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## A Roundtable Discussion

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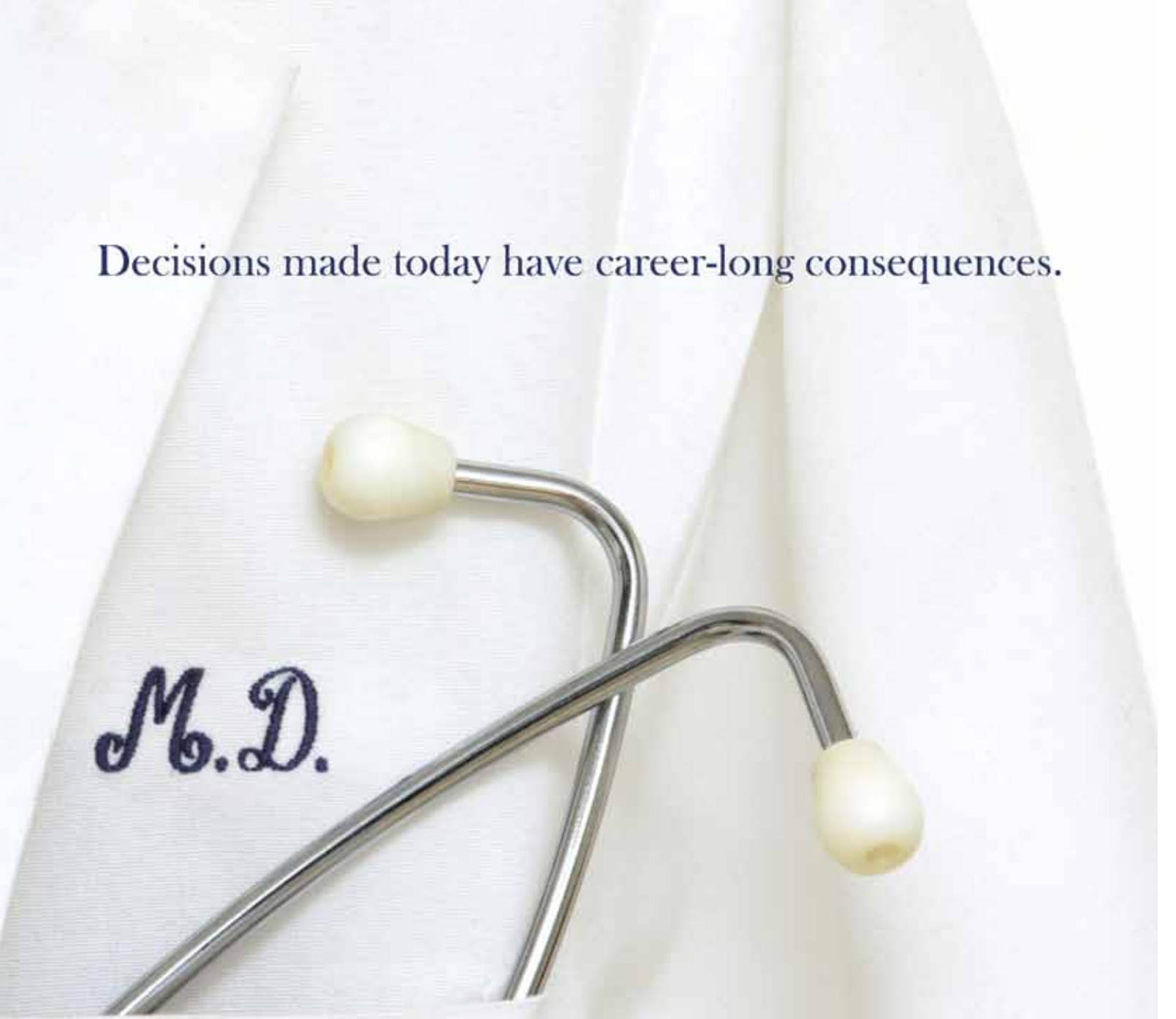


