

wyoming

MEDICINE

Volume 4. Number 1.

A day in the life of a WWAMI student

Patient safety in Wyoming

Medicaid Expansion

Rural
medicine
in Wyoming

Dr. Nelson
talks about
life as a
Pediatrician
on the
reservation
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**January 2013
Editor's Page**

**By Robert Monger, MD
Chief Editor**

An important result of the recent election is that the Affordable Care Act (ACA, also known as "Obamacare") is here to stay. Whether you personally support or oppose the ACA, with the reelection President Obama in 2012 the ACA will remain the law of the land. One thing this means for Wyoming is that the Wyoming Legislature needs to decide what to do about Medicaid expansion.

The ACA is a politically charged issue, and after much debate the Wyoming Medical Society (WMS) recently developed the following policy statement in support of Wyoming Medicaid expansion:

"The Wyoming Medical Society (WMS) supports the expansion of Wyoming's Medicaid program under the provisions contained in the ACA. WMS physicians believe it is critical to provide access to quality healthcare for all Wyoming citizens. WMS represents a diverse population of Wyoming physicians who- like the rest of the state's constituents- have varying opinions about the appropriateness of expanding government programs. While WMS formally supports expanding Medicaid in Wyoming, we strongly urge the elected state leaders to carefully consider both the costs and benefits expansion of this program will bring to its citizens and the workforce of healthcare professionals who serve them."

Why expand the Wyoming Medicaid program? According to an extremely well done report recently published by the Wyoming Department of Health (WDH), available at www.health.wyo.gov, Medicaid expansion could save more than \$47 million dollars in state budget funds over a six-year period (2014-2020), while at the same time significantly reducing the number of uninsured state residents.

How does expanding Medicaid save the state money? I'd encourage anyone interested in this issue to read the WDH report, but the bottom line is that by expanding Medicaid the state will realize a number of cost offsets that get shifted to the federal government for programs that the state is currently paying for, such as HIV/ AIDS medications, mental health and substance abuse outpatient programs, renal dialysis, the Wyoming State Hospital, and more.

The most important thing about Medicaid expansion, however, isn't budgets and accounting. Medicaid expansion is about providing

health care to tens of thousands of Wyoming residents who right now who have no health insurance and only limited access to health care. And access to health care can literally be a life and death issue.

It makes common sense that if people with medical problems such as diabetes and hypertension are able to obtain medical care then their health will improve. But are there studies that show that Medicaid expansion actually leads to better health outcomes and even potentially saves lives? The answer is yes.

A 2012 study by the Harvard School of Public Health (published in the *New England Journal of Medicine*: 367:1025-34, September 13, 2012) found that state Medicaid expansion is significantly associated with reduced mortality. That's right: by providing access to healthcare for people who are now uninsured Medicaid expansion saves lives.

How many lives are we talking about? According the WDH report, if we extrapolate the results of the Harvard study to Wyoming then expansion of

the Wyoming Medicaid program could prevent more than 100 Wyoming deaths per year. That's right: the current best estimates are that expansion of Wyoming Medicaid will save the state tens of millions of dollars and prevent the deaths of hundreds of Wyoming residents.

Politics aside, what is the downside of Medicaid expansion? From a WMS perspective the biggest problem with Medicaid expansion is that extending medical insurance to so many people will exacerbate healthcare provider shortages. Even for our small population Wyoming already has one of the lowest per-capita numbers of doctors of any state. More patients entering the system will only make it worse, particularly in small towns.

What can the Wyoming Legislature do to address provider shortages? Fully supporting the College of Health Sciences at the University of Wyoming and the WWAMI medical school program will continue to be important; loan repayment programs for physicians who agree to work in Wyoming can help recruit physicians to our state.

Addressing provider shortages will be an important issue for the Legislature going forward.

The people most likely to benefit from Medicaid expansion in Wyoming are the working poor. People employed in places like restaurants and nursing homes work extremely hard, often at more than job, but often don't have health insurance. For them, Medicaid expansion is a critically important decision. While the working poor don't have political action committees or lobbyists at the Capitol, hopefully Wyoming's leaders will do their best to put politics aside and come to a decision about Medicaid expansion will be the best decision for Wyoming's residents.

On the cover of this edition of Wyoming Medicine we feature the incredible Dr. Jackie Nelson, who has worked with the Indian Health Services at Fort Washakie for 21 years. You can read an interview with her, and also a story by WMS President Dr. Mike Tracey about a recent Patient Safety Meeting in Casper in our current edition.

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Why patient safety?

By Mike Tracy, MD
WMS President



Is “patient safety” a necessary focus for physicians generally, and the Wyoming Medical Society (WMS) specifically, when physicians are already trained to practice safe medicine and provide safe care? A participant attending the first annual Wyoming Medical Society-Wyoming Hospital Association (WHA) Patient Safety Summit in Casper during October asked this very question. The answer: while physicians usually know what to do when treating patients, there is often a gap between what healthcare providers know to do and what actually happens. This gap is largely a function of system problems, rather than people or knowledge problems. Addressing this gap is important because physicians are ultimately responsible for what happens to patients under their care. Patient safety is a topic that is relevant to all practicing physicians.

Patient safety and quality are two related but distinct concepts physicians encounter every day while caring for patients. The medical literature and lay media are filled with information on safety and quality. The difference between safety (safe care) and quality (quality care) is worth discussing briefly. Safety refers to efforts to keep patients from experiencing harm, while quality refers to the experience of the patient receiving care. Patient safety efforts typically focus on preventing bad events and outcomes,

thereby reducing the incidence of such events. Quality efforts seek to improve the overall patient experience and generally focus on doing things well. Patient safety and quality efforts have historically been covered under the general heading of “Quality Improvement” (QI), but perhaps “Safety and Quality Improvement” would be a better description. In general, a facility that offers consistently safe care will offer quality care, and vice-versa. Healthcare providers strive to provide safe, quality care for patients.

