HEARTBEAT

THE BIMONTHLY NEWSLETTER OF THE ALASKA STATE MEDICAL ASSOCIATION April 2024

PRESIDENT'S COLUMN

Network Adequacy

Any health care system creates continuous tension between those who deliver care, and those who pay for it. If you've been following these pages, you are aware of the current struggle in Alaska regarding the 80th percentile rule, and the fact that ASMA is participating in a lawsuit against the Division of Insurance. The Division has used obviously fraudulent data to justify removal of an important consumer protection. As of this writing, the State of Alaska has offered to pursue mediation, which suggests that the state attorneys have recognized the merit of our suit.

Steven Compton, MD

While we continue our work on the 80th percentile rule, ASMA's larger goal is to protect patients' access to care in every way we can. That's why we cannot ignore the efforts of the private health insurance industry to control the markets in Alaska.

Private health insurers cannot avoid an implicit conflict of interest. In-

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Plan to Attend

May 1, 2024

ASMA General Membership Meeting

5:00 to 8:00 pm

BP Energy Center and on Zoom

Please RSVP to pventgen@asmadocs.org for those attending in person for food planning.

ASMA's Physician Health Committee

ASMA has supported the Physician Health Committee for over 35 years. The committee is made up of volunteer members of ASMA. Current members are Mary Ann Foland, Mike Herndon, Alexander von Hafften, Paula Colescott, Joe Llewellyn and Sarah Troxel. The committee has one staff support person, currently Pam Ventgen, ASMA's executive director, who also serves on a volunteer basis.

When it began in the late 1980's it was called the Impaired Physician Committee. The name changed along the way with the realization that physicians who were treated and in recovery were thought of as repaired, not impaired. The committee's work also broadened from the initial work with physicians suffering from alcohol and drug abuse and now also works with physicians and physician assistants with other mental and physical health issues. The committee is also instrumental in working with physicians seeking a license to practice in Alaska if they have had drug, alcohol or mental health issues in another state.

The PHC has been working for five years with the State Medical Board and the Division of Corporations, Business and Professional Licensing to update the licensing application questions that tend to discourage professionals from seeking help. This

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ASMA Website Info:

- For those that have not logged in yet, the site did not carry over your password. You **WILL** need to reset it in order to login.
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- Physician images were **not** imported to the new site so please be sure you log in and upload a new photo for the OMD (Online Medical Directory).
- The system currently does not support Company Admin's uploading individual physician photos. You may email photos to Cjeanes@asmadocs.org, but please include the physician name and company so that we can be sure we're uploading to the proper profile.

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spring, the Division finally recognized the problems with the wording on many professional licensing applications and are updating the questions to the current standard. We are assured the Medical Board's applications for initial and renewal applications will be updated before October, 2024, when the license renewal process will begin.

THE CURRENT QUESTIONS ON APPLICATIONS:

1.In the past two years, have you been diagnosed as having, or been hospitalized for, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No

2. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? Yes No

3. In the past two years, have you been the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner? Yes No

4. Are you currently engaged in the illegal use of drugs, or the use of illegal drugs? Yes No

5. In the past two years, have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner? Yes No

6. Are you currently taking a controlled substance that limits your ability to practice medicine in a fully competent and professional manner with safety to patients? Yes No

7. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession?

THE NEW QUESTION:

Are you currently suffering from any condition, mental or physical, that impairs your judgement or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

This updated wording is in line with the Federation of State Medical Boards, the Federation of State Physician Health Programs, the AMA, and the Dr. Lorna Breen Heroes' Foundation.

WWAMI
School of Medical Education
UNIVERSITY of ALASKA ANCHORAGE

ALASKA WWAMI

IS SEEKING NEW ADMISSIONS COMMITTEE MEMBERS

The Alaska WWAMI Admissions Committee is actively searching for new Alaska physician members. The Admissions Committee meets annually for 1 week in person in Anchorage in late January/ early February to interview candidates for admission to the Alaska WWAMI program/ University of Washington School of Medicine. The committee is tasked with selecting candidates for the next incoming class that will start the following July and is managed through the U. of Washington School of Medicine Admissions office with active support and participation by the Alaska WWAMI leadership.