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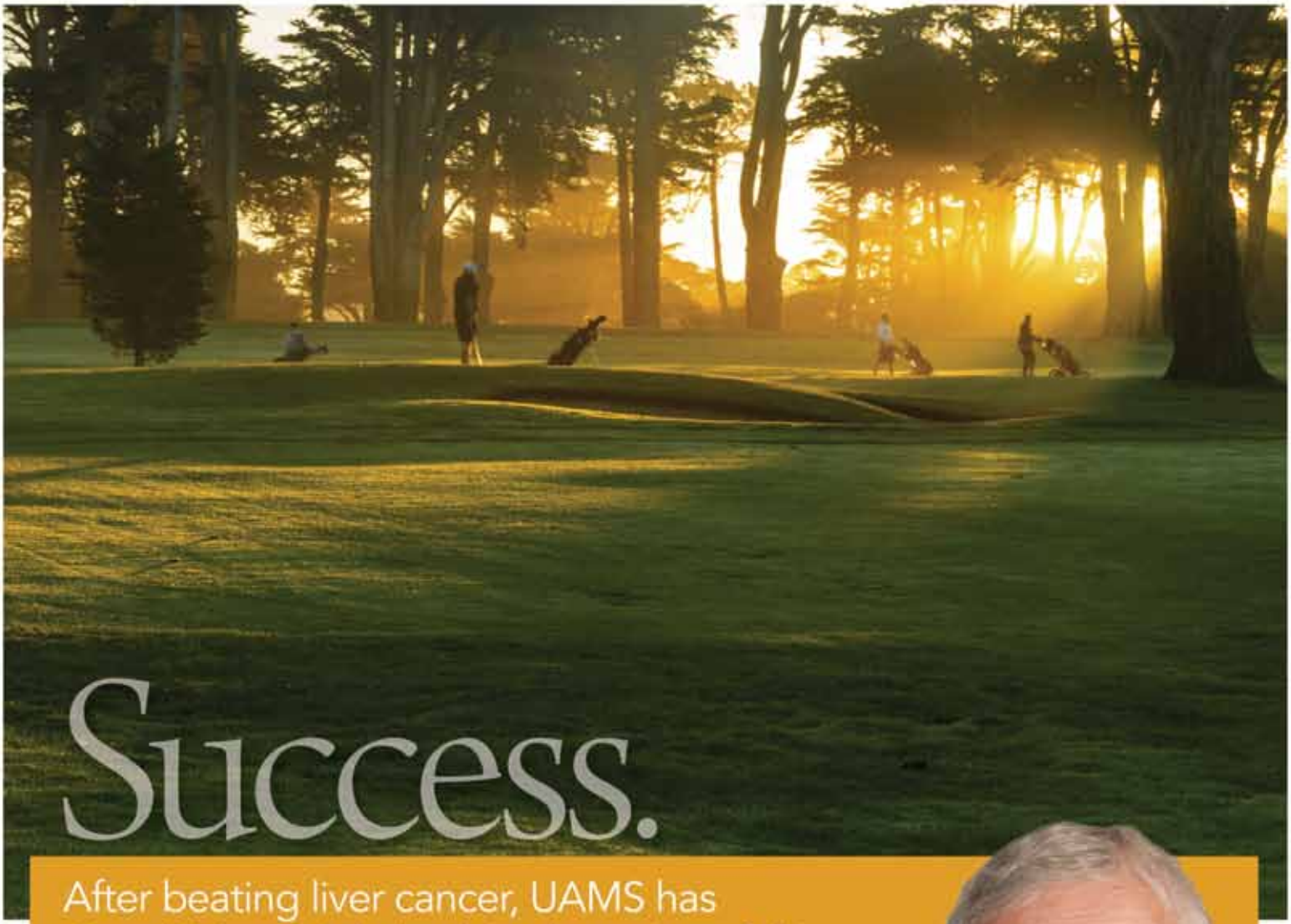

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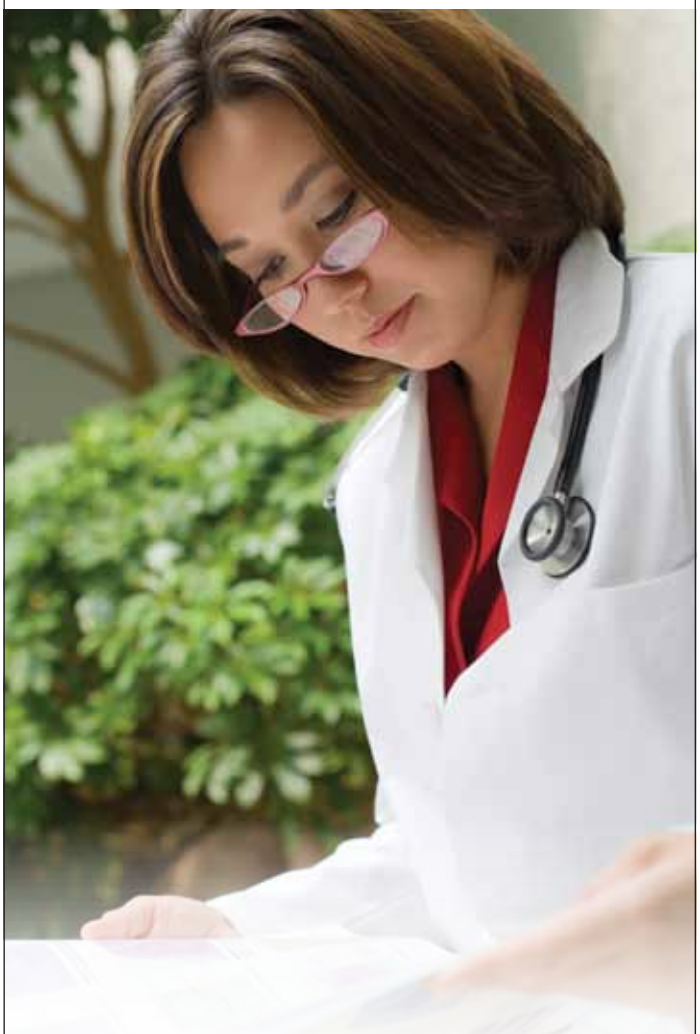