Physicians have historically engaged in quality improvement efforts in the hospital setting. Most efforts to improve care have focused on hospital events and outcomes such as providing correct care to hospitalized patients with pneumonia or congestive heart failure. Examples of safety and quality efforts being made in the outpatient setting include intentional diabetes management, cancer screening activities, and medication reconciliation. Quality improvement efforts are most effective when planned and proactive. The historical approach of hospital quality improvement has often been reactive, like the game “Whack-a-Mole”. The player’s role in the game is to wait for a toy mole to emerge from a hole and then whack it in the head with a mallet. The corollary would be the QI Committee waiting for a mistake to be made so the mistake (and the person who caused the mistake) could be “whacked.” This approach has not proven effective in decreasing the recurrence of similar mistakes.

So, why should the physician care about patient safety and quality efforts? Two reasons are clear. First, it’s the right thing to do for patients. Physicians should all want their patients to have a safe, quality experience as they navigate a complex healthcare system. Second, if physicians do not choose to care about it, someone else will step in to care about it for physicians. Pay-for-performance is

an example of an issue that may involve safety and quality measures and it will benefit both providers and their patients to have physicians at the proverbial table as these metrics are developed.

Physicians often voice concern when other stakeholders in patient care, such as insurance companies or government agencies, take a lead role in patient safety and quality improvement efforts. The article “Zen and the Art of Physician Autonomy Maintenance” by Dr. James Reinertsen is worth reading (*Annals of Internal Medicine* 2003). Reinertsen makes the case that physicians are losing autonomy because patients and payers have recognized gaps in the science of medicine and the application of it by the medical system. The paradox is that physicians will not retain their autonomy by holding onto it “kicking and screaming”, but rather by working together as a collective group to apply the science of patient care and safety to the problem. While this may be easier said than done, Reinertsen’s paper is worth reading in the context of this discussion.

Finally, there is an intersection between tort reform and patient safety efforts. While the 2004 tort reform efforts in Wyoming were not successful, making patient care as safe as possible is likely to decrease the opportunity to be named in a malpractice suit. The article “Making Patient Safety the Centerpiece of Medical Liability Reform” outlines ideas for improving patient safety to decrease malpractice liability (*New England Journal of Medicine*, 2005). During the WMS-WHA Patient Safety Summit in Casper, many ideas were discussed including medical error disclosure, the COPIC 3 R’s program in Colorado, and Wyoming’s apology law. The general topic of a patient safety organization in Wyoming was also discussed as a legally protected venue to gather patient safety data and network to improve the safety and quality of healthcare in Wyoming. **WM**

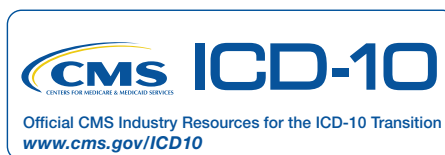


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Rural medicine in Wyoming

By Christy Chadwick



Dr. Jackie Nelson, MD with Hadlee Robinson, 3, and Hailey Meeks, 14

Just 20 miles northwest of Lander, Wyo. is Fort Washakie where a clinic stands. The building was built in 1884 with long narrow hallways, brick walls, and plenty of rooms to house the military. Once used by the US Cavalry as a commissary, it was converted into a hospital and morgue in 1919. In 1955 it was transferred from the Bureau of Indian Affairs to Indian Health Services, who renovated it in 1978 and added onto it in 1996. They maintained similar features, staying true to the original structure, increasing their capacity to better suit their needs to serve patients from the reservation.

The Indian Health Service's clinic in Fort Washakie serves over 11,000 people from around the area, including the two tribes from the area: Arapahoe and Shoshoni. Jackie Nelson, MD, is the pediatrician at Fort Washakie. Dr. Nelson sees over 20 patients per day, between her rounds at the Lander hospital and the two clinics in Fort Washakie. She sees several children with a range of medical problems and social challenges. One of her main health concerns for her patients is diabetes. Her youngest patient with diabetes is just 6-years-old with Type 2 Diabetes.

Dr. Nelson works alongside her colleagues in the clinic to provide the best care possible, including a dentist, eye doctor, physical therapist, and a psychologist.

Where did you grow up?

I grew up in small towns in Montana, North Dakota and Wyoming. My Dad worked for the Forest Service, managing grasslands in those areas.

Where did you receive your education?

I graduated from University of Wyoming 1983 with a BA. I attended the University of Utah Medical School and graduated in 1987 - MD

Where did you go after your graduated from Medical School?

I completed a general surgery internship at Maine Medical Center in Portland, ME in 1988 and a pediatric residency at University of Massachusetts Medical Center in Worcester, MA in 1991.

How long have you lived in Fort Washakie?

I live in Lander and work on the Wind River Indian Reservation – Indian Health Service since July 1991.

How did you come to practice on the Indian Reservations for IHS?

I owed the state of Wyoming money for participating in the Wyoming Contract Program. The Indian Health Service seemed to be the best fit for me when completing my residency. I wasn't sure that I would stay there long term, but thought that I could do anything for two years. Now 21 years later it seems to be a really good fit.

How does IHS differ from Medicare/Medicaid and conventional healthcare plans?

The Indian Health Service is the payer of last resort. In other words if a patient qualifies for Medicare/Medicaid or private health insurance they will be billed instead of Indian Health Services.

The services included in this would be anything provided outside of our facility – referrals to specialists, surgery, CT-scans, MRI, chemotherapy, etc.

We have to make sure that we have the funds to pay for these services thus we have a referral process based upon need. There are times when we don't have



enough money for various visits and thus these referrals will be deferred.

It can be frustrating for both patients and providers but is a way of cost containment.

We are a fairly comprehensive facility, providing dental, optometry, medical, behavioral health services and physical therapy. In addition we have community health providers – nutritionists and public health nurses who go out into the community and do classes, and home visits.