Requirements:

1. Availability for approximately 1 week each winter to interview prospective students. Only travel-associated expenses are reimbursed for this activity, if applicable.
2. Willingness to become familiar with 20 to 30 applications – each is approximately 40 pages long and must be reviewed prior to the interviews.
3. Tech and computer savvy with access to internet; all admissions work is conducted online and by e-mail. All Interviews are 30 minutes and conducted online.
4. An understanding of the unique challenges in providing medical care in our diverse state. We are especially interested in representing *all areas* of the state and the broad spectrum of needed medical specialties
5. An understanding of Alaska's physician workforce needs.
6. An understanding and appreciation of the unique contributions and importance of Alaska's Native Peoples to healthcare in the state.
7. A willingness to serve for 6 years to provide continuity in Committee dealings.

Please send a short statement explaining your interest (≤ 1 page) and a brief CV to:

Alaska WWAMI School of Medical Education
University of Alaska Anchorage
3211 Providence Dr., HSB 301
Anchorage, AK 99508
Attn: Nancy Hall
njhall@alaska.edu

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surers can only maximize profit by restricting the very product they purport to deliver: health care. Insurance companies accomplish this by restricting authorization for service, delaying authorization for service, reducing payment for service. Insurance companies look for ways to pass costs to consumers and look for new ways to charge patients beyond their monthly premium payments.

Although the Division of Insurance is charged with protecting consumers from these tactics, the Dunleavy Administration has shown, through action, that its priority is protection of the private insurance industry. These activities undermine patients' access to timely care. Good medical care reduces suffering and saves lives, but delays and denials can exacerbate disease and, in some cases, hasten death.

Insurance providers take advantage of asymmetric information. Insurers are well aware of the fees charged by different providers within a community, but it's illegal for providers to discuss fees with their competitors. Insurers maintain the information asymmetry during contracting, by prohibiting providers from comparing their insurance contracts. Insurers make up their own prices for out-of-network care. The repeal of the 80th percentile UCR protection is their latest assault.

Insurance providers sell care "networks" to consumers/patients, but a common theme is to use highly restricted networks for the benefit of the insurer. Insurers are incentivized to use the narrowest possible networks, particularly when they are not really paying out-of-network providers. A "network" can potentially include a handful of primary care providers, excluding the majority, and can sign up the hungriest, lowest-quality specialists to guarantee volume. This may sound far-fetched, but the "narrow network" problem has become widespread in the lower 48.

The insurance industry and the State of Alaska are reducing access to health care. That's why **ASMA is advocating for patients by empowering their providers to speak as a single voice.**

- Restoration of usual/customary/reasonable rates for out-of-network care. The 80th percentile rule was developed by the Murkowski administration to protect patients from the deadbeat insurance companies. ASMA has proposed a noninflationary solution that expands patient access to care rather than restricting access.
- Prior Authorization requirements are designed to deter patients and providers from pursuing appropriate care. ASMA is supporting a Prior Authorization relief law in Juneau, to keep your practice from being bogged down with endless phone delays and inappropriate denial of care.
- Asymmetry of fee information empowers insurance companies while hobbling providers. ASMA has supported the state's development of an all-payer claims database to shine a public light on the medical market and force payers to recognize economic forces.
- ASMA's next initiative is to pursue legislation in Alaska to guarantee the adequacy of local health care networks. The National Association of Insurance Commissioners has written guidelines that have become law in 37 states, including our neighbors in Washington. Working with Jeff Davis, past CEO of BC/BS Alaska, ASMA hopes to pass legislation that ensures that our patients retain access to solid networks for their clinical care.

