gave her a pill for it.

Years have passed by. Her completely white skin was "beautiful – pure, smooth and clear." For whatever reason, she also lost all hair on her body with the exception of her head. Every time she allowed some skin to be seen, she received praises from strangers in the stores or at the beauty salon. Little by little, she went back to wearing normal clothing that allowed her legs and arms to be seen. Slowly, she regained confidence. She would say jokingly to her family, "I am the first black-white woman, and I am proud of it." She would also think without daring say it to anybody else, "What would I say of somebody who was born black and feels white or vice versa?" or "What would I say of the boy who feels he is a girl or the girl who feels she is a boy?" Sometimes, her imagination would take her even farther, "What would I think of somebody who thinks that they are an elephant or a tree or a dog?" She knew that in the last cases people were likely sick but she was not sure about the other ones.

At age 60, she was diagnosed with breast cancer. I saw her after her surgery. I walked into the room, introduced myself and was also surprised – only for a second – by the difference between her color and that of the rest of her family. After she told me her story, we agreed on a plan and started her on chemotherapy. As we proceeded with the treatment, she began noticing black spots on her face. I know from my experience with other black people that chemotherapy causes increased pigmentation on the palms and soles, and sometimes in the mouth and on the face. This effect is transient. It usually goes away a year later. After we completed chemotherapy, she asked me hesitantly, "Do you think I may be black again?" Her question caught me off guard. "Are you not happy where you are now? I thought you were." She answered with a melancholic voice, "Yes, but I had to give up my identity." And after a moment of silence, "If this were to happen, I mean, if I can become black again because of the cancer, I would consider cancer the best present that God has given me."

After satisfying their physiological and safety needs, individuals focus on social relationships and belonging, esteem, and self-actualization. Central to these needs is the development of a clear and strong sense of identity. Diseases impact patients' identities in many ways. I never thought of cancer as a "present." As I hear some patients acknowledge how cancer was the wake-up call that they needed to change their life's direction, I realize the power of the human spirit to turn adversity into success and salvation when provided with a nurturing environment. I do not know if Mrs. S. will ever be black again, but I am sure that her new identity was not able to erase her original one, probably because of the continued hidden bias against her. Her strong spirit helped her create a new identity despite social rejection and opened her eyes to understanding other people who were struggling to define theirs. How many patients have had a broken identity from disease and were unable to find a new one because there was nobody there to listen and accept them and give them a helping hand? AMS



by CASEY L. PENN

Arkansas Works Implements New Work Requirements

What Arkansas Physicians Need to Know

Arkansas has become the third state to begin requiring work (or its equivalent) from able-bodied, non-exempt beneficiaries of its state-and-federally funded health insurance subsidy programs. Our program, Arkansas Works, is phasing in its newly implemented work component by age group and will eventually require all non-exempt beneficiaries ages 19-49 to work 80 hours per month or to engage in other approved activities such as job training, job searching, education, volunteering, or a combination of these.

This month, *The Journal* shares information pertinent to AMS members and other health care providers as they deliver medical care to patients held to these new requirements. Assisted by Mary Franklin, director of county operations for Arkansas Department of Human Resources, we will touch on some questions and concerns of our membership. But first, the basics.

Putting the Work into the Program

Arkansas Works (formerly referred to as "the private option") comprises Medicaid expansion here in Arkansas. Through the program, Medicaid pays the premiums for individual qualified health plans. Most enrollees are covered by three approved carriers: Ambetter, Arkansas Blue Cross and Blue Shield, and QualChoice. However, those considered medically frail are still served under the state's traditional fee-for-service program. As of March 2018, Arkansas Works covered health care for about 284,000 Arkansans.

The Arkansas Works legislation that passed in January 2017 included some encouragement* towards work, but it wasn't until May of last year that legislation began to **require** work by some adult Medicaid recipients. During a May Special Session, the Arkansas General Assembly passed Act 3, thereby enacting work requirements and adjusting eligibility of the Medicaid program from 138% poverty level down to 100% poverty level. Federal approval for the *work* part of this legislation came March 5, 2018, from the federal Centers for Medicare and Medicaid. (The poverty level requirement adjustment approval is still pending but has not hindered the state from implementing the main portion of the bill.)

As mentioned, Arkansas Medicaid is phasing in the work component one age group at a time. For 2018 (beginning June 1), approximately 98,000 Arkansas Works enrollees aged 30 – 49 are subject to the new work and community engagement rule; however, of those, about 60% have an identified exemption. Consequently, only about 40% of enrollees in this age group are without an identified exemption and thus required to comply with the new requirements.

Mary Franklin, DHS

In 2019, DHS will bring in the next age group. About 69,000 Arkansas Works enrollees ages 19 – 29 will become subject to the work and community engagement requirement at that time. (Of those, about 57% ***currently*** show an exemption identified and approximately 43% **currently** do not show an identified exemption.)

Ample Notice, Gradual Phase-In

You may wonder how aware of new requirements Arkansas Works beneficiaries are, and further, if they understand their responsibilities. According to Franklin, the parties involved – DHS, Arkansas Department of Workforce Services, and the insurance carriers providing Arkansas Works qualified health plans – are working together to make sure that beneficiaries and the medical community are aware of the new requirements. In addition, the Arkansas Foundation for Medical Care, DHS's vendor for Medicaid beneficiary relations, will be reaching out to Arkansas Works beneficiaries – to help them understand their requirements and the resources available to help meet them.

Since the approval of the work requirement, DHS has been sharing details on its scheduled implementation. "DHS mailed its first of three notices to the entire Arkansas Works population by March 15 and had information out to the media and other community outlets from day one," said Franklin. "The DHS communication team (with other concerned stakeholders) has also spread the word through libraries, legislators, social media, and health care groups that include Arkansas Foundation for Medical Care, Arkansas Hospital Association, and (with this article) the Medical Society.

"That first mailing let recipients know that they will be required to provide DHS with an email address if they have not already done so, and that no other action would be needed at that time. The second notice, sent April 1 – 8, offered full details about the work requirement, how to access and log onto its portal, and how to contact the Department of Workforce Services for help with job search and job training programs.

"A final notice was sent May 8 specifically to beneficiaries who were to begin the work requirement in June. The group required to start in July should receive their notice around June 8. (The 30-49-year-olds are being phased in over four months from June-September.) DHS includes in these mailings useful information about work requirements, exemptions, allowed activities, how to use the reporting portal, and how to connect with the Department of Workforce Services."

With the work component comes required community engagement (qualifying "work" or other activity) and the reporting of it. The 20 hours a week (or 80 hours per month) required by non-exempt, able-bodied Arkansas Works recipients may be fulfilled in numerous ways. In addition to (or in some cases in place of) being "on the clock," these individuals may engage in approved job training, education, and volunteer work. In addition to completing the work hours (or their equivalent), beneficiaries must report the work online through the state's Access Arkansas portal.**

As part of its campaign to share information (ongoing) with respect to all things Arkansas Works, DHS has launched a public-facing, informational share site. The public share site, or "Dashboard," is available at https://ardhs.sharepointsite.net/ARWorks/default.aspx

"Help is here for patients, for physicians, for everyone," said Franklin, "through the Arkansas Works share-point site. We built this site not only for our clients, but also for our partners, agents and brokers, and our staff – to have one place to go to for up-to-date information. We will also have available on that site a comprehensive resource map that we've put together to help identify for recipients where to access computers, libraries, universities, how to reach DHS and DWS, transportation and housing information, job training sign-up, volunteer opportunities, and more. It's a comprehensive portal containing all the information an individual might need to be able to get started and comply with work activities. It's a work-in-progress but will be updated as we go."