What are some of the health challenges facing the people living on the reservation?

As a pediatrician, I think the number one issue is the high level of toxic stress that infants, toddlers and children are exposed to. There is data to indicate that this ultimately leads to changes in their health and well-being leading to issues with diabetes, CAD, substance abuse – including alcohol, and obesity.

Addressing these issues after the fact – when they are adults – is difficult and often not always successful.

What's the best part about practicing on the Indian Reservation?

I love the people I take care of and my coworkers – they are great people both as patients and co-workers.

Another advantage to working here is the opportunity to be a part of the Wind River Child Protection Team – advocating for our children. I am also a WRITE (WWAMI Rural Integrated Training Experience) site coordinator. A third year student comes out to Wind River/Lander for 20 weeks and works with myself, a Pediatrician, and my partners – Family Doctors and Justin Hopkin – Internal



Clock hanging in Dr. Nelson's office
Medicine in town. **WM**

WWAMI: Wyoming's medical school

By Suzanne Allen, Rich Hillman, and Matt McEchron



The WWAMI medical education program has been an innovative leader in medical education for 40 years. As the medical school for the states of Washington, Wyoming, Alaska, Montana and Idaho, the medical school's missions are met through decentralized and often very individualized training. Constant commitment to excellence and the varied and complex needs of the region have made WWAMI a very strong and competitive program.

Wyoming joined WWAMI (becoming the 2nd "W") in 1996 with the first students starting at the University of Wyoming in 1997. Sylvia Moore, PhD was the original 1st Director for Wyoming WWAMI with Matt McEchron, PhD taking over for Dr. Moore in 2008. James Blackman, MD was the first Assistant Clinical Dean with Richard Hillman, MD taking over for Dr. Blackman in 2001. The Wyoming WWAMI program has grown significantly in the 15 years since its inception.

Currently, three of the four years of medical education can be completed in Wyoming. Wyoming students attend their first year of medical school at the University of Wyoming in Laramie, their second year in Seattle and complete their required and elective clerkships in numerous locations across the five state WWAMI region.

In addition to the 4-year medical school, the WWAMI vision provides a framework for a broad range of ancillary training programs. Programs include:

high school science enrichment programs, college pathway programs to medical school, medical school, graduate medical education, continuing education and public service programs.

WWAMI Pathway programs

The Wyoming AHEC is located at the University of Wyoming at Laramie. The Wyoming AHEC has two programs for students interested in a future career in a health care profession. The programs are called "The Great Hospital Adventure" and the other is "Healthcare Careers Summer Camp". The AHEC also helps with rural experiences for health professions students during their education.

Pre-Med Physician Shadowing Program – Cheyenne Regional Hospital and physicians in Cheyenne have helped the Wyoming WWAMI program develop shadowing opportunities for pre-med students. Most medical schools around the country now require students to shadow a physician prior to their application to medical school. This program helps Wyoming students have the shadowing experience they require for their application.

Rural/Underserved Opportunities Program (R/UOP) – This month long experience, located in communities across Wyoming, is designed to expose students between their first and second year of medical school to rural or underserved practice and how that medical practice intersects with the community in which it is located. The communities that have participated in R/UOP in Wyoming include: Afton, Buffalo, Casper, Cheyenne, Cody, Douglas, Evanston, Ft. Washakie, Gillette, Green River, Jackson, Kaycee, Kemmerer, Lander, Laramie, Lovell, Newcastle, Pine Bluffs, Powell, Riverton, Rock Springs, Saratoga, Sheridan, Sundance, Thermopolis, Torrington, Wheatland and Worland. Thanks to all of the physicians

in these communities who help in teaching Wyoming WWAMI medical students.

Update on WWAMI Activities at the University of Wyoming

The WWAMI Medical Education Program is housed in the College of Health Sciences. The Division includes WWAMI, the Wyoming Area Health Education Center (AHEC), and other grant-funded public health programs. The WWAMI Director reports to the Director of the Division of Medical Education and Public Health.

Faculty members from three different colleges at the University of Wyoming teach the WWAMI medical students. Throughout the year faculty participate in various activities with students. Each spring there is a "white-coat" ceremony where the local physician preceptors award their students with short white laboratory coats with the University of Wyoming logo.

With the E12 class, a total of 203 Wyoming applicants have started their medical school education at the University of Wyoming's WWAMI Program. Only two of those students have left medical school. Several students have expanded the time spent in medical school to five years to take advantage of additional training opportunities such as international study or research, or to attend to personal or family issues. The original class size was 10 students a year in 1997. The class size expanded to 12 students in 2005, 14 students in 2006, 16 students in 2008 and to the current class size of 20 students in 2011.

WWAMI students are contract students. They must return to Wyoming to practice medicine for three years after completion of graduate medical education (residency) or they must repay the State of Wyoming the amount of money expended on their behalf, along with interest.

Wyoming WWAMI Clinical Programs

The third year of medical education includes six required clinical rotations. These rotations include internal medicine (12 weeks), family medicine (6 weeks), pediatrics (6 weeks), obstetrics and gynecology (6 weeks), surgery (6 weeks) and psychiatry (6 weeks). One four-week elective rotation may be done during third year. Any of the clinical rotations can be done across the five-state WWAMI region allowing students the ability to design the clinical education that they want. Internal Medicine is offered in Douglas, Jackson and Sheridan; Family Medicine in Buffalo, Cheyenne and Torrington; OB/GYN in Cheyenne, Cody, Lander, and Rock Springs; Pediatrics in Cheyenne and Jackson; Surgery in Casper and Sheridan and Psychiatry in Casper and Cheyenne.