In summary, private health insurance is an intrinsically conflicted business in which companies are forced to work against the interests of their customers. In the absence of appropriate guardrails, private insurance companies, by design, will erode access to quality medical care. We providers are charged with providing the best possible care to our community, and ASMA is the organization that allows us to shout with a single voice in defense of our patients.

Debunking Sport Related Concussion Myths: New Insights into Treatment, Recovery, and Long-Term Impact

Emily Mika Reynolds, DO, Neurologist, Brain Injury Medicine, Clinical Neurophysiology

Concussions have long been a topic of concern, especially in contact sports like football and soccer. Over the years, various myths have circulated about concussions: initial acute concussion treatment strategies, when to "return to play", and their long-term effects, particularly regarding Chronic Traumatic Encephalopathy (CTE). However, recent research has shed new light on these misconceptions, challenging our understanding of concussions and their implications. Here, we debunk some common myths and explore the latest findings in concussion science.

Myth 1 : Mild traumatic brain injury (TBI) is a more severe form of concussion.
Fact: The terms "concussion" and "mild TBI" are often used interchangeably, as they refer to the same condition—a disruption of normal brain function following a head injury with normal brain imaging or neuroimaging was not clinically indicated. Both concussions and mild TBIs can result in symptoms such as headache, dizziness, and confusion. Regardless of the label, proper diagnosis and management are crucial for ensuring a safe recovery. (Silverberg)

<u>Myth 2: The direct blow to the head can only create a coup and counter coup injury.</u>
FACT: it's crucial to understand the multifaceted nature of head trauma. Impacts can result in three distinct types of head motion: the initial impact-induced motion, the brain's recoil response, and the rotational forces stemming from the head's position atop the neck. (Carlsen)
Particularly in scenarios involving significant rotational forces, like a knockout punch in boxing targeting the chin, the brainstem undergoes severe strain, often leading to loss of consciousness. Recovery from such injuries are notably prolonged, with boxing return-to-play guidelines mandating a minimum three-month hiatus from competition following a knockout with loss of consciousness. (Neidecker)

Myth 3: There exists a universal consensus on the definition and diagnostic criteria for concussion or mild traumatic brain injury (TBI)
FACT: For sports-related concussions, commonly referenced criteria include those outlined in the Consensus Statement on Concussion in Sport: 6th International Conference on Concussion in Sports:
"Sport-related concussion is a traumatic brain injury caused by a direct blow to the head, neck, or body resulting in an impulsive force being transmitted to the brain that occurs in sports and exercise-related activities." Consensus statement on concussion in sport: 6th International Conference on Concussion in Sports-Amsterdam, October 2022.(Patricios)
As well as the diagnostic criteria established by the American Congress of Rehabilitation Medicine in 2023:
"Traumatic Brain injury results from a transfer of mechanical energy to the brain from external forces resulting from the (1) head being struck with an object; (2) head striking a hard object or surface; (3) brain undergoing an acceleration backwards/deceleration movement without direct contact between the head and an object or surface; and/or (4) forces generated from a blaster explosion.
The injury event causes an acute physiological disruption of brain function as manifested by one or more of the clinical signs listed below.

- Loss of consciousness immediately following injury
- Alteration of mental status immediately following the injury
- Complete or partial amnesia from events immediately following the injury
- Other neurologic signs–example observed motor incoordination upon standing, seizure, or tonic posturing immediately following injury." (Silverberg)

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Additionally, the Neurotrauma Task Force on Mild Traumatic Brain Injury of the WHO Collaborating Centre offers valuable insights, as summarized in their 2005 report:
"Mild traumatic brain injury is an acute brain injury resulting from mechanical energy to the head from external forces. Operational criteria for clinical identification include (1) one or more of the following : Confusion or disorientation, loss of consciousness for 30 minutes or less, posttraumatic amnesia for less than 24 hours, and or other transient neurologic abnormalities such as focal signs, seizure, and intracranial lesion not requiring surgery; (2) Glascow coma scale of 13–15 after 30 minutes post injury or later upon presentation for healthcare. These manifestations of mild TBI must not be due to drugs, alcohol, or medications; caused by other injuries or treatment for other injuries." (Holm)