What do Physicians Most Need to Know about Arkansas Works?

With the work requirement now being implemented, AMS Executive Vice President David Wroten asked Franklin to address areas of possible concern for Society physicians:

- What are the penalties for not fulfilling the work requirements or failing to report work done?
- Will physicians know if a patient has lost coverage or is in jeopardy of losing coverage?

Arkansas WORKS

What You Need To Know About the Work Requirement

DHS

You are getting this notice because you have Arkansas Works health insurance. Some people who get Arkansas Works have to participate in work activities to keep their insurance. Those people will have to report work activities to DHS. During 2018, this does NOT apply to anyone who is:

- 29 or younger
- 50 or older

For everyone else: DHS decides if you have to report work activities. DHS needs some information from you to decide that. This notice explains how to report work activities and what kinds of activities DHS accepts.

Section 1: What if I receive both SNAP and Arkansas Works benefits?

If you have a work requirement for SNAP and Arkansas Works, you can report online at www.access.arkansas.gov or report to the SNAP program.

Section 2: How do I know if I have to report work activities to DHS?

Are any of these statements true for you?

- I get TEA Cash Assistance.
- I get Unemployment Benefits.
- I work and make more than $736 a month before taxes.
- I have a disability (includes blindness) or need help with daily living activities.
- I have a child under 18 in my home.
- I am pregnant or was pregnant within the last 60 days.
- I care for a person who cannot care for him/herself.
- I can't work or look for work because of a short-term disability.
- I am in an alcohol or drug treatment program.
- I go to school, vocational, or job training full time.

If any statement is true, then you may have an "exemption" and may not have to report work activities. However, you MUST tell DHS which statement applies to you. Section 3 tells how to do this.

If none of the statements are true, then you MUST report work activities every month. Section 4 tells how to do this.

NOTE: All adults in your household who get Arkansas Works should read these statements to see if they must report work activities. Remember: during 2018, if you are 29 or younger OR you are 50 or older, this does not apply to you. You do not have to do anything.

Section 3: If I think I have an exemption, what should I do?

If you think you have an exemption, you must tell DHS which statements in Section 2 are true for you.

- Report this online at Access Arkansas at www.access.arkansas.gov. See Section 8 about how to use Access Arkansas.
- After you make the report, DHS sends a letter about what to do next. Always read all mail from DHS as soon as you get it.

Section 4: I do not have an exemption. What do I need to do?

If you are not exempt (see Section 2), you must do 80 hours of work activities **each month** to keep Arkansas Works insurance. Report this online at Access Arkansas at www.access.arkansas.gov. If you need help finding a work activity, see the information at the end of this notice. You can combine hours from any of the work activities below to make 80 hours:

Section 8: How do I use Access Arkansas?

To use Access Arkansas:

Arkansas WORKS Report Work Activity / Exemption

1. Go to www.access.arkansas.gov between 7:00 am and 8:00 pm.
2. Answer the voter registration question with 'Yes' or 'No.'
3. Click 'Arkansas Works Log-In.'
4. Click 'Arkansas Works – Report Work Activity / Exemption.' Look for the button!
5. Log in to your online account. If this is the first time to log in, you must create an account. Be sure to save your account user name and password. You will need them each time you log in.
6. Follow the instructions to report your information.

If you need help with Access Arkansas, call 1-855-372-1084 between 8:00 am and 4:30 pm (Monday – Friday). Operators can help, but they cannot do the report for you.

REMEMBER

- **Be sure to read mail from DHS as soon as you get it.**
- Report any changes affecting your Arkansas Works eligibility or changes in your household.
- Do 80 hours of work activities each month.
- Report work activities at www.access.arkansas.gov. You can use any computer with Internet access or lobby computers at your local DHS office. **Do not miss the 5th day of the month deadline!**
- If you do not meet work requirements for any 3 months in a year, you lose Arkansas Works for the rest of the year (through December). This is true even if you meet the requirement later in the year.
- For help with anything in this notice, you can call 1-855-372-1084 or visit a local DHS office.

> Continued on page 272

- If a beneficiary loses coverage amidst a long-term treatment process, will the physician be paid for care that's already been delivered to that patient?

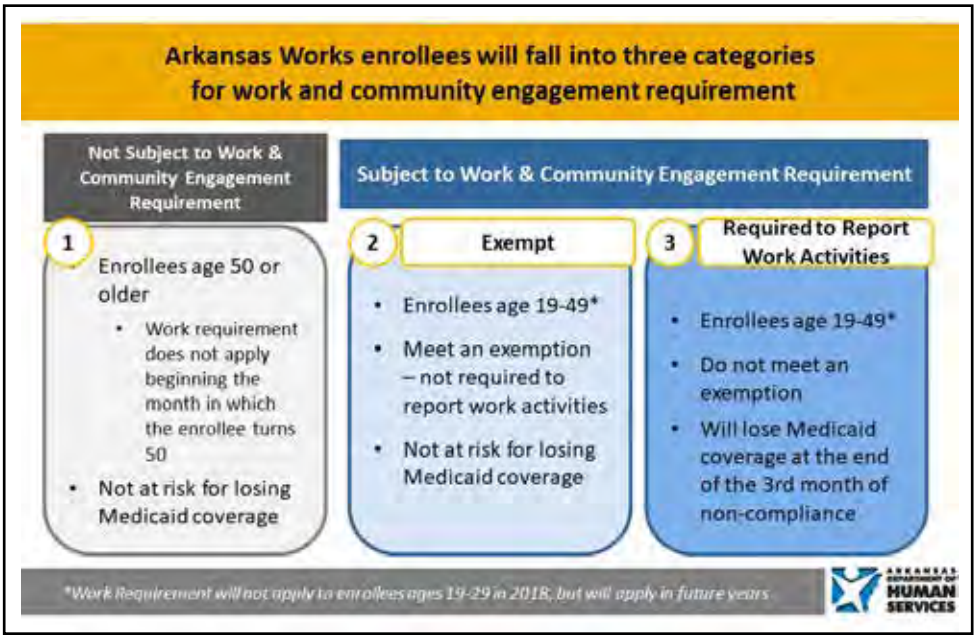
Wroten asked, "In short, how is this going to affect the medical care being provided to those under the work requirement?"