The fourth year of medical education includes four required clinical rotations and four months of elective rotations. The required rotations include emergency medicine (4 weeks), neurology (4 weeks), chronic care (4 weeks) and a surgery subspecialty (4 weeks). Emergency medicine, neurology and surgery subspecialty clinical rotations are offered in Wyoming including clinical electives over a range of different specialties.

The Wyoming Track or Wyoming Rural Clinical Experience was developed as a program that emphasizes rural medicine and also allows students to spend a significant amount of their third year clinical experience in Wyoming.

Students complete at least four of their third year clinical rotations in Wyoming, at least one of the clerkships must take place in a Wyoming site other than Casper or Cheyenne. All UWSOM WWAMI students are encouraged to participate in the program. A maximum of four students per year may participate. Clerkship assignment preference

will be given to students enrolled in the program. Students participating in this program may schedule all of their Wyoming-based 3rd year clinical rotations consecutively in order to complete the program with minimal travel and disruption to their clinical studies. Clerkships outside of Wyoming may be scheduled prior to or after the consecutive Wyoming rotation schedule.

The WRITE program (WWAMI Rural Integrated Training Experience) provides third-year students with five months of extended education in a rural community with primary care physicians and other healthcare professionals. The experience comes after successfully completing the first two years of medical school and third-year prerequisites, including six weeks of obstetrics and gynecology, eight of the required twelve weeks in medicine, six weeks of surgery, three weeks of pediatrics, and three of the required six weeks of psychiatry. From February through June students then move to WRITE sites developed in rural communities throughout the region. Students who successfully complete WRITE receive four weeks of credit for internal medicine, three weeks pediatrics, three weeks psychiatry, six weeks family medicine, and four weeks of credit for a fourth year family medicine elective. During WRITE, students identify a community service project to complete based on a community needs assessment.

At the completion of the WRITE program, students begin the fourth year and complete their remaining clinical requirements for medical school graduation. Wyoming sites are located in Douglas, Lander and Powell.

Wyoming WWAMI Outcomes

As of October 2012, 203 students started medical school through Wyoming WWAMI, 126 students have graduated, 63 students are eligible for practice, and 41 have returned to the State of Wyoming to practice for a 65% return

rate to date.

Future of Wyoming WWAMI

The future of Wyoming WWAMI remains bright. There is a strong group of applicants applying to the Wyoming WWAMI program. The number of physicians who help with educating WWAMI students continues to grow across the state. The University of Washington School of Medicine is in the middle of a curriculum renewal process that will continue to provide high-quality, cost-effective medical education across the WWAMI region. **WM**

If you have any questions about WWAMI or would like to help with educating medical students, please contact Matt McEchron at mmcechro@uwyo.edu; Rich Hillman at rhillman@uw.edu or Suzanne Allen at suzaalle@uw.edu.

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A day in the life of a WWAMI medical student

By Ellen Thompson
University of Washington/WWAMI Class of 2016

There are 20 University of Washington/WWAMI first-year medical students in Laramie, and there are 20 versions of a day in the life of a WWAMI student. For Krista Lukos, of Wilson, that day starts early. She is often the first one in the building. For Aaron Freeman, of Cheyenne, it ends late – and the day before a test, it doesn't end at all. And we are not sure how much sleep Alex Colgan, of Cheyenne, gets, at least not around finals. He seems to be up early and still up late.

But for all the hours we spend apart following our own rhythms, we spend a lot of time together. Most days feel like an endurance race through PowerPoints, all in one classroom that begins to feel like a large, well-lit (poorly heated) cage. But rather than the Gu that Karren Lewis, of Laramie, drinks during her triathlon races, we take our sustenance from a coffee pot, an electric kettle that we broke from overuse and whatever has been left in the refrigerator by kindly neighbors in the Health Sciences building. They know leftovers from a meeting or event, will soon be devoured by the WWAMI students. (If it hadn't been for the work of Sarah Sowerwine, of Hulett, who cleaned the WWAMI kitchen at the end of the semester, our detritus might have posed a public health risk come spring.)

We all know that Ross Orpet, of Laramie, will be the first at the grub, with Andrew Maertens, of Big Horn, right on his heels. Both need the sustenance for their fast metabolisms. Maertens played professional basketball in Germany before joining the WWAMI class. He is just one of the athletes in our class, including Eric Jacobson, of Casper, a former college Nordic skier for the University of New Hampshire, Ryan Griesbach, of Laramie, a cross country and distance track runner for the University of Wyoming, and Sawley Wilde, of Gillette, a soccer player for Jamestown College in North Dakota. Our class has also fielded a

co-ed soccer team, which has featured great saves by goalie Daniel Holst, of Sheridan, who made us contenders in the playoffs. Other class activities have included impromptu hacky sack games that clogged the Health Sciences hallways so much they have been temporarily discontinued. Those games were kicked off by Aaron Freeman, and joined dutifully by Mike Sanderson, Max



This is the WWAMI classroom where we spend up to 8 hours a day. Dr. Rick Dreiling is presenting an anatomy lecture on the upper limb.

Kopitnik, and Dan Grissom, all of Casper, Bryan Dugas, of Cheyenne, and Jory Wasserburger, of Gillette.

And after-hours we choose to spend still more time together. Whether in the

various study groups that have formed – or socializing – WWAMI students stick together. In this WWAMI class, we joked about the presence of the term “WWAMI-ly” to describe the tight-knit, family group that one-year taking 50-some-odd credits together helps form. (We all then move together to Seattle to continue our medical education at the University of Washington, which serves as the regional medical school for Wyoming, Washington, Alaska, Montana and Idaho – WWAMI.) By the end of the first semester, the phrase “WWAMI-ly” now makes sense.

Before classes even began, Tobin Dennis, of Wilson, had already hosted a barbecue, making use of his big yard and horseshoe pit while the weather was still warm. A Halloween pumpkin-carving party, a cocktail party, a Fantasy Football tournament, a ski weekend and an ugly sweater holiday party are just a few of the group activities that followed. And the women of WWAMI (all five of us) have held our own occasional ladies nights.