Myth 4 : It is safe for newly concussed athlete to return to play after 72 hours of rest .
Fact: The idea that athletes can safely return to play after a brief period of rest is outdated and potentially dangerous. While symptoms of a concussion may resolve within a few days, the brain often requires more time to fully recover. Returning to physical activity too soon can increase the risk of Second Impact Syndrome—a rare but life-threatening condition characterized by rapid brain swelling following a second head injury before the first has healed (Stovitz). Current guidelines recommend a gradual return-to-play protocol under the supervision of a healthcare professional to ensure the athlete's safety and prevent long-term complications. (Stovitz)

Myth 5: Average concussion recovery time for sports related concussion is 3 months.
FACT: In recent years, there has been a growing body of research shedding light on the recovery trajectory of college athletes following a concussion. According to a recent study focused on concussion recovery in this population, the median duration for athletes to recover is approximately two weeks. Remarkably, up to 85% of concussed athletes are able to return to play within one-month post-injury through utilization of progressive return to play treatment guidelines. The study's findings provide valuable insights into the timeline of recovery among college athletes. Specifically, the data revealed that 16% of athletes can resume play within one week of sustaining a concussion, with the majority (57%) returning by day 14. By day 21, approximately 77% of athletes have returned to play, and by day 28, this number increases to 85%. These statistics underscore the importance of effectively communicating recovery expectations to athletes and their caregivers. It's crucial for primary care providers to convey that while most athletes can expect to return to play within a month, the process may vary for each individual. Moreover, setting realistic expectations is key to managing athletes' perceptions of their recovery journey. Furthermore, informing athletes that most individuals become symptom-free within 14 days without physical exertion can help temper expectations and alleviate concerns. This knowledge empowers athletes to navigate their recovery process with a clearer understanding of the timeline and potential outcomes. Effective communication regarding recovery expectations not only promotes physical health but also contributes to the athletes' overall mental and emotional resilience throughout the rehabilitation process. (Broglio)

Myth 6: If an athlete experiences multiple concussions from their sport, they have an increased risk of post-concussion syndrome or other disability and should no longer participate in that sport.
FACT: While a prior history of concussion might seem like an obvious risk factor for post-concussion syndrome (PCS), recent research indicates otherwise. Surprisingly, it's not the concussion history itself that significantly predisposes individuals to PCS. Instead, other pre-existing conditions such as a history of migraines, mood disturbances, and attention-deficit/hyperactivity disorder (ADHD) play a more substantial role in predicting the likelihood of developing PCS. (Skjeldal) (Moargan). These factors interact with the physiological and psychological aftermath of a concussion, potentially exacerbating symptoms, and prolonging recovery. Understanding these nuances is crucial for healthcare professionals when assessing and managing patients with concussions, as it allows for more targeted interventions and support strategies tailored to everyone's specific risk profile. Also, contrary to popular belief, experiencing multiple

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concussions does not necessarily lead to permanent disability. While each concussion should be taken seriously and managed appropriately, it is crucial to dispel the misconception that a certain number of concussions automatically equates to lifelong impairment. Implementing a gradual return-to-play protocol for athletes and providing appropriate classroom accommodations for students recovering from concussions address both the physical and cognitive aspects of recovery. Furthermore, it is crucial to emphasize the role of preventive measures in reducing the risk of concussions, particularly in high-risk sports such as football, hockey, boxing/combatives, and soccer. Education about proper technique, equipment safety, and concussion recognition is essential for minimizing the likelihood of sustaining a concussion in the first place. (Alsalaheen) (Ransom) (Mooney)