Coverage

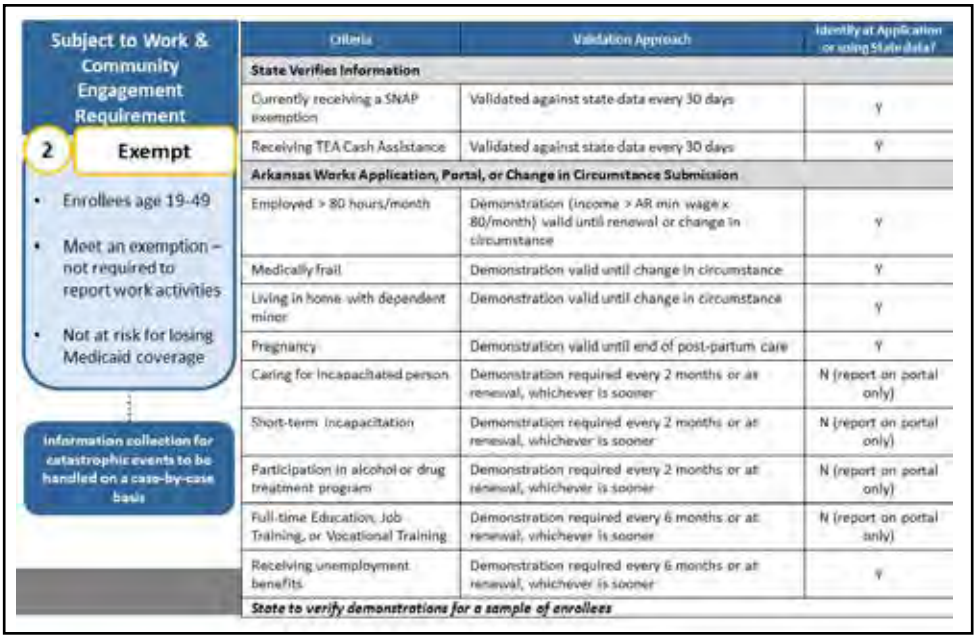
With any program starting out, there are some unknowns. While Franklin stopped short of speaking to specific "what-if' patient scenarios, she did share some set-in-place penalties and the policy of DHS to look at certain situations on a case-by-case basis. "Just as physicians can now check to see if a patient is covered by insurance, they will be able to check for Arkansas Works eligibility / coverage prior to treatment," she said. "If a patient's coverage is not active when he or she receives care, the provider providing the care would not be compensated for those services.

"We would like for physicians to remember a couple of things about Arkansas Works coverage. First, the requirement to complete and report monthly work and community engagement activities will affect approximately 40,000 out of the approximately 284,000 adults without an exemption during 2018."

A beneficiary's coverage, Franklin shared, is tied to his or her "case," which is open or closed at month's end in all cases other than the death of the beneficiary. While an Arkansas Works patient case is open, that patient's coverage is safe – as is the payment for services rendered. "If a case is active on the date of medical service," she clarified, "then the claim can be billed up to a year after the date of service even if the case has been closed."



Requirements per DHS.



Exemptions as listed in Arkansas Works communication materials.

Penalties for Non-compliance

"Adults who accumulate three months of non-compliance with work requirements during a calendar year will lose their coverage in Arkansas Works for the remainder of the calendar year," explained Franklin, noting that those three months do not have to be consecutive and that if a patient's case is closed for non-compliance, providers will be able to see that information by the following day. "However, beneficiaries may reapply and return to the program if eligible in the following calendar year. Also, it's important to note that individuals who have been disenrolled for non-compliance with work and community engagement requirements may apply [immediately] for Medicaid in *other* categories (such as pregnancy and disability) according to eligibility."

Exceptions / Exemptions

In some cases, beneficiaries who are otherwise non-exempt may qualify for what DHS has termed a *good cause exemption*. This typically requires catastrophic circumstances, which may include natural disaster, fire, hospitalization, or the death of a family member living in the home.

"There is a process by which Arkansas Works individuals request good cause exemption for not completing work activities or reporting work activities. Normally this would be done by the individual by contacting his or her county office," said Franklin. "If the individual is incapacitated to the point that they cannot report for themselves, then a loved one may make the request. We will handle good cause requests on a case-by-case basis. Individuals whose requests for good cause are approved will have their non-compliance removed and may be reinstated without a new application if their case was closed."

Help Direct Patients to the Arkansas Works Online Portal

To help themselves and their patients, physicians and other health care professionals can start by understanding the requirements, sharing information and reminders in their clinics, and pointing Medicaid patients towards the help DHS has made available to them – specifically, the information on the DHS public sharepoint site. The reminder to report their work activities on the Arkansas Works – Work Requirement online portal located at access.arkansas.gov.

Beyond this, it's always helpful to remind patients to stay in touch with their health care plan. Arkansas Works is part of Medicaid, and Medicaid patients are expected to keep in touch with changes that may affect their medical care.

"Most importantly," noted Franklin, "please direct individuals who need help finding a job or job training to the Department of Workforce Services. DWS is a vital resource for beneficiaries to comply with work and community engagement requirements."

Again, the Arkansas Works sharepoint site portal is an exhaustive source of information. It includes links to informational videos, information on setting up an email account, linking the email address to an online account, linking an online account to its associated health care plan, logging work or other approved "engagement," a list of exemptions, where to access a computer, job search and job training assistance, transportation assistance information, what qualifies as approved volunteer work, and more.

"We don't want people to lose coverage," stressed Franklin. "We encourage people to be in the habit of staying in touch and reporting any changes in their status. They can take care of that on the online portal, which is user friendly and mobile device friendly. Anywhere you have access to the internet, you can access the portal. You don't have to be in a DHS office to access the portal, but we do have computers available in our lobby and staff members available to assist you. We want members to have access to good health care. We at DHS, along with the carriers that offer our plan and the Department of Workforce Services, are all here to help."

Learn More

For more information on Arkansas Works and full description of the new work requirement and how to make sure you or your patients understand its effects on health care coverage, visit the DHS public-facing share site at ardhs.sharepointsite.net/ARWorks/default.aspx. From there, you can also visit the Arkansas Work Online Portal at https://access.arkansas.gov/Welcome.aspx. You may also feel free to call Mary Franklin at (501) 682-8377 or email mary.franklin@dhs.arkansas.gov.

*According to Franklin, when Arkansas Works legislation first passed, it included a requirement for DHS to send recipients with income 50% or less than the federal poverty level a referral to the Arkansas Department of Workforce Services for job search and job training opportunities. DHS sent referrals to *all* members. There was not a requirement (in that first legislation) for recipients to follow through with DWS or otherwise show work.

**Access Arkansas – https://access.arkansas.gov/Welcome.aspx AMS

DHS Creates New Processes as Part of Work Requirement Launch

Beneficiaries need to create online accounts at access.arkansas.gov to report work activities.

As the Arkansas Department of Human Services (DHS) prepares to implement the Arkansas Works work and community engagement requirement June 1, the agency is rolling out new efforts to help beneficiaries get ready for the changes.

"It's important to us that people have a clear understanding of what is expected of them once the work requirement is live and they have the support they need," said DHS Director Cindy Gillespie. "We especially wanted to take steps to address potential barriers to reporting work activities, such as a lack of reading skills and lack of home access to the Internet."

To address literacy issues, DHS has created a process that allows beneficiaries to designate a trusted individual or organization to help them report their work activities or exemptions just as they would today with family, insurance carriers, and hospital financial staff when applying for Arkansas Works. The designated person will be called a registered reporter and will be required to complete a short online training that explains what information is required, how often work activities/exemptions need to be reported, and the importance of keeping people's information confidential. For in-person assistance from DHS, beneficiaries can go to their local county offices.