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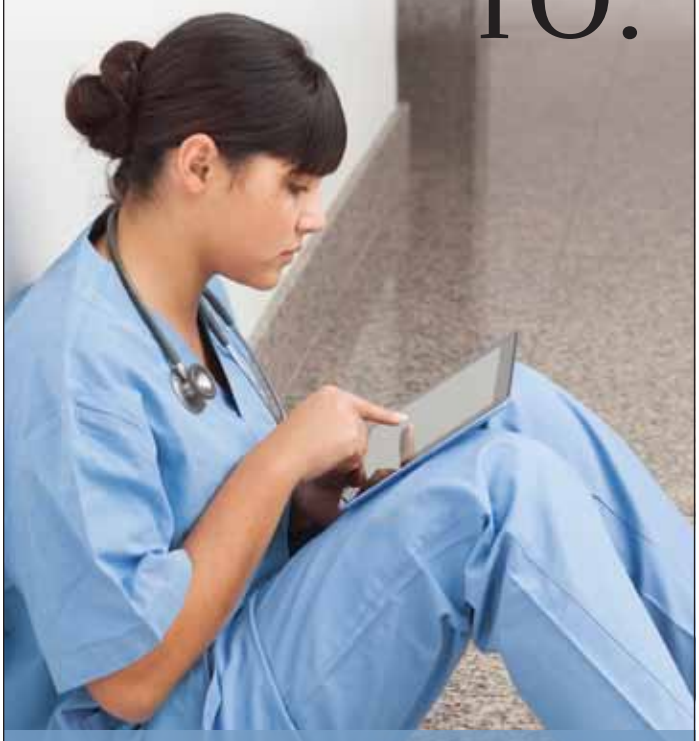

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# Breathe Better for Better Health

There are many wonderful suggestions for entirely improving one's health that are rarely discussed, mostly because there isn't an economy to benefit from them.

For example, take the importance of the breath. Focusing on proper breathing provides many health benefits, but how often is it discussed or practiced? Just from a mental perspective, good breathing techniques help to calm the mind, reduce mental chatter, reduce fearful thoughts, and bring better mental awareness. The physical benefits are almost too many to mention.

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We are always looking for better solutions, but some of the best and most basic notions are often simple and overlooked.

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# THE STATE OF nursing IN ARKANSAS

# A Roundtable Discussion

From left, Lorraine Frazier, Jacquelyn Wilkerson, Carolynn Whitley, Chris Dent, Peggy Henderson and Rhonda Finnie.

This summer, *Healthcare Journal of Little Rock* hosted a Nursing Roundtable at the offices of Wright, Lindsey & Jennings in Little Rock. Nursing professionals from area facilities were invited to join a discussion about issues and challenges affecting nursing today. Participating in the roundtable were Chris Dent, VP Clinical Services, AR Heart Hospital; Rhonda Finnie, President, Arkansas Nurses Association; Lorraine Frazier, Dean, UAMS College of Nursing; Peggy Henderson, Director of Nursing, Methodist Family Health's Methodist Behavioral Hospital; Carolynn Whitley, Chemotherapy Supervisor, CARTI; and Jacquelyn Wilkerson, CNO, Conway Regional. The discussion was moderated by Chief Editor Smith W. Hartley.

**What are some of the characteristics of an effective nurse manager either on the floor or in administration?**

**Jacquelyn Wilkerson** I think the biggest characteristic is communication skills. When I am looking at hiring someone in a leadership role, the biggest thing I look for is, I can teach clinical skills, but just that natural way to communicate and be able to tailor that to different personalities and how you approach people. To me, I think that's the key to success. We can work on some of the other things, but when I find we have an issue or when I find we are going down the wrong hole it seems to all boil back to miscommunication.

**Lorraine Frazier** When you think about nursing administration today, things are changing so much in our nursing administration master's and doctorate. We teach organizational behavior. We teach informatics. We teach financial basics. We teach looking at data. We teach communication skills because all of those skills are much more important than they ever were before. I think "nurse manager" can mean anything from a CNO like Jacquelyn is all the way to a nurse manager on a unit, so more and more for nurse managers on units they are expecting a master's and for Jacquelyn's level they are expecting a doctorate. So it's a lot more sophisticated than it was.

**Jacquelyn Wilkerson** I actually have an MBA in business healthcare administration so I have two degrees, one in nursing and one in business, and the reason is because of the financial business background you need when you get into a leadership role in nursing.

**Carolynn Whitley** I think nurses have to have people skills where they have the ability to empower those that are around them and inspire them to want to better themselves to get their buy-in. I think that's important in a leader.

**Lorraine Frazier** They create the culture of the organization for people to thrive. They create a culture of civility, a culture of communication. I think if you do that in a leadership role it goes all the way down to the patients and how the staff treats each other.

**Rhonda Finnie** I think it really creates a lot of respect if you have a nurse manager that understands what it is to be in the trenches, who understands and can communicate that. The most successful nurse managers I have seen are people who can do that, who can be the leader when they need to be the leader, but also allow other people, as you said, to thrive and really step up when it's time for them to step up. So I think respect is a huge part of being a successful leader.

**Chris Dent** And credibility. I think people have to be able to build their own credibility with their staff and with their peers and with their superiors.

**Peggy Henderson** And then I think that depending on what role of nurse manager that you are playing, sometimes you can roll your sleeves up and just get in there and help. I think you get a lot of respect from that also, being flexible, communication, as you say, and the listening skills because you work with different age groups. I know in the role that I play I work with a lot of immature employees that are just getting into the work field and so a lot of training, a lot of teaching, and a lot of patience. It just depends on what role and where you are, the facility, the size, things like that.

**Carolynn Whitley** I think too, that a manager has to be an agent of change like you mentioned a while ago. Healthcare is undergoing tremendous change and those changes start with the managers. It's easy to explain and implement a change, the challenge is maintaining the culture change.