Each get-together has included good food. That tradition began on day one, when the class came together with an orientation picnic that included a Top-



Ryan Griesbach, of Laramie, (left) and Jory Wasserburger, of Gillette, (right) remind themselves of the muscles of the superficial anterior forearm while preparing for an anatomy final.

Chef challenge. Matthew McEchron, Dean of Medical Education for Wyoming, said he had never seen a class do as well. (Though he may not have expected this statement would be repeated for other classes to read! ... But it's true – of course.) Each of five groups created delicious, varied concoctions with limited budget and time. The feast that resulted included fajitas with shredded chicken, bacon-wrapped steaks and cheese-stuffed burgers. There was homemade corn salsa and fried plantains for dessert. This culinary tradition has carried forward, with Alicia Gray, of Rock Springs, bringing her famous jalapeno poppers to several occasions and with an array of tasty hors d'oeuvres brought by class members to a cocktail party hosted by Krista Lukos.

Several of the get-togethers have also included the two class babies, my (Ellen Thompson, of Laramie) daughter Eliza and Anna, Derek Wille, of Cody's daughter. (Wille and his wife are expecting a second daughter soon. And it will be another class daughter for Eric Jacobson and his wife Sarah. This generation of WWAMI may be mostly male – but for the class entering in 2034 ... That may change.) **WM**



Eric Jacobson, of Casper, (left) navigates a class ski trip to Steamboat, while Daniel Holst, of Sheridan, looks on.



Sarah Sowerwine, of Hulett, brings a little playtime into the classroom. She got into character for a Systems of Human Behavior presentation that fell on Halloween. She saved Gotham City from the evils of the stress response and prolonged cortisol exposure.



The E-12 WWAMI class

The path to health care reform

Continued from August 2012

By Eric Wedell, MD

Germany established the first national system of compulsory sickness insurance in 1883 under the rule of Otto von Bismarck. Similar systems were set up by ten other European countries. The original function of this sickness insurance was to provide support for lost wages. In Europe, the Socialist Party and trade unions were strongly allied. However, in the United States there was no such alliance. This prevented the emergence of working-class support for social insurance.

Between 1870 and 1910 hospitals became places to get well, formal nursing training began, and surgery became more sophisticated. This resulted in an increase in hospital construction as well as operating costs. In the early 20th century there was also a growing emphasis on individual health examinations. Gradually, the cost of sickness evolved from the need for help with lost wages to the need for help in affording the cost of doctor and hospital care.

In 1910 Teddy Roosevelt supported social insurance, including health insurance, in the belief that no country could be strong whose people were sick and poor. His defeat in the 1912 election postponed national government support for social insurance until the 1930s.

Progressive Party proposals and support for universal health insurance failed after World War I for complex reasons. By the 1930s reformers had extended their proposal for universal health insurance to the middle class as well. In Europe health insurance was gradually becoming a system of financing medical care for the entire population. In the 1920s a privately funded Committee on the Costs of Medical Care was formed. Their report, however, opposed compulsory health insurance.

During his first term, from 1932 to 1936, FDR was interested in national

health insurance as well as old age and unemployment insurance. In 1938 a National Health Conference met in Washington, D.C. Representatives from labor, farmers, and the health professions recommended legislative action which resulted in the New Deal laws which adopted compulsory unemployment insurance, old age pensions, and workmen's compensation. Health insurance was the exception, however. Toward the end of his life FDR wanted to press for health insurance as well. He asked Congress to affirm an "economic bill of rights," including a right to adequate medical care. President Truman repeated the request in 1945. It included a proposal for a single health insurance system that would include all classes of society.

Truman's plan for compulsory health insurance was initially supported. However, after Truman's victory in 1948 the AMA campaigned successfully against compulsory health insurance, in part by labeling it as "socialized medicine." Compromise proposals by Representative Richard Nixon and others had considerable support but neither the AMA nor liberals were interested. By 1950 the Truman administration's attention turned to Korea.

The great expansion of employee health plans came about after World War II. The Internal Revenue Code of 1954 stated that employer contributions to health benefit plans were tax exempt. Prepaid group practice plans such as the Group Health Cooperative of Puget Sound and Kaiser Permanente began and grew from 1945 to 1955. After World War II commercial indemnity insurance plans grew rapidly.

By the 1960s health care for senior citizens had become a real concern. Democrats were finally able to pass Medicare and Medicaid which were signed into law on July 30, 1965. Omitted from coverage by Medicaid

were most two parent families, childless couples, widows, other single persons under 65 years of age, families with fathers working at low-paying jobs and medically needy families in the 22 states that did not provide such coverage.

In the 1970s medical care costs were skyrocketing. Realization grew that not only was healthcare in the United States too expensive but the health of Americans was not as good as that of people in most other industrialized nations.

On February 18, 1971, President Nixon announced a "new national health strategy." HMOs were the major innovation proposed. His strategy would still have left 20 to 40 million people uncovered. After the election of 1972, the new secretary of HEW, Caspar Weinberger, decided to propose a much enlarged plan which would have covered the entire population and would have provided more comprehensive benefits than had been offered in 1971. President Nixon approved the plan and proposed it to Congress on February 6, 1974, as "an idea whose time has come in America." Nixon was the first president of either party to send a specific plan for near universal health care coverage to Congress. However, Watergate ended this plan and his political career by the fall of 1974.

As a candidate Jimmy Carter spoke about a comprehensive national health insurance plan, but as President other problems took precedence. Senator Teddy Kennedy and others proposed a plan using private health insurance plans, negotiated rates for hospitals, and usual and customary fees for doctors—all forced to operate within budget constraints. But Kennedy was defeated by Carter, and Carter was defeated by Reagan, and these plans vanished.