Through a contract with the Arkansas Foundation for Medical Care (AFMC), DHS also will help people over the phone who need help creating their online accounts at www.access.arkansas.gov and linking their accounts to their Arkansas Works coverage. It is important that beneficiaries create and link their online account because that account is the only way they can report their work activities. This week, at the request of DHS, AFMC began proactively calling beneficiaries who will be subject to the work requirement June 1. The caller's goal is to make sure beneficiaries understand what they need to do to comply with the new work requirement, and to ensure that they have a current email and mailing address on file.

The caller may ask beneficiaries to confirm their email addresses, but AFMC will never ask for protected information such as social security or Medicaid numbers or any passwords.

In 2018, Arkansas Works beneficiaries who are 30-49 years old will be subject to the work and community engagement requirement unless they are pregnant, disabled, already working 80 hours a month, or have some other exemption. DHS will begin rolling beneficiaries into the requirement several thousand people at a time between June and September. Beneficiaries who will be subject to the work requirement June 1 will get a letter next week notifying them of their status.

DHS also mailed letters to all Arkansas Works beneficiaries between the ages of 30 and 49, regardless of their work requirement status, that included a list of at least two sites in every county that have free Internet-accessible computers for use. All DHS county offices have a computer available for use.

To learn more visit www.access.arkansas.gov where you can watch a DHS video for step-by-step instructions or find guides that will walk you through the process.

More information about Arkansas Works can also be found on the DHS home page by clicking the "Arkansas Works" button on the right-hand side of the page at www.humanservices.arkansas.gov. AMS

ARKANSAS DEPARTMENT OF HUMAN SERVICES

CASE STUDY

Fatal Accident Caused by Displacement of an Unsecured Home-Heated Humidifier Unit in a Child with a Chronic Tracheostomy Requiring Long-Term Mechanical Ventilation

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Keywords:
Mechanical Ventilation, Respiratory Technology

Abstract:

Due to improved medical care, there are increasing numbers of children with chronic tracheostomies who require long-term mechanical ventilation. Reported preventable tracheostomy-related causes of death are rare. We report an additional potentially preventable cause of death: accidental displacement of an unsecured home-heated humidifier unit located above the level of the child and resulting in catastrophic spillage of water into the ventilator circuit and tracheostomy tube.

Introduction:

There are increasing numbers of children with chronic tracheostomies requiring long-term mechanical ventilation.[1,2] Mortality in this population is primarily due to the child's underlying condition; however, an estimated 7-50% of deaths are due to preventable tracheostomy-related causes[2-5] including: accidental tracheostomy decannulation,[5] tracheostomy obstruction,[3,5] tracheal bleeding,[3] accidental disconnection of ventilator-tubing,[4] and replacement of the tracheostomy tube into a false track.[3] Children on chronic mechanical ventilation via a tracheostomy require heated humidification to prevent injury to the airway epithelium, loss of ciliary function, and thickening of airway mucus. This is usually provided by a heated humidifier unit utilizing a gas source directed through a heated water chamber.[6] We describe an additional cause of potentially preventable tracheostomy-related death, namely accidental displacement of an unsecured home-heated humidifier unit located above the level of the child with resultant catastrophic spillage of water into the inspiratory limb of the ventilator circuit and tracheostomy tube.

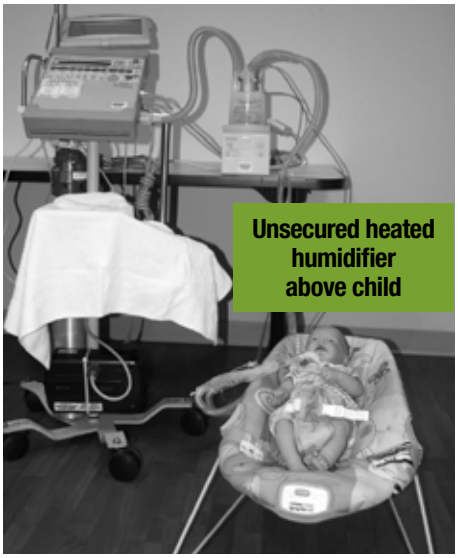


Figure 1: Home ventilator and heated humidifier unit showing incorrect setup with a tracheostomized infant mannequin in an infant bouncer below the level of an unsecured heated humidifier unit.

Event Description:

The patient was an 18-month-old former 24-week, 739g premature infant with severe chronic lung disease of prematurity and chronic respiratory failure who was initially discharged home from a tertiary care children's hospital at eight months of age. Echocardiogram prior to initial discharge was normal without evidence of pulmonary hypertension. Between 8 and 18 months of age, the patient had several hospital admissions, including an admission at 12 months of age after tracheostomy tube dislodgement requiring cardiopulmonary resuscitation (CPR) effectively provided by the family. Capillary blood gases during the last hospitalization at 17 months were normal (pH 7.38-7.44 and PcCO2 36-39 mmHg).

The patient had a Pediatric Bivona 3.5 flextend tracheostomy with deflated cuff and was chronically ventilated with a LTV 1150 ventilator. The patient's parents and adult cousin all received tracheostomy, ventilator and resuscitation training and were skills validated. The patient had been at home at baseline health for one week prior to the fatal event. Just prior to the event the patient was in the patient's room with two family members. The patient's ventilator and heated humidifier unit were on a nearby table at a level below the child when being held or in the crib. The humidifier unit had been filled with water about 30 minutes prior to the event and was unsecured on the table. The patient was placed in an infant bouncer on the floor, while the humidifier unit remained on the table 2-3 feet higher than the patient. When placing the patient in the infant bouncer, the humidifier unit was inadvertently tipped over, causing water to be spilled into the inspiratory limb of the ventilator circuit, the patient's tracheostomy tube, and the patient's airway. Almost immediately, a family member disconnected the ventilator tubing from the patient's tracheostomy. Mother witnessed the event on video monitor in a nearby room and was at the patient's bedside within seconds. Resuscitation efforts were initiated including one or two back blows, CPR with chest compressions and ventilation utilizing a resuscitation bag connected to the tracheostomy tube. EMS was contacted, arrived within approximately 20 minutes and transported the patient to the nearest local emergency department. Prior to transport, the patient was noted to have a faint pulse. Resuscitation efforts were continued, but despite receiving several doses of epinephrine, the patient expired. Although a death scene investigation was done by the county coroner, an autopsy was not performed.

Event Reenactment:

Utilizing similar equipment, we attempted to simulate the event in a more controlled setting. Figure 1 shows a home LTV ventilator serially connected

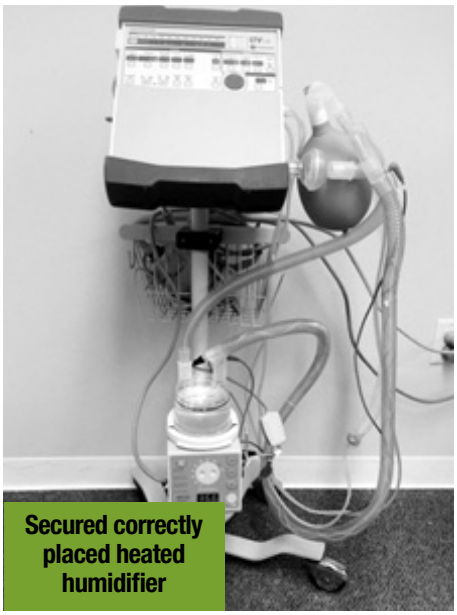
by standard corrugated one-inch diameter plastic tubing to a home-heated humidifier unit with water bath placed in an unsecure manner on a table. The volume of the water bath was approximately 300 mL. The humidifier unit was connected by the same type of tubing to standard Y-connector that was connected via a short standard flex tubing to a tracheostomized infant mannequin in an infant bouncer on the floor. During reenactments, the flex tubing was connected to a 500 mL test lung. On three separate occasions, the humidifier unit was quickly displaced onto its side and within less than two seconds 175-200 mL of water was rapidly dumped into the inspiratory limb of the ventilator circuit with approximately 25-50 mL entering the test lung.