Myth 7: A concussion screening tool is comparable to a side-line gait and balance exam in identifying concussion.
FALSE: Although gait and balance abnormalities are common symptoms after a concussion, immediately after injury musculoskeletal etiologies can also cause balance abnormalities. Studies have demonstrated that the Sports Concussion Assessment Tool (SCAT) has the highest sensitivity (88%) and specificity (82%). The downside to this tool is it must be administered by a healthcare professional, thereby reducing practicality as having a licensed healthcare provider at every youth sport event is unrealistic. Overall, the best concussion recognition strategy is for coaches, parents, and athletes be familiar with common concussion signs and symptoms after an impact to the head i.e.- loss or change in consciousness, confusion, behavioral change, poor balance/dizziness, and forgetfulness. If any of these are observed or suspected best practice is to have a low threshold to remove the player from the field to avoid further injury. (Dharnipragada) (Eliason)

<u>Myth 8: Strict bed rest until resolution of all concussion symptoms is the best management.</u>
False: Evidence is recommending relative (not strict) rest with inclusion of light-intensity daily activities, such as walking, is best for efficient concussion recovery. (Patricios). Reduction in screen time for up to 48 hours after concussion helps to keep cognitive engagement low. Physical and cognitive activities can be gradually introduced and increased in intensity as tolerated by concussion related symptoms such as headache, dizziness, concentration fatigue. Anything more than mild exacerbation of concussion symptoms should dictate that cognitive/physical activity be downgraded to prior level for at least 24hrs before attempting to increase intensity.

Myth 9: Chronic Traumatic Encephalopathy (CTE) is only caused by concussions.
Fact: CTE can develop without a history of concussions.
New evidence since 2019 highlight cases of postmortem tissue with CTE pathology and no prior experience of concussions or sub concussive exposure. According to the CDC 190 Americans die from TBI related injury each day in 2021 <u>https://www.cdc.gov/traumaticbraininjury/index.html</u>.
At the same time systemic review of ALL CTE cases reported in the medical literature 1954-2013 demonstrated only 153 cases meeting CTE pathological diagnostic criteria. (Iverson) (Maroon)
Bibliometric analysis has demonstrated that scientific articles that demonstrate a positive connection between CTE and contact sports or military service have 3 times more citations over articles which demonstrate no association between CTE with contact sports or military service. (Eagle) While concussions have been linked to an increased risk of CTE later in life, the overall risk of developing CTE appears low.

In conclusion, understanding the realities of concussions and their associated risks is essential for promoting brain health and athlete safety. While misconceptions persist, ongoing research continues to refine our knowledge of concussion management and prevention. By debunking myths and embracing evidence-based practices, we can better protect individuals from the potentially devastating consequences of head injuries.

Resources for concussion recovery guidelines:

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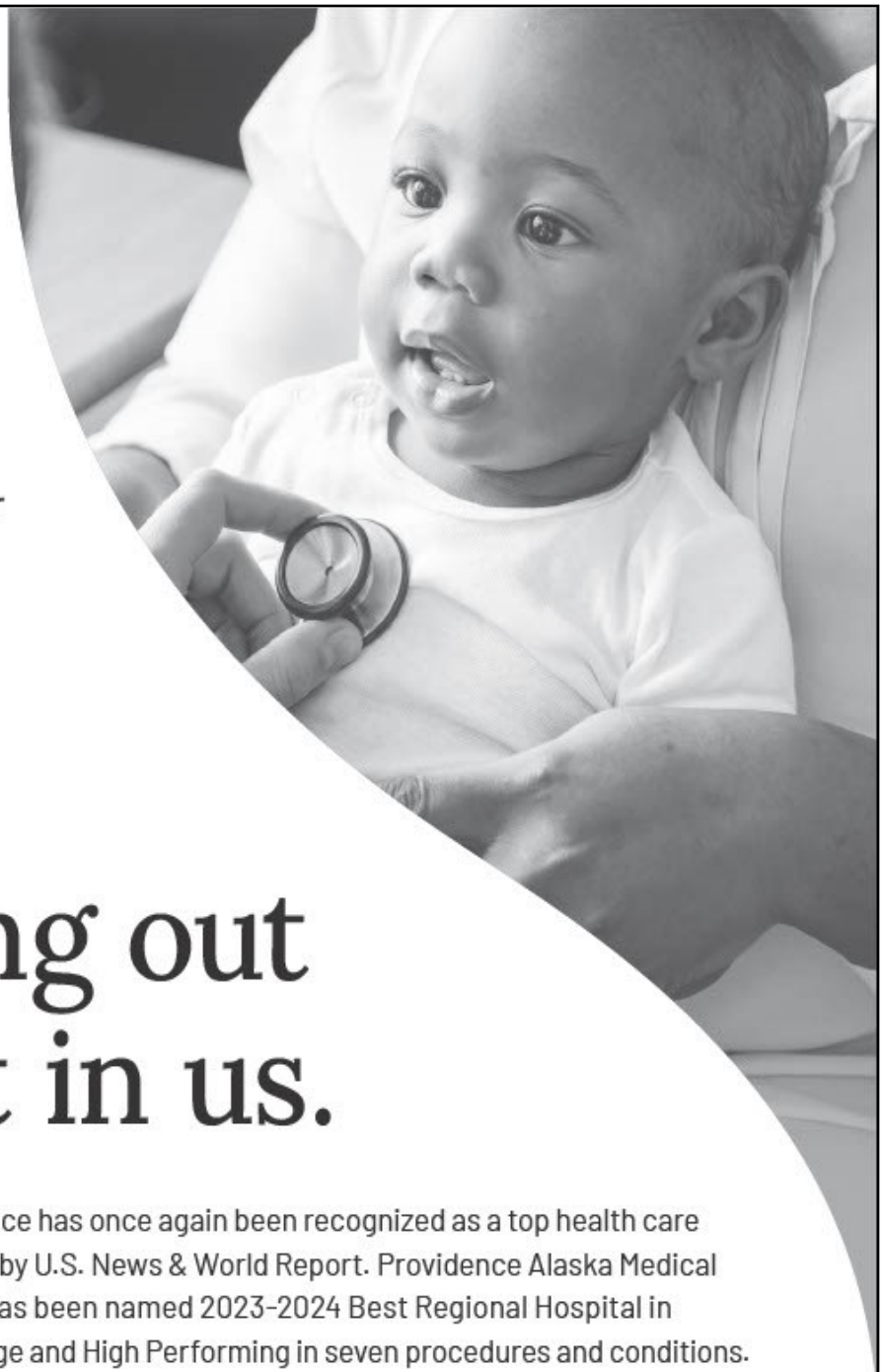

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For ER providers: https://www.acep.org/patient-care/clinical-policies/mild-traumatic-brain-injury2/

This a policy/guideline created by the American College of Emergency Physicians about concussion/mild TBI diagnosis, work up, and patient take home instructions.

If you take care of Pediatric and Adult athletes:
https://www.cdc.gov/headsup/index.html
This is a site with concussion information for both healthcare providers and parents/patients. There are concise fact sheets you can print for outpatient clinics, videos and social media sites for patients, as well as training modules for clinicians, coaches, school staff who work with athlete students, and athletic trainers.

For samples of concussion screening tool, return to activity guidelines, and TBI symptom management guidelines:
https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence
The TBI Center of Excellence from the Military Health System has a comprehensive collection of TBI recovery resources that can be used in a non-military setting for non-military patients.

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HEALTH CARE COSTS

The next time you wonder why health care is so expensive, here are the salaries/compensation of some health insurance executives in 2020:

Premera Blue Cross $4.7 million
Cigna $19.9 million
United Health $17.8 million
Anthem $17.1 million

The total annual health care spending is more than $4.4 trillion in 2020. Administrative costs make up 73% of that total. Physicians' salaries: 8%. When your doctor can't get you the tests/ imaging/ procedures/surgery/medication you need, remind yourself that the middle management, CEOs, lobbyists and so on did not swear an oath to put your health above profits. Your doctor did. The doctor who is missing sleep, skipping vacation, missing family events, answering calls on weekends, missing recitals and hockey games.

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