During President Reagan's administration conservative thought was that the

Continued on p. 20

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Director, Sleep Lab and Pulmonary Rehabilitation Program

Continued from p. 18

problems of healthcare in America could be cured by relying on competition and incentives. By the second year of his administration, Reagan was backing away from this competitive approach. There was a shift from nonprofit and governmental organizations to for-profit companies in healthcare which answered to their shareholders.

In 1989, Congress passed the Children's Health Insurance Program, or CHIP. Medicaid programs also had to cover the cost of Medicare deductibles, co-payments, and other expenses for the elderly poor. A group of 20 Senate Republicans, during President George H.W. Bush's term, co-sponsored a bill that, among other things, had an individual mandate. The individual mandate, therefore, is an idea first introduced by moderate Republicans in the early 1990s.

During the 1992 presidential campaign Bill Clinton set out an ambitious agenda for healthcare reform. He called for universal health care coverage "privately provided, publicly guaranteed" under a system of "competition within a budget." In a speech to Congress he stated,

"millions of Americans are just a pink slip away from losing their health insurance and one serious illness away from losing all their savings. Millions more are locked into jobs they have now just because they or someone in their family has once been sick and they have what is called a pre-existing condition." He wanted freedom for Americans to live without fear that their own nation's healthcare system would not be there for them when they needed it.

However, the Clinton administration failed to distill the plan down to its essentials and find understandable ways to convey it. Certain deals were never closed, compromises were never reached, and there was backpedaling by some Republicans and moderate Democrats.

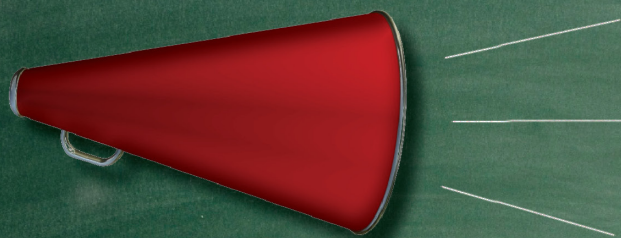
From 2002 to 2006 health care costs and insurance premiums rose far more rapidly than incomes, renewing the sense of urgency about health care reform. The model for health care reform legislation in 2010 originated in bipartisan reform that came from the state of Massachusetts

and its Republican governor, Mitt Romney. Governor Romney insisted on an individual mandate based on "personal responsibility." During the 2008 presidential campaign, candidate Obama learned that the health insurance industry would accept a reform plan that included policies with no pre-existing condition exclusions if the legislation also included a universal mandate.

There was a difference between the House and Senate versions of the Affordable Care Act. The Senate version, which was the one finally passed, had no public option; no Stupak amendment; more power to the states; state-based insurance exchanges; started reform on January 1, 2014; had an independent payment advisory board; and a tax on high-cost insurance plans. The Affordable Care Act was signed into law in the spring of 2010. It had taken 100 years for the people of the United States to finally have something close to universal health insurance coverage.

All of the above, and more, may be found in *Remedy and Reaction* by Paul Starr, Yale University Press, 2011. **WM**

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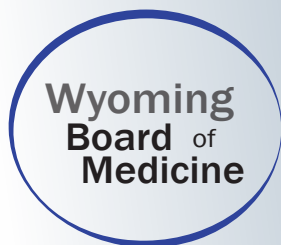
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Medical regulation, Wyoming style

By Kevin Bohnenblust, Executive Director

State medical licensing boards protect the public through two primary functions. First, the licensing process requires physicians to demonstrate a fundamental level of training and skills prior to receiving a license to practice medicine. Second, the investigation and disciplinary process deals with the very small percentage of physicians whose practice presents a danger to their patients and others.

As one would expect from a state-based system of regulation, there is great variety in the approaches and philosophies taken by state medical boards. Highly-populated states with big metropolitan areas, numerous medical schools, and dozens of large hospitals can take hard-line positions when dealing with physician discipline. The real effect of removing 50, or even 100, physicians from practice in a state each year is negligible to the public.

In Wyoming, though, our perpetual shortage of physicians, and the difficulties faced in recruiting and retaining them, means that the removal from practice of even a single physician can devastate the health care delivery system of a small community. Therefore, the Board tries to do what it reasonably can to help rehabilitate and retrain physicians who have engaged in misconduct or have demonstrated gaps in their skills and knowledge.

The Board regularly refers licensees to programs designed to assess physicians' physical or mental health, alcohol or substance abuse problems, or their skills and fund of medical knowledge. These assessments provide an objective basis from which the Board can determine what steps can be taken to return the physician to the safe and skillful practice of medicine in Wyoming.

From there, the Board will often work with a physician in trouble to address his or her needs. For problems related

to medical knowledge and skills, that may include additional training, chart reviews, mentoring and other tools. For behavioral or alcohol and substance issues, that may include monitoring (including random drug and alcohol screenings) by the Wyoming Professional Assistance Program, worksite monitoring, practice conditions or restrictions, or other means of ensuring that patient care is not compromised.

Although the Board works hard to help physicians stay in practice, there are times when sanctions must be imposed. In determining which sanction to apply – ranging from a simple reprimand, to conditions or restrictions on a license, to suspension, to even outright revocation of a license – the Wyoming Board of Medicine again takes a different approach than do some of its counterparts in other states.

Thank God and Greyhound

In the past, courts and medical boards would let offenders walk away from charges if they promised to leave the state and never return. This made life easier for the court or board, but it also had the effect of foisting a problem onto an unsuspecting public in another state.

While some state medical boards still give their licensees the metaphorical "bus ticket out of town" to avoid taking disciplinary action, the Wyoming Board of Medicine has taken a "Golden Rule" approach. Just as the Wyoming Board wants to know about the issues a physician has had in another state (or medical school, residency, the military, or wherever), the Board feels it is only fair and right that a physician with problems in Wyoming not be allowed to leave the state under cover of darkness, undisciplined, and able to repeat the behaviors in another state.