Discussion:

To our knowledge, this is the first case report that identifies accidental displacement of a home-heated humidifier unit as a preventable cause of tracheostomy-related death in a child on long-term mechanical ventilation. Contributing factors to this unfortunate incident include unsecured placement of the home humidifier unit and location of the unit above the level of the child. These factors allowed the unit to be accidentally displaced and catastrophically spill water into the ventilator circuit and tracheostomy tube. During reenactment, we found that when the humidifier unit was quickly displaced onto its side, 175-200mL of water from a full water chamber rapidly filled the inspiratory tubing and 25-50mL of water entered the test lung. We believe this volume of water to be sufficient to cause a tracheostomized small child on long-term mechanical ventilation significant distress and possible fatal outcome, as in our patient.

A brief phone survey revealed families were not consistently instructed by our institution or their local home durable medical equipment (DME) company to secure the home-heated humidifier unit so it could not be displaced or to ensure the heated humidifier unit was situated below the level of the patient. These instructions were not included in a recent respiratory care practice guideline,[7] but a warning that the humidifier should always be mounted and positioned lower than the patient was found in the technical manual for a commonly used home-heated humidifier unit.[8] Review of United States Food and Drug Administration (FDA) safety communications for heated humidifiers revealed only one public health notification that concerned the risk of fire or electrical injury.[9]

Based upon this incident, we strongly recommend the following: 1) heated humidifier units should be secured to a non-tipping medical pole via appropriate mounting clamp or bracket (see Figure 2) or the device should be clamped or bolted to a flat table or sturdy non-tipping stand; 2) heated humidifier units should always be below the level of the child; 3) local and national DME and home nursing companies should be made aware of this potential hazard; 4) appropriate verbal and written safety instructions should be given to all families who have a child with a tracheostomy on long-term mechanical ventilation; 5) a heat and moisture exchanger (HME) should be utilized when the child is on the floor or below the level of the heated humidifier unit; and 6) appropriate methods of securing and safe use of heated humidifier units in the hospital should be modelled. Since this incident, we have incorporated additional heated humidifier safety information into our in-hospital tracheostomy training, provided verbal and written education to families with children who are already at home, and notified our local DME and home nursing companies of this potential hazard.



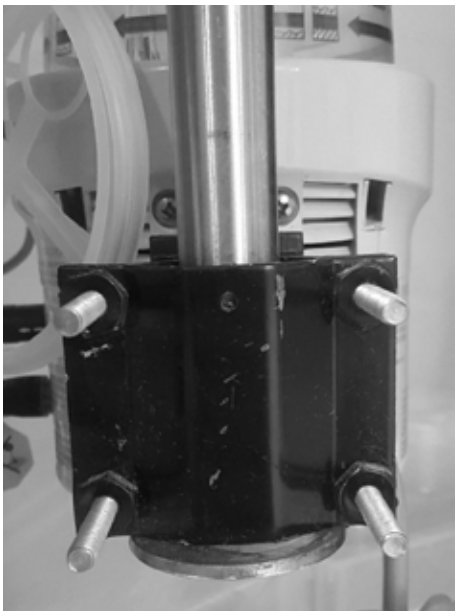


Figure 2: Home ventilator and heated humidifier unit showing correct setup: a) heated humidifier unit mounted as low as possible on non-tipping medical pole, and b) close up posterior view of mounting bracket and heated humidifier unit.

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Proactively Ask About Care Preferences

BY KIMBERLY GARNER, MD, JD, MPH; and JAMIE JENSEN, LCSW

Imagine one of your patients, hospitalized for several weeks with a life-threatening illness, is now unable to communicate their care preferences. Do you know what is important to your patient?

Regardless of their age or health status, you should proactively and routinely ask your patients about their care preferences. Life-threatening illness or injury can happen to anyone at any time. Your patients should be encouraged to regularly reflect on their values, communicate with those they trust and document preferences for future medical care.[1,2] Research indicates that patients who plan[3] for these challenging decisions are more likely to receive care that is aligned with their values and goals. Planning also relieves stress, anxiety and depression for their decision makers.[4]

Your patients can utilize a statutory legal document called an Advance Directive (AD) to document their preferences. One free version of this document is on the Arkansas Department of Health website under Health Care Decision Forms (**https://www.healthy.arkansas.gov/programs-services/topics/health-care-decision-forms**). This document, like most ADs, has two parts, both of which are important. Your patient can choose to complete either one or both:

- A Durable Power of Attorney for Health Care (DPAHC) allows patients to appoint a trusted, surrogate decision maker if they become unable to make or communicate their own decisions.
- A Living Will allows patients to document specific care preferences to serve as guidance to their health care provider(s) and surrogate decision maker.

The nature of these conversations will vary depending on whether they are healthy, have mild to moderate chronic illness or have a life-threatening condition.[1,2]

Regardless of their health status, it's a good idea to routinely ask if they are willing to have this discussion.

- **If they are not ready, tell them this is important** and that you will ask them again in the future.
- **If they are ready, a good way to start the discussion is to ask:** *"Can we talk about whom you would want to make decisions for you, if you were ever seriously ill or injured?*
- **Your discussion should also involve the challenges that surrogates face** in making difficult decisions for someone else: *"Who could advocate for you in a medical setting? Who can get your care preferences achieved, even if it is not what others are wanting or expecting to happen?"*
- **If your patient appoints more than one surrogate,** ask who will be the primary and if surrogates disagree, how that should be handled. You should also discuss how much leeway your patient wants a decision maker to have. For example: *"How would you want your surrogate to follow your guidance … follow it exactly or use their own judgment? What if your surrogate(s) disagrees with your preferences? What if other family members or friends disagree?"*
- **If your patient is not healthy, it is critical to establish your patient's understanding** of his or her current health status and what decisions may have to be addressed. This will help you understand what information or guidance you need to provide

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to help your patient make an informed choice about health care. Some providers ask:
"Tell me what you understand about your current health or [specific condition or illness…i.e. COPD, lung cancer, dementia, heart failure, etc.]? What does your [spouse, surrogate(s), family] know about your health?"

- **If you identify gaps between what your patient and surrogate know and what you think they should know,** you will need to provide clarifying information. This should include facts about their condition/prognosis and examples of decisions about treatment(s) or procedure(s) they, or their surrogate, may face in the future. You might say:
  - *"I know this is difficult to imagine, but your dementia may affect your ability to eat enough to stay alive. If this happened, would you want to be fed with a feeding tube?"*
  - *"This can be hard to think about, but if your [specific condition or illness] were to worsen and your heart stopped … would you want someone to try and bring you back?"*
- **If your patients indicate they would want these treatment(s) or procedure(s),** acknowledge and document preferences in their medical record and encourage them to do so in their AD. However, do not stop there. It is very important to keep asking questions to learn whether there may be circumstances that would affect their preferences. For patients who prefer life support, ask how long they would want the support to last and what criteria should be used by their surrogate decision maker(s) and health care providers to decide when to stop.
"I will document in your record that you want [specific procedure…i.e. feeding tube, CPR, etc.]. However, I'd also like to talk about whether there are any circumstances when you wouldn't want [specific procedure] to be done? Would you want to try these treatments for a limited period? If so, how long?"