**Lorraine Frazier** You know when you think about it, and it came up today, we look at evidence-based practice and we expect our nurses to use it on the floor. Our accreditation expects us to look at it with what we teach students. We teach faculty evidence-based and it really begins with leadership. We make decisions based on data more today than ever before, so we need to be able to gather that data and synthesize it and really make decisions that are effective.

**Some of the difficulty is in getting physicians and nurses to sit down at the table together to collaborate about the patient care and the evidence-base, even in nursing, to help not compete, but just collaborate along with them for that.**

**How is the increased implementation of evidence-based practice changing the nursing profession?**

**Rhonda Finnie** I think it is huge. I think the challenge is taking what is in the literature and translating those things to the bedside. We write a lot of stuff, but we have to be able to translate that into practice and I think nurses are more savvy, particularly the younger nurses, because they know how to manage the data, they know how to evaluate it, and you see them with their smart phones–they are not talking on the phone, they are looking up drugs, they are looking up, "What do I do with this situation?" And so they are really utilizing the technology to bring evidence-based more to the bedside than ever before. When I was in nursing school we had a notepad and I had to go to the library to look things up and to find where the evidence was. It was much more difficult.

**Lorraine Frazier** And there wasn't as much evidence.

**Jacquelyn Wilkerson** I think that what you are seeing now in the profession of nursing is a change. I hope we stay into the challenge. Right now what we are going to see, and I think it's great, is evidence-based nursing in collaboration, truly as a leader in a profession, along with the physicians, for increased quality outcomes. What I have seen in a rural healthcare setting is that change is getting hard because you have older physicians that aren't used to that. Some of the difficulty is in getting physicians and nurses to sit down at the table together to collaborate about the patient care and the evidence-base, even in nursing, to help not compete, but just collaborate along with them for that. Right now that culture is changing–I am seeing that in the community rural healthcare setting and we're seeing some physicians that are at retiring age and that's very different for them.

**Carolynn Whitley** I agree. I think they are learning to trust our education whereas in the past, when we were young nurses, they didn't...they didn't trust our education at all.

**Lorraine Frazier** When we teach evidence-based practice, we teach those nurses, "Look at the evidence, clinically sound evidence, look at the assessment that you make, and look at the patient preference. Put those three together and come up with a decision that's good for the patient." And, we hold them accountable for the outcomes more than we ever did before. So it's a lot different and Jacquelyn, you were right, when you spoke about older practitioners. It used to be you could actually tell when a physician graduated from medical school by how they practiced. Today we can't do that anymore because we have patients who look on the web and they know what's going on. So you really can't operate any more like that. Which is a good thing.

**Is there a need for more interdisciplinary education and communication?**

**All** Absolutely!

**Rhonda Finnie** And I think it needs to be broader. We typically think about Allied Health Professions as therapy, pharmacy, dietician, that kind of thing; we don't think about engineers. I had the opportunity to see an article in the *Arkansas Engineer* and the cover story was "Engineering Healthcare."

So I emailed the engineer. He is doing wireless monitoring. They are putting them in the helmets of the football players at the University of Arkansas to monitor wirelessly impact of head trauma and so forth. So I think that even more broadly than just allied health we need to look at business, we need to look at the engineers who do the industrial engineering for our structures, our sites, how they are set up. I think that article certainly broadened my perspective on how I view interdisciplinary. It's much broader than I ever thought it could be.

**Lorraine Frazier** But you know in accreditation today medical schools have to have interprofessional education to get accredited. That's a big deal. So that's saying not only is it nice, it's necessary. We have interprofessional education at UAMS. The provost heads it. That tells you how important it is.

**Jacquelyn Wilkerson** To get Magnet status you have to demonstrate physician and nursing collaboration. It's important. To be recognized and accredited you have to show the physician/nursing collaboration.

**Lorraine Frazier** To get funded today you have to have interprofessional aspects of a grant. I mean, it's important and there's no choice about getting on that bandwagon if you want to be successful. They know that because the patients are getting better care. What's really driving it is patient care.

**Would you say that the people coming out of nursing schools now are adequately trained and prepared for the workplace?**

**Lorraine Frazier** Can I address that being a dean? We give them technical skills, but we teach them how to critically think, we teach them how to use evidence-based practice. Five years from now what we teach them may be outdated or obsolete. We have to have them be lifelong learners. We have to show them how to do that and that's the critical piece. We'll send them into hospitals, community centers or health systems who will mold them to their needs, but we make sure when they leave, that they are able to critically think, that they have a basic knowledge of the pathology, and the ability to take facts and create knowledge. And any worker in the future of healthcare will be able to take data, put them together, and make knowledge to help them make decisions. And that's what we produce as a generalized nurse. Now in the nurse practitioner program it's much more clinically oriented and so they have to be a real fine clinician and that's very different, so we work hard to make those clinicians. We hope we do a good job.

**Lorraine Frazier**
Dean, UAMS College of Nursing

**I think one thing, too, that nurses do well, is we communicate so well with the families and patients. And patients feel safe with nurses. They don't feel intimidated so they tell us things and we really know things that may be important for their care that they are not going to tell you in a five minute session. That angle and that connection I think is critical in healthcare. We're always going to have that. Even 20 years from now.**

**Rhonda Finnie** I think the other aspect of that lifelong learning is certification. We have so many nurses who are in specialty areas. If we look at perioperative practice as an example, much of that education is out of nursing curriculum because they have to create other strands in the curriculum. So certification is a way to demonstrate competency, it's validated, and that is a way to keep up with current evidence-based.