This is especially important in a time when physicians are increasingly mobile. Between multi-state telemedicine

practices and rapidly-evolving physician employment models, the tradition of a physician practicing his entire career in one community, or even one state, is fast disappearing. This further emphasizes the need for the Board to take action and not "kick the can down the road."

Double Secret Probation

Some state medical boards regularly impose "private" disciplinary actions. Often these cases involve sexual boundaries violations or other moral or ethical misconduct. The Wyoming Board of Medicine, on the other hand, nearly eliminated non-public sanctions. This is based on the philosophy that the public is best protected when it is well informed.

Another reason the Board avoids non-public sanctions is that the persons who are harmed by a physician's misconduct are entitled to know if a disciplinary action has been taken. The self-governance model of medical licensure already lends itself to accusations of "doctors covering for each other." Private discipline only bolsters that argument.

Finally, the Wyoming Supreme Court has noted that professional licensing actions are "quasi-criminal" in nature. The public would be justifiably troubled by criminal courts handing out secret fines and prison sentences. When a medical board holds a physician accountable for misconduct, it does so on behalf of the public, and the public has a right to know about the sanctions imposed. If the misconduct is serious enough to merit disciplinary action, it should not be hidden in back rooms.

Get Out Your Checkbook

Many state medical boards have authority to levy civil fines, and some have the ability to impose administrative citations – also called "cite and fine," a process akin to a traffic citation – for minor violations. These include late license renewals, failure to report

malpractice settlements and judgments, and other violations not related to patient care. The licensee has the option of paying the fine and moving on, or contesting the citation in a formal proceeding before the board.

The Wyoming Medical Practice Act does not provide for administrative fines. It does permit the Board to levy civil fines of up to \$25,000 for violations of the Act, although in recent years that sanction has been used only a handful of times, and always for less than the maximum possible fine. This is in sharp contrast to other states' boards that regularly impose fines of several thousand dollars for seemingly minor infractions, and fines of \$50,000 or more in serious cases.

The Wyoming Medical Practice Act also permits the recovery of the Board's

"costs" in disciplinary cases. This can include the professional fees paid to the Board's prosecuting attorney, the hearing officer, court reporters, expert witnesses and consultants, and others. Because the Board's operations are funded almost completely by license application and renewal fees, the Board feels it can be appropriate to recover the costs of prosecuting physician misconduct. The idea is that the overwhelming majority of physicians in the state who practice medicine well and carefully should not have to pay 100% of the cost of investigating and prosecuting the small minority of physicians who do not.

Looking Forward

The Board believes this approach to the regulation of the practice of medicine in Wyoming reflects the needs and

concerns of not only members of the public, but also the physicians who care for them. And, just as medicine in Wyoming will continue to evolve and progress, the Wyoming Board of Medicine will work to keep pace with the expectations of the public and Wyoming physicians.



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THE AFFORDABLE CARE ACT (ACA) AND OPTIONAL MEDICAID EXPANSION

WHAT COULD IT MEAN FOR WYOMING?

WHAT IS THE ACA?

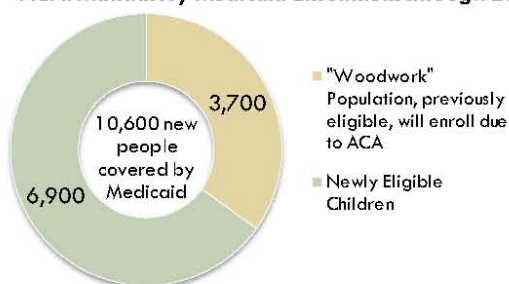
The Affordable Care Act was passed in 2010, and attempts to reduce the number of uninsured individuals through four primary components. These are: the individual mandate, health benefits exchange, employer penalties and subsidies, and the optional expansion of Medicaid. This fact sheet focuses only on the optional expansion of Medicaid.

IS THE ACA NOW LAW?

Yes. On June 28, 2012, the U.S. Supreme Court issued its ruling, which upheld the individual mandate as a constitutional exercise of Congress's authority to tax. The Court struck down the penalties that could be imposed upon states that did not expand their Medicaid programs to adults. This decision is interpreted as making the ACA Medicaid expansion optional for states, although coverage for groups already eligible for Medicaid will still be mandatory.

WHAT IS THE IMPACT OF THE ACA ON WYOMING MEDICAID?

ACA: Mandatory Medicaid Enrollment through 2016

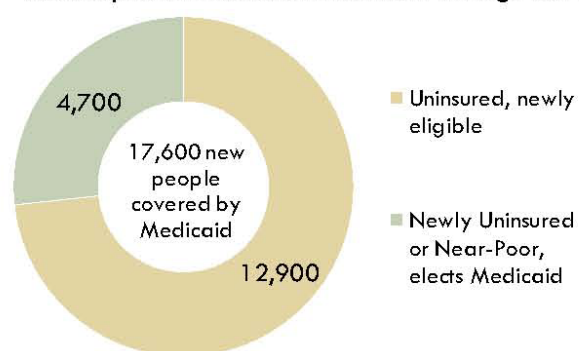


While some details are still unknown, the ACA will impact Wyoming whether it decides to opt-in to the Medicaid expansion, or not. Starting in 2014, all people will be required to have health insurance, so public insurance plans such as Medicaid will see an increase in the number of adult and child enrollees as people who have always been eligible come out of the 'woodwork.' The best estimate for Wyoming at this time is that 10,600 people will enroll due to the ACA.

WHAT IS THE OPTIONAL EXPANSION OF MEDICAID?

The Optional Expansion is related to low-income adults not currently eligible for Medicaid who earn less than 133% of the Federal Poverty Level. These adults could become eligible in 2014 if Wyoming decides to participate in the Expansion. Best estimates¹ for Wyoming at this time indicate that 17,600 additional people would enroll in Medicaid if it were expanded. Services for this Expansion group would be reimbursed via federal match at 100% from 2014-16, and then step down to 90% by the year 2020, reducing the burden on Wyoming's state funds.