By communicating their preferences and documenting them in an AD [advance directive], your patients are being given a voice in their health care and have a greater chance of ensuring care is aligned with their goals and values.

By communicating their preferences and documenting them in an AD, your patients are being given a voice in their health care and have a greater chance of ensuring care is aligned with their goals and values. It is very important to encourage your patients to provide a copy of their AD to you and, their surrogate(s) and family members. Also, provide a copy to any medical center where your patient anticipates being admitted for care. Your patients should regularly be reminded to revise their plan if relationships or health status change. An AD can be revoked with a simple oral declaration. If the AD is revoked, be sure the documents are removed or rescinded and any new documents are added to the medical record.

As a health care provider, you have seen what can happen when patients don't prepare for these challenging decisions. Reflect on how having a plan, or a lack of one, had an impact on the "in-the-moment decisions" for your patient. How did it affect their family and others involved in their care? Your proactive actions to encourage patients to plan ahead can relieve stress, anxiety and depression for their surrogate(s) and family during a very difficult time. This planning is an essential component of providing patient-centered and goal-concordant care.[5] ▲

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Marshallese HCR 1012

Pearl Anna McElfish, PhD, MBA
University of Arkansas for Medical Sciences Northwest

Abstract:

On March 29, 2017, in the presence of more than 100 members of the public, Gov. Asa Hutchison signed resolution HCR 1012, which encourages "a state plan amendment to the Centers for Medicare and Medicaid to provide access to coverage for migrant children and pregnant women from the Compact of Free Association Islands."[1] The resolution, put forward by Rep. Jeff Williams and Sen. Lance Eads, had strong bipartisan support from both the House of Representatives and the Senate. The resolution encourages coverage of all lawfully residing children whose families meet other eligibility requirements to receive ARKids First coverage. It is estimated that approximately 2,000 children will benefit from this coverage. This resolution is a significant step in strengthening the health and security of Arkansas and our nation.

Marshallese Community Context

Arkansas has one of the largest populations of Marshallese outside the Republic of the Marshall Islands (RMI).[2] The RMI was controlled by the United States (U.S.) as part of a United Nations Trust Territory of the Pacific Islands from 1947-1986.[3] From 1946-1958, the U.S. used the Marshall Islands as a test site for atomic and nuclear weapons.[4] This testing program in the RMI is important in contextualizing the relationships with Marshallese migrants. The equivalent of 7,200 Hiroshima-sized bombs were detonated in the RMI, exposing the Marshall Islanders, as well as their water and food resources, to significant levels of radiation.[5-7] Years of weapons testing caused significant destruction of natural resources and significant ongoing health disparities.

The RMI gained its independence in 1986 through the Compact of Free Association (COFA), an agreement between the U.S. and the RMI.[8] Through the COFA, the U.S. gained control of a large area of the Pacific Ocean and 10% of the RMI land mass for strategic military purposes. The RMI is home to the Ronald Reagan Ballistic Missile Defense Test Site, and Marshallese citizens serve in the U.S. military at higher per capita rates than U.S. citizens. As part of the COFA, the U.S. agreed to provide financial compensation to the RMI designed to help build the country's economy and improve the education and health of its citizens. The COFA also permits citizens of the RMI – as well as citizens from the Federated States of Micronesia and the Republic of Palau – to live, work, and study freely in the U.S. without a visa.[8] This agreement created the unique legal status of COFA migrants, distinct from other immigrants who are subject to U.S. Citizenship and Immigration Services administration.

Between 2000 and 2010, Marshallese migration to Arkansas and other states of the U.S. tripled from 6,700 to 22,434 according to census estimates.[2] The exact number of COFA migrants is difficult to ascertain, because COFA migrants can move freely without a visa and tend to move back and forth between the U.S. and their native countries in the Pacific. The actual number of Marshallese living in the U.S. is estimated to be much higher. Using school enrollment and health department birth record data, it is estimated that ~10,000-14,000 live in Arkansas and ~40,000 COFA migrants live in the U.S.[2,9,10]

Limited Access to Health Care and Health Insurance

Many Marshallese COFA migrants who come to the U.S. do not have adequate access to health care services or health insurance. According to local needs assessments, approximately 50% of Marshallese living in Arkansas are uninsured.[11,12] When the COFA was signed in 1986, COFA migrants were eligible for federal benefits programs, including Medicaid. However, with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996, COFA migrants lost Medicaid eligibility because the law only extended coverage to "qualified aliens," which excluded lawfully residing non-immigrants such as COFA migrants.[13] This left state governments the option to continue Medicaid coverage for COFA migrants using only state funds. Only a few states chose to extend coverage at their own cost; Arkansas did not.

The Children's Health Insurance Program (CHIP) was created by the Balanced Budget Act of 1997 as a joint state-federal partnership that provides access to affordable health care for children whose families have modest incomes that would not otherwise qualify them for Medicaid. Some states have opted to add these children directly to Medicaid, and others have created a separate but similar CHIP program. In Arkansas, this program is called ARKids First. CHIP provided access to medical care for millions of children across the U.S., but the narrow terminology used in the legislation did not include COFA migrant children. In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) included an option for states to extend this coverage to children who are "lawfully present." To extend CHIP coverage to COFA migrants as well as other immigrant and migrant children who have been in the U.S. for less than five years, states were required to amend their Medicaid plan with authorization from CMS. Arkansas did not initially amend its plan. But with an enhanced federal match rate implemented in 2015, Arkansas had the opportunity to take this new coverage option at no cost to the state.

On March 29, 2017, in the presence of more than 100 members of the public, Gov. Asa Hutchison signed resolution HCR 1012, which encourages "a state plan amendment to the Centers for Medicare and Medicaid to provide access to coverage for migrant children and pregnant women from the Compact of Free Association Islands."[1] The res-

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> ***On March 29, 2017, in the presence of more than 100 members of the public, Gov. Asa Hutchison signed resolution HCR 1012, which encourages "a state plan amendment to the Centers for Medicare and Medicaid to provide access to coverage for migrant children and pregnant women from the Compact of Free Association Islands."***

olution, put forward by Rep. Jeff Williams and Sen. Lance Eads, had strong bipartisan support from both the House of Representatives and the Senate. The state plan amendment extends ARKids First to COFA children; this change will make an important impact on the health of Arkansans. Marshallese COFA children were being served by local doctors, clinics, and health systems in Arkansas; however, this care was often sporadic and unreimbursed.