Mine was good for five years, but I had to have so many hours and continuing education to recertify. When you look at Magnet hospitals, certification is a big part of that process. So I think in terms of lifelong learning, certification is a way to demonstrate competence in specialty on top of the foundation you get in the nursing curriculum.

**Carolynn Whitley** I absolutely agree and in my field, oncology, I have nurses that are brand new nurses. I love baby nurses. I would have a brand new nurse, fresh out of school, any time. But I set goals for them every year and one of the goals that we set this year is that every single nurse will be ONS certified, oncology nursing certified, every single nurse that administers chemotherapy, because of the future that we have. Even with chemotherapy now, we're seeing 700 patients a day. But in the future, oral chemotherapy is becoming more and more the trend and we have to be prepared for that. My nurses can't just know chemotherapy, they have to know oncology. So coming fresh out of school, they can't be specialized. They can't teach them everything in school. They can only teach them where they need to look. "Here's your basics, go find your passion."

**Lorraine Frazier** Hopefully we give them a passion for learning.

**Carolynn Whitley** Well that's what education is and my brand new nurses are ready.

**Chris Dent** It is the more experienced ones that are slower to catch on, the toughest to change.

**Peggy Henderson** I agree with you on the baby nurses. I love baby nurses also, but I think my reason maybe a little different as an older nurse. They teach me a lot, too, so they keep me on my toes. Because of the changes in technology and trends and things like that, they bring it to me. And when I learn something different that means I am going to go and research because I need to know, being a nurse manager. I love them a lot.

**Jacquelyn Wilkerson** We started a nursing residency program. When you think about nursing school, they get another year at Conway. I interview them. I want to meet every new grad that we hire. First, it energizes me, but then I want to know that I am hiring the best of the best. If I am going to invest a year of training in these people then I want to meet them and I want to know that they've got that commitment. So we go through the Nursing Practice Act again. They have a mentor that's been through the other programs so they feel that they can talk to each other about the scariness of getting on the floor, things like that.

**Rhonda Finnie** I think that shows a lot of leadership on your part because many new graduates are afraid of the CNO. It's a little intimidating so I think that's wonderful that you do that.

**Carolynn Whitley** I have a past life as a CNO. But that used to be my favorite thing...when we would have new nurses. They would come have lunch with me. I would go have lunch with them. I would say, "Surely you are not going to stop here. Where are you going honey?" and it would go on from there. And it does put that barrier down.

**Rhonda Finnie**
President, ARNA

**But, it wasn't so long ago I worked nights in the intensive care unit and when we transitioned from paper to electronic records it was a bit of a transition because you really felt like you spent your time at the keyboard. You were not with the patient. I think that we are becoming more sophisticated in terms of what we need out of the data, and we need the standardized data because it tells us about nursing interventions and the outcomes and those things are measured nationally with other databases. The technology in the beginning can seem a little bit stifling and a little bit more of a burden, but as you get used to that it's valuable.**

**Medical technology is constantly changing. In the nursing profession is it more of a burden or a benefit for providing good nursing care?**

**Chris Dent** Technology is wonderful. It's a nurse's friend.

**Rhonda Finnie** But, it wasn't so long ago I worked nights in the intensive care unit and when we transitioned from paper to electronic records it was a bit of a transition because you really felt like you spent your time at the keyboard. You were not with the patient. I think that we are becoming more sophisticated in terms of what we need out of the data, and we need the standardized data because it tells us about nursing interventions and the outcomes and those things are measured nationally with other databases. The technology in the beginning can seem a little bit stifling and a little bit more of a burden, but as you get used to that it's valuable.

**Jacquelyn Wilkerson** Everybody is going through this EMR change. I don't think anybody's been very long into it and you see these other industries that have it and it's so much more advanced than in healthcare, it's like someone who was nonclinical built it. You feel like, "It's so easy. I know you can make it do this." You kind of have to push and you eventually get there. It's really useful, but it's limited.

**Lorraine Frazier** I mean, can you imagine Google or Amazon if every time you went to buy something they had to reassure it was you? Go through all of this. And that's what we used to do with the patients. Yes, I know, but let's take your history again. They would never sell a thing would they?

**Rhonda Finnie** You know really and truly I envision a day when we won't have to worry about keyboards. The nurses can just speak their assessment at the bedside.

**Lorraine Frazier** I'm thinking they can just think it.

**Rhonda Finnie** Maybe you can get with the engineers at U of A in Fayetteville and we can work on these brainwaves. But I really think you could just speak it, "Open chart," and you are assessing. You are with the patient more than at the keyboard. I really think that day will come.

**Lorraine Frazier** I think the other thing it does is it brings patients to be partners with their healthcare. If you look at MyChart and you see your own medical record, your own tests, you see everything in a patient portal, and it really has changed how I look at my own healthcare. I think, "Huh, that's all my stuff. I'm impacting that." I think it will be great for patients taking some accountability for their health.

**Do you feel the nursing profession has had enough of a voice in healthcare reform?**

**All** No.

**Chris Dent** Some of that's our fault.

**Lorraine Frazier** We are not on the boards. We could be on more hospital boards. Robert Wood Johnson and the IOM, Institute of Medicine, has a real push for that. Arkansas is a great state and Rhonda you are a great leader here. We are trying to get women nurses on more boards.