ACA: Optional Medicaid Enrollment through 2016



ARE THERE BENEFITS TO EXPANDING MEDICAID?

Yes. The two primary benefits include a decrease in the number of uninsured Wyoming residents (approximately 83,000 people), and a decrease in the approximately \$200 million dollars of uncompensated care that hospitals experience each year as they serve the uninsured. Other benefits include a positive impact on Wyoming's economy via increased federal funding, and the potential for increased local healthcare employment opportunities.





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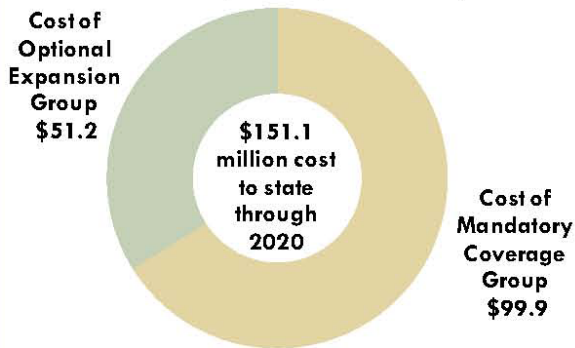
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THE AFFORDABLE CARE ACT (ACA) AND OPTIONAL MEDICAID EXPANSION

WHAT COULD IT MEAN FOR WYOMING?

ARE THERE COSTS TO EXPANDING MEDICAID?

Both the mandatory and optional components of the ACA will mean increased costs for Wyoming and the federal government between 2014 and 2020, and beyond. A recent study¹ estimated these costs through the year 2020 separately for both parts, finding that the mandatory group would cost the state approximately \$99.9 million and the optional group would cost approximately \$51.2 million through 2020.



ARE THERE WAYS TO MINIMIZE THE COSTS?

Yes. If Wyoming chose to participate in the

expansion of Medicaid, state costs would decrease. The WDH conducted an internal analysis, and found that more than 100% of the costs of both the mandatory group and the expansion group could be paid for through by the elimination or reduction of existing programs because the services provided would now be provided to Wyoming residents by Medicaid or other health insurance plans (offsets). Most of these programs are currently paid for entirely by state funds.

For example, state funds currently pay for a wide variety of mental health related services for Wyoming residents. Under the ACA, health insurance plans (including Medicaid) will cover many of these services, which means the state-funded mental health program could be reduced with little impact on clients.

Ultimately, the estimated offsets could result in a cost savings of approximately \$47.4 million for the state of Wyoming through 2020.

NO Expansion: Costs and Offsets (Mandatory ACA Groups Only)

	2014	2015	2016	2017	2018	2019	2020	Total
Federal Share	\$7.4	\$16.0	\$18.3	\$20.2	\$21.1	\$21.9	\$21.8	\$126.7
State Share	\$6.8	\$14.1	\$14.4	\$14.7	\$15.4	\$16.5	\$18.3	\$99.9
State Offsets	(\$0.5)	(\$1.0)	(\$4.0)	(\$4.1)	(\$4.3)	(\$4.5)	(\$2.1)	(\$20.5)
State Net	-\$6.3	-\$13.1	-\$10.4	-\$10.6	-\$11.1	-\$12.0	-\$16.2	-\$79.4

YES Expansion: Costs and Offsets (Mandatory + Optional ACA Groups)

	2014	2015	2016	2017	2018	2019	2020	Total
Federal Share	\$57.5	\$119.6	\$129.1	\$134.3	\$137.0	\$142.0	\$144.9	\$864.4
State Share	\$8.1	\$16.9	\$17.6	\$21.0	\$25.7	\$28.4	\$33.6	\$151.1
State Offsets	(\$8.7)	(\$23.2)	(\$31.2)	(\$32.5)	(\$33.8)	(\$35.1)	(\$34.0)	(\$198.5)
State Net	+\$0.6	+\$6.3	+\$13.6	+\$11.5	+\$8.1	+\$6.7	+\$0.4	+\$47.4



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¹See the Milliman, Inc. Medicaid Cost Study (2012), available at: <http://www.health.wyo.gov/default.aspx>. The administrative costs for each year that were left out of the tables in this study have been added in by the Wyoming Department of Health (WDH) for the purposes of this fact sheet.

What are other states doing?

A review of Medicaid Expansion across the US

The Advisory Board Company published a map after the 2012 election, monitoring other states and their decision on whether to participate or not. As of January 16, 2013, 18 states and the District of Columbia are participating in Medicaid Expansion, five are leaning towards expansion, 11 are undecided/no comment, 10 are not participating in expansion and five states are leaning towards not participating in expansion.

Among the states participating, Arizona, typically known to be conservative, Governor Jan Brewer(R) made the announcement on January 14 and said that they plan to expand, which would extend health care services to an estimated 300,000 more state residents. Colorado's Governor, John Hickenlooper (D) announced on January 3 that they would be participating. This would give coverage to about 160,000 of Colorado's low-income residents and save Colorado

an estimated \$280 million over 10 years.

Oklahoma is a state choosing not to participate in Medicaid expansion. Governor Mary Fallin (R), said on November 19th that the program would cost the state as much as \$475 million over the next eight years. Governor Paul LePage (R), of Maine called the expansion and the state-based insurance exchanges a "degradation of our nation's premier health care system." Other states, including Alabama and Georgia have said that they simply can't afford it.

Regardless of where each state stands on the issue, as a nation, the ACA, also known as "Obama Care" has given the states a difficult decision to make, which will be guaranteed to change the way our health care system looks in the United States. For more on this issue and to read the entire article, which includes each state, visit www.advisory.com.

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