It is estimated that approximately 2,000 children will benefit from this coverage. School officials report that many Marshallese children do not get the immunizations and preventive care needed to optimize their learning experience. Now that they are eligible for ARKids First, these children will have better access to lower-cost preventative care, immunizations, and acute-care services. Access to these services is important to the health of these children and to the overall health and economy of Arkansas. The Marshallese community suffers from disproportionate rates of chronic (type 2 diabetes, hypertension) and infectious (hepatitis and tuberculosis) diseases that can be prevented or managed with appropriate care.[11,14,15]

More Work Ahead

Taking the state option to cover COFA migrant children is an important step toward providing equitable access to care to lawfully residing COFA migrants; however, more work is still needed. First, the Arkansas Department of Human Services and community partners need to provide bilingual outreach to help Marshallese sign up for and understand ARKids First coverage. Recent research shows that many Marshallese are unaware of how to use insurance and the nuances of using a primary care provider and referrals to specialty care.[12] Bilingual community health workers are needed to ensure Marshallese families sign up and use ARKids First coverage appropriately.

While COFA children will be covered under ARKids First when the state takes this option, many COFA migrant adults are still without adequate insurance or access to health care.[11,12] After PRWORA, coverage has been incrementally restored for many legal immigrant groups; however, COFA migrants continue to be excluded. It is imperative that Medicaid coverage be restored for COFA migrants.

As more COFA migrants move to the middle of the U.S., Compact Impact Aid is needed to provide financial support to those states. Under the 1986 COFA agreement, Compact Impact Aid was allocated for Hawaii, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa to offset costs associated with COFA migrants.[16] It has been more than 30 years since the COFA agreement, and large numbers of COFA migrants have moved to Arkansas, Oklahoma, Oregon, Utah, and Washington, but these states are not receiving any Compact Impact funds. U.S. Rep. Colleen Hanabusa of Hawaii put forth an amendment to the 1986 COFA agreement in 2011 and in 2013 that would have provided aid to states like Arkansas to cover any "costs incurred by affected jurisdictions as a result of increased demands placed on health, educational, social, or public safety services or infrastructure."[17] However, the legislation was not granted a vote in committee either year. Compact Impact Aid must be provided to all states with significant numbers of COFA migrants. We must continue to pursue these important issues until all lawfully residing COFA migrants receive the coverage they need and states are equitably provided resources for the support services they provide.

Conclusion

With the passage of HCR 1012 and the upcoming Medicaid plan amendment, Arkansas will take a significant step in providing equitable care to thousands of COFA migrant children. This is an achievement worthy of celebration, but more work is needed to ensure equitable coverage for lawfully residing COFA migrants. Furthermore, we must continue to pursue appropriate reimbursement for health care providers in Arkansas who are forced to assume the cost of the federal compact agreement. These efforts are important because access to health insurance and quality health care services has both personal and public health consequences.

Finally, many Marshallese COFA migrants argue that the U.S. has an ethical duty to provide access to affordable basic health care benefits, given the legacy of nuclear testing in the RMI and the long-lasting effects on health.[12] The U.S. and Arkansas continue to derive significant military and economic benefits from its relations with the RMI and the Marshallese people. One repeated refrain by Marshallese is that they have been "good friends to the U.S.." They continue to provide their land for the Missile Defense base to protect our country, and Marshallese COFA migrants continue to serve and die in the U.S. armed forces at higher per capita rates than our own citizens.[12] Their exclusion from health programs, which were provided when they signed the COFA, is seen by the Marshallese as a betrayal of their sacrificial relationship with the U.S..[12]

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Successful Treatment of Severe Atopic Dermatitis With Dupilumab Therapy

Kathleen Spitz, BS;
Sandra Marchese Johnson, MD, FAAD

Introduction:

Atopic dermatitis (AD) is a chronic, inflammatory cutaneous disease caused by up regulation of T helper cell cytokines that respond to numerous environmental antigens. This condition results in intractable pruritus and has been shown to significantly reduce the quality of life in those suffering from moderate to severe disease. [1,2,3] The current mainstay of treatment for AD includes first-line topical emollients; second-line topical glucocorticoids, topical calcineurin inhibitors, and oral antihistamines; and third-line escalation therapy to systemic immunosuppressants.[1,4] Treatment with systemic immunosuppressants have variable efficacy and multiple safety concerns with long-term use.[5]

Dupilumab, a human monoclonal antibody, is the first biologic or systemic agent approved by the FDA for the treatment of moderate to severe AD.[6] Here we present the case of a middle-aged female suffering from treatment-resistant AD that resulted in dramatic reduction in quality of life. This case highlights the benefits of Dupilumab as a novel biologic agent for treatment of an extremely severe case of AD.

Case Report:

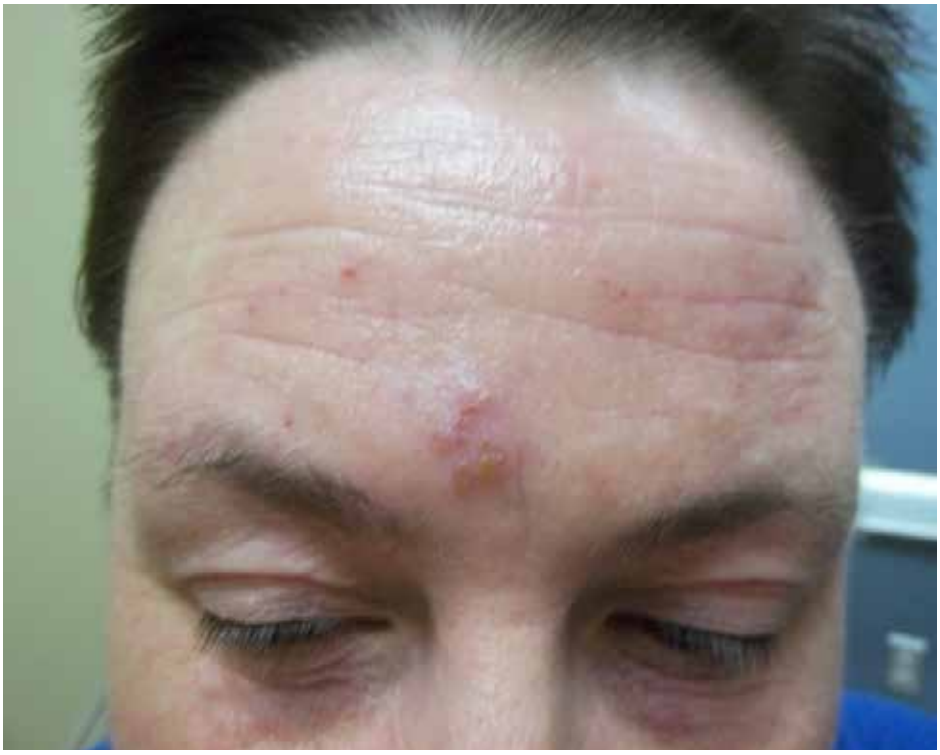
Our patient is a 48-year-old female who presented to our clinic with a lifelong history of severe, treatment-refractory AD. She initially developed symptoms of AD at the age of two weeks old when her skin began to crack and develop patches. From there, she developed skin infections and after months of trying topical therapies with minimal improvement, she was diagnosed with AD. Due to the severity of her condition, she was trialed on topical steroids, oral betamethasone, and finally oral prednisone 2-3 times per month. Additionally, she was kept on a strict regimen of 20-minute baths to soak her skin followed by total body coverage in steroid cream and moisturizing ointment. In order to control the ongoing pain of the disease, she was prescribed Atarax and Benadryl. The crusts and purulent fissures on her body would lead to sleep disturbances as well as needing assistance to extend her arms and legs. The severity of her disease caused isolation and embarrassment. Eventually, our patient's AD manifested in her joints and caused extreme pain as well as hand deformities. As a nurse, she was required to use her hands and be on her feet for a majority of the day. Due to the severity of her disease, she could barely use her hands or walk because of the intense pain in her joints. She was started on cyclosporine and prednisone in the hopes that this would alleviate her joint pain and AD symptoms. These medications resulted in her acquiring multiple infections during this period. She discontinued these medications after six months due to the unbearable side effects and was told there were no other options to treat her AD. She was given injections of this drug every 14 days. After a month, she noted significant improvement in her symptoms. She has continued on Dupilumab now that the medicine is commercially available and FDA approved. Her skin quality and her atopic dermatitis has greatly improved with less excoriations and lichenification. She even develops fewer episodes of herpes simplex or eczema herpeticum as noted in her photo from 2011.