**Jacquelyn Wilkerson** That would be great.

**Lorraine Frazier** That's one of the pushes you guys need to be in, the IOM Action Committee, because there is a big push to do that. It will change because they are going to find out how valuable nurses are for healthcare, for quality, for safety, for finance. We've been doing it for years. So I think that will change, but we are going to push it. We are going to make an effort to be involved.

**Jacquelyn Wilkerson** We need more voice.

**Carolynn Whitley** I think we have more voice than we have had in the past, but we are not a strong voice by any means. I think we need to visit the legislature more. When there's a bill that comes up that's concerning to us we need to be there and we are not.

**Rhonda Finnie** And I think that is a challenge. You know as I look back historically, one of the goals for baccalaureate education for nurses was to create citizens. That was one of the goals at UAMS and the college of nursing, not only to create a community nurse, but to create a citizen.

**Lorraine Frazier** Well the Florence Nightingale Pledge talks about what you do out in the community.

**Rhonda Finnie** And I think that is an aspect—that we are not just nurses, but we are citizens in a country where we have the freedom as women and as healthcare providers, to be able to impact decisions.

**Lorraine Frazier** Never before in the history of healthcare, since I have been involved with it, has there been a call for some to be leadership at the table. Before we were kind of blocked under law, but now with the healthcare reform this is the time when everybody wants to be at the table. So I don't think we fall short too much because there hasn't been that much change like there is today.

**Jacquelyn Wilkerson** Maybe in the educational world, but in the acute care setting, I know I am getting more familiar with Baptist Boards, St. Vincent Boards, I am not so familiar with Arkansas Heart Board, but we do have a Dean of Nursing on our board. So that's great. But that was a big milestone. A lot of it is still male, financial, business background and non-clinical.

**Is recruitment and retention an issue in nursing?**

**Chris Dent** We all compete for the quality nurses. All of us around this table. It's definitely an issue and it always will be because we don't want the lower tier, we all want the upper tier.

**Jacquelyn Wilkerson**
CNO, Conway Regional

**The national statistic has shown a tremendous growth in turnover across the nation. So we are not the only ones seeing that increase. I did a study for a board presentation and there was a tremendous spike in the turnover across the nation. I think it's because we are constantly having to change to keep up with the change and the healthcare reform and the older, experienced nurses are like, "We just started this and now we are changing it to something else?" I think they are getting confused, and frustrated maybe, at the constant change. But it's not going to get any easier. You've got to be willing to change.**

**Jacquelyn Wilkerson** You know I read the Nursing Roundtable in *Healthcare Journal of New Orleans* and I thought it was sad that one person said they no longer hire new grads.

**Lorraine Frazier** That's shortsighted.

**Jacquelyn Wilkerson** And here I am doing the opposite. You do have to have the seasoned, but you've got to have a melting pot. You've got to grow your own, too. We do have to have a balance, but I do want to say that new grads are the future of nursing. And it's our responsibility to grow that. In education as well as after the fact, but then you have to balance that with season and that is hard to do. They seem to flip on a dime now, don't they?

**Rhonda Finnie** What about keeping them at the bedside? Because I had a conversation with one of the administrators where I work and she said it's very difficult to keep your experience at the bedside any more. They move forward and they move on and so I think that's an issue as well. It's not just the new graduate, it's that you're constantly in the turnover, constantly turning over experience and expertise.

**Peggy Henderson** I really don't have a problem with recruitment. It is the retention that I have the problem with. At the facility where I work we open the door for a lot of nursing students. I have about four schools that come through there for clinical, RNs, LPNs, and I find that's a good thing for me as far as recruitment. Once I recruit them it takes everything I have to retain them. I always say that, "I am recruiting, I am training, I am getting you seasoned, and then you leave me." So I think the retention is my biggest problem.

**Carolynn Whitley** Do you think that's because you are a specialty hospital and they come and realize that's not their thing? When they leave school we encourage them to go find their passion so they are searching and we are turning over and turning over until they find themselves?

**Peggy Henderson** That's probably true. And I do encourage them. Especially coming to a behavioral hospital because I believe in medical. So one of the things that I encourage all new grads...if they decide to come into something like mental health, I work with kids, I encourage them and I talk to them about working at the medical and trauma hospitals because I know if you don't use it you lose it. And if you are coming out of school and right away you go into mental health you are not getting that medical background that you may want later on. Once you work in mental health a certain length of time, it's hard to get back into the medical aspects of nursing.

**Peggy Henderson**
Director of Nursing
Methodist Family Health's Methodist Behavioral Hospital

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**Carolynn Whitley** Do you think, too, that it could be that some of our nurses are seeing all the cultural changes going through healthcare right now and they feel insecure? Used to be, when you and I went to school, going to nursing school was the safest thing we could do. We would always have a job. That's not true anymore. I think that some nurses feel that healthcare is unstable right now, it's insecure, so they seek other things.

**Lorraine Frazier** You know in the world of academics it is very hard to recruit. I recruit across the nation because we want researchers and we want mid-level faculty and every college of nursing across the nation is trying to recruit. Today we were looking at someone from Pennsylvania. We need to really bring them in, it's a tier process to recruit someone. We have to recruit their families, look for jobs for their husbands. It is really difficult to recruit faculty, and they don't

know anything about Little Rock. But when they come they really like it. It's charming, it's a big, small town, it's got the most wonderful people, but getting them here is a challenge. We've recruited two people from out of state in the past six months, but we continue to work on that, because in academics we want different colleges represented, we don't just want to grow our own, so we try to populate from all over. It's like a big family across the whole nation. We know a lot of people who are in different colleges so I think that's a real effort. But it was an effort in Houston, too. Who wants to go to a big city? So, it's a challenge.

**Are there challenges right now as far as scope of practice for nurses in Arkansas?**

**Rhonda Finnie** Yes. Yes, there are.

**Chris Dent** Maybe more so in advanced practice.

**Rhonda Finnie** Yes, more so in advanced practice, but I look at even at the Registered Nurse level, at transitional care models. For nurses, particularly baccalaureate educated nurses, one of their competencies is coordination of care and those kinds of things and now we know CMS has a reimbursement code for those transitional care models. I think that even at the RN level, to be able to expect that nurses can do that. I am seeing nurses actually be able to really communicate intelligently to providers about a patient's condition or what they may need at home. So I have seen that transition.

In advanced practice we need prescriptive authority that we're educated and certainly licensed to provide. We could be primary care providers. We went to the legislature last year and said, "Can we be primary care providers for Medicaid patients?" and it didn't come out of committee. So there are things that we need and I think part of that is full practice—every nurse practices to the fullest scope of practice to how they are educated, licensed, credentialed, and so forth. If we would do that, we would see a big improvement in the quality of care and in the number of people that we can take care of.

**Carolynn Whitley**
Chemotherapy Supervisor, CARTI

**I think that nurses are going to become more important. There are going to be more nurse navigators to help patients navigate through the healthcare system because it is becoming so complicated. And also, we are so specialized that her patient has had an MI, but he also has colon cancer and a pain in his leg. Well he calls his oncologist, who says, "I don't know." Then he calls his heart doctor, who says, "I don't know." There's got to be someone who can stand in that gap for that patient to navigate where they are going.**

**Lorraine Frazier** A good way to look at that is if you have an advanced nurse practitioner and she wants to open her own practice in a rural community she has the same overhead that any clinician would have, yet she gets reimbursed 25% less for doing the same interventions. She still has the same overhead and for that collaborative practice that's required, she has to pay for that. That physician is going to charge her some piece off the top, so how can she exist financially? What hurts is the patients, because there may not be any provider in that area and she or he can't make a living because financially it's not possible. So those collaborative practices are actually impacting patients' ability to have care in areas where there's nobody available.

**Rhonda Finnie** It doesn't matter if you have insurance for coverage—you have to have people who can take it. And the nurse practitioners are willing to see patients, but financially it is prohibitive. We know people who have actually closed their practice.

**Jacquelyn Wilkerson** In an acute care setting it is difficult to utilize them at the full scope because of medical staff bylaws and rules and regulations.

**Rhonda Finnie** I still write orders under verbal orders just like an RN would in the acute care facility.

**Jacquelyn Wilkerson** You talk about overhead and the physicians are like, "I don't think we want to be the collaborative person with an advanced practice nurse." Some of those are limiting what we can utilize in the acute care setting where you would have more costs.

**Rhonda Finnie** Well, and too, better management of the patients. I do know nurse practitioners who are serving as hospitalists on a unit. The surgeon just wants to do the surgery. They don't want to deal with hypertension or hyperglycemia.

**Lorraine Frazier** And Rhonda that's a very important part. Because of them allowing a nurse practitioner to practice within her scope it frees them up to do those things.

**Carolynn Whitley** That would help so much... but we are not there yet.

**Rhonda Finnie** But the reimbursement also has to be there, because with some insurances, even though I see a consult in the hospital I don't get paid for that consult unless he walks in the door. All he has to do is walk in the door and contribute significantly to the plan that I've really already delineated.

**Are there any challenges specific or unique to nurses in the Greater Little Rock area as compared to the rest of the state, or in the rest of the state compared to the nation?**

**Lorraine Frazier** I think, like any metro or urban area, the challenges are they want a better prepared and better educated nurse force. Some hospitals are saying, "We are just going to get the BSNs because we want to get Magnet." So the managers, masters, doctorate–I think that's different compared to the rural areas.

**Jacquelyn Wilkerson** I will say that one of the new things that I did on our nursing residency because I wanted to hire the best of the best, this time I was able to be a little bit pickier, choosier and I limited it to BSN nurses. I have over 600 in the nursing division and we have a 57% BSN rate. I think the nation is about 60%. The goal at the Institute of Medicine is 80%.

**Lorraine Frazier** We are working on 80 and right now in Arkansas 40% of the nurses have a BSN. The reason we want that is it's based on evidence. There is evidence to suggest that the safety outcomes in facilities are better when they have BSNs.

**Jacquelyn Wilkerson** Every nurse could increase your mortality by one percent. There's evidence.

**Chris Dent** I spoke to a nurse from rural Arkansas, and it's about as rural as you can get, just this week. She's a nurse manager of an OB unit and she's concerned about a takeover or a purchase by a larger facility who uses an all RN staff. They don't use all RN staffs in rural Arkansas because the availability isn't there. She is wondering what they are going to do. She said, "We do well to have one RN in our unit at a time."

**Chris Dent**
VP Clinical Services
AR Heart Hospital

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**Lorraine Frazier** I think one thing we do differently in Arkansas compared to some states is because we have such a rural state we educate advanced practice nurses where they are. We have a great telemedicine and communications system around the state so for their masters we have regional programs and clinicians that help educate nurses. If they are in the Delta, we keep them in the Delta. If they are in the Northwest, we keep them there. And that's incredibly important for communities. You don't bring them to central Arkansas because they don't go home. So we have all kinds of technology available to us to keep them where they are. Arkansas does a tremendous job with that. I think better than any other state.

**Rhonda Finnie** And it's the seamless progression as we look at web-based education and things like that, although we're working on more seamless, with the Action Coalition. Even at the graduate level, being a little bit more tolerant of how we educate and really more respectful of online education than probably we were before.

**Lorraine Frazier** But we have the ability to have those clinical specialists in their area to help even with the assessment and clinical parts of it, which is pretty cool. One thing about nurses...nurses support nurses in education. We have preceptors, every college does, all over the state, and they are practicing nurses that help us work to educate other nurses, which is amazing. I think that is unique. We don't pay them. I think it is something they do professionally for their community and their profession and I am just always amazed at that.

**How do you see the future for nursing? How will things develop over time?**

**Rhonda Finnie** I think we are finally going to really develop ourselves.

**Jacquelyn Wilkerson** Emerge.

**Rhonda Finnie** I think that's a great term. Emerge.

**Lorraine Frazier** Entry into practice for advanced practice will be as a doctorate. I think people are going to wake up and say, "Gosh, nurses are talented, let's get them at the table."

**Jacquelyn Wilkerson** We talk about the triad with value-based purchasing, high quality healthcare, with a healthy bottom line—you have to have a bottom line of some kind, even if you are a non-profit, you have to pay the light bill—and then patient experience. You've got to have those three and I think to get all of that, who's going to emerge through that? Because we're at the bedside to have that patient experience. The doctor comes in once a day for about two or three minutes. We've got to make sure of the quality outcomes, the patient experience, and who's lower cost right now, the physician or the nurse? So I see a big emergence.

**Carolynn Whitley** Also the nurse is your transition of care to keep down your readmission rates in a hospital. Most readmission rates are from time of discharge to their first appointment.

**Jacquelyn Wilkerson** Who's going to do that? Nurses.

**Carolynn Whitley** Hello! That's where I was going. I think that nurses are going to become more important. There are going to be more nurse navigators to help patients navigate through the healthcare system because it is becoming so complicated. And also, we are so specialized that her patient has had an MI, but he also has colon cancer and a pain in his leg. Well he calls his oncologist, who says, "I don't know." Then he calls his heart doctor, who says, "I don't know." There's got to be someone who can stand in that gap for that patient to navigate where they are going.

**Rhonda Finnie** You are right and I see in primary care we have lost the RN in many places. We have lost that and I think that transitional care piece or that point person, is a role that a RN could fill in those primary care practices to make sure they have follow-up with oncology, etc.

**Carolynn Whitley** Or did they fill their prescription? Why are they back in the ER with hypertension? Because they didn't get their blood pressure medicine.

**Rhonda Finnie** Exactly! I am seeing RNs be more useful for the community because there is a lot of need. You know when I worked as an RN with the neurosurgeon I now work with, that was my biggest job—coordinating between specialties. I saw them in the clinic, I assisted in surgeries, saw them in post-op, and transitioned them back. To get that whole process is a journey for the patient, but it's so important that you have the right person doing it and it really needs to be a nurse.

**Carolynn Whitley** Can you imagine just in oncology, not just transitioning all the different disciplines, just at CARTI alone, a patient has to navigate from their PCP who says, "I see something funny," to the oncologist appointment that says, "In fact he does." Now he has to have radiation, chemotherapy, surgery. Those are all different people, all different areas, and that's in one discipline. Can you imagine, like I said before? And he also has a heart condition, so now he has all of these, and his heart, and he's depressed.

**Lorraine Frazier** IT is helping a lot. Electronic records. It's amazing.

**Carolynn Whitley** I am looking forward to electronic records. So when they go to the oncologist, the oncologist has everything he needs that the cardiologist told him, because the patient certainly can't remember what he said. Then when he goes to see the cardiologist he is never going to remember the big words that the oncologist said.

**Chris Dent** Or what medicines he's on.

**Carolynn Whitley** Never the medicine. Or the "Oh you are back in the hospital again? For what?" Really? That's important.

**Chris Dent** And it's going to take him three days to get those reports.

**Lorraine Frazier** I think one thing, too, that nurses do well, is we communicate so well with the families and patients. And patients feel safe with nurses. They don't feel intimidated so they tell us things and we really know things that may be important for their care that they are not going to tell you in a five minute session. That angle and that connection I think is critical in healthcare. We're always going to have that. Even 20 years from now.

**What would you say to someone who is considering a career in nursing?**

**Chris Dent** I would say to plan to study hard and to learn everything you can learn. Be flexible because change is your friend. You are going to continue to change, change, change.

**Peggy Henderson** I would say that if you are compassionate and like helping people, being patient, and listening, then go for it. At least try it.

**Rhonda Finnie** I would say that it's a very exciting journey. It's almost limitless in terms of where you can go and what you can do. So if you want something with a lot of diversity in terms of options