Discussion:

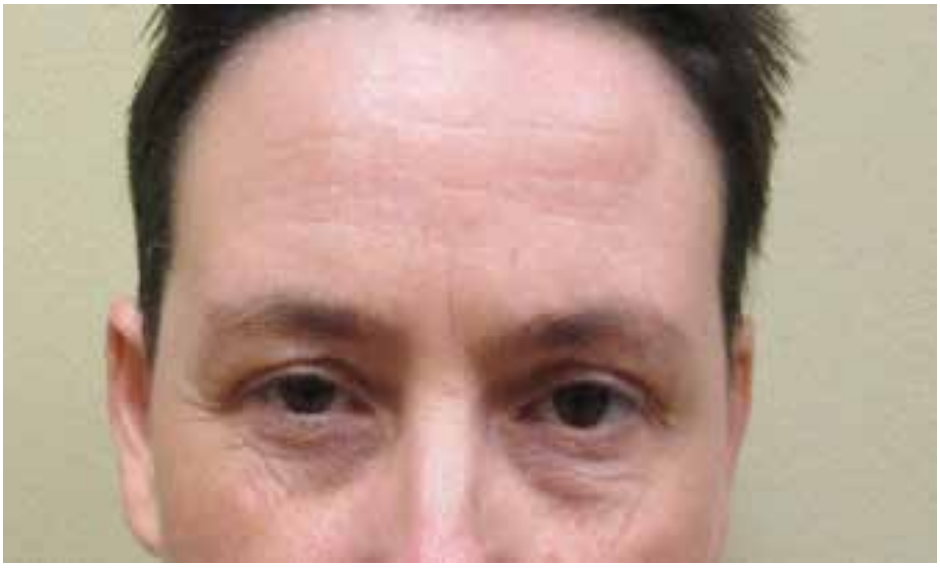
AD is a chronic skin condition that has a worldwide prevalence ranging from 1 to 20%.[1] Many patients who suffer from AD have an onset of the disease in early childhood.[7] The overall course of AD can be relapsing and remitting in nature, with repeated flare-ups.[8] These patients suffer from symptoms that include erythema, oozing and crusting, edema, xerosis, erosions/excoriations, and lichenifcation.[9] AD is accompanied by a large disease burden and reduced quality of life. Much of the reduction in quality of life is due to the intense pruritus that patients with AD suffer from.[1] Additionally, patients with AD report high rates of depression, anxiety, and sleep disorders.[10] This disease impacts patients in all aspects of life, including impairment of social, academic, and occupational functioning.[7] Multiple comorbidities commonly occur in those diagnosed with AD, including food allergies, asthma, and allergic rhinitis/rhinoconjunctivitis.[9]

Of the patients that receive a diagnosis of AD, 20% are found to have moderate-to-severe disease.[1] It has been shown that compared to mild disease, those suffering from moderate-to-severe disease report increased pruritus, pain, sleep disturbance, anxiety, and depression.[3] While there is no gold standard laboratory or serological test to determine severity of AD, some disease parameters used to measure severity include: clinical signs, disease extent, patient symptoms, strength of treatment required, and impact of disease on quality of life.[11] Clinically, this distinction of mild versus moderate-to-severe disease is important because response to treatment is less favorable in patients diagnosed with moderate-to-severe disease.

AD is characterized by a disrupted skin barrier, increased staphylococcus aureus colonization, and overexpression of T helper cytokines.[1,2] These cytokines produce interleukin-4 and interleukin-13, which are central to the pathogenesis of this atopic disease.[1,12] The FDA approves using emollients, topical glucocorticoids, and calcineurin inhibitors for the treatment of AD, but these treatments show little efficacy for those suffering from moderate-to-severe disease.[1] Due to the continuous and relapsing-remitting nature of AD, those suffering from moderate-to-severe disease



Patient presented in 2011 with long history of atopic dermatitis (AD) and recurrent herpes simplex virus (HSV) infections. Note the background lichenification, excoriations and erythema consistent with AD. Note the acute vesicles in the glabellar area consistent with HSV.



Same patient in May 2016, after two years of dupilumab treatment. Note the improvement of background erythema, lichenification, and excoriations. Note no active HSV lesions or scarring from prior lesions. Note the improvement even of periorbital erythema and edema.

often require treatment with systemic immunosuppressants, which are variably effective and result in multiple safety concerns.[5,8] Current immunosuppressive treatment options include agents such as oral corticosteroids, cyclosporine, azathioprine, methotrexate, and mycophenolate modafonil.[6,8] The side effects of these agents can be severe, especially if used for long periods of time. Some commonly seen side effects include increased risk of infection, hypertension, diabetes, osteoporosis, nausea, vomiting, and (for those taking cyclosporine) nephrotoxicity.[6,8,13] Given the inconsistent efficacy and significant side-effect profile of systemic immunosuppressive therapy for AD, there is an unmet need for long-term, efficacious treatments for AD that have minimal side effects.

In March 2017, the novel treatment for AD, Dupilumab, became the first biologic agent approved by the FDA for treatment of moderate to severe AD.[6] Dupilumab is a fully human monoclonal IgG4 antibody that inhibits interleukin-4 and interleukin-13 signal transduction by blocking the shared alpha subunit of the interleukin-4 and interleukin-13 receptors.[1,12] This treatment results in changes in gene expression such as down regulation of markers of epidermal proliferation and inflammatory mediators, and up regulation of structural proteins, lipid metabolism proteins, and epidermal barrier proteins. These changes normalize the skin and relieve symptoms of AD.[12]

In clinical trials, Dupilumab has shown promising results for successful treatment of AD. In one randomized, controlled trial of adults with AD who lived in North America, Europe, and Asia, a group receiving Dupilumab injections demonstrated improvement across multiple outcome measures compared to a group receiving placebo treatment. These outcome measures included objective signs of AD, subjective symptoms such as pruritus, mental health, and overall quality of life.[2] Dupilumab has a favorable side effect profile with common adverse events including injection site reactions, exacerbations of AD, nasopharyngitis, and conjunctivitis. When comparing the risks of long-term usage of immunosuppressants versus risks of long-term usage of Dupilumab, it is clear that Dupilumab is likely the safer and more effective long-term option.[6] This case emphasizes the safety and efficacy of Dupilumab treatment in a patient with severe AD. Clinicians should be aware of this treatment and the potential benefit it has to the large number of patients suffering from severe, treatment-resistant AD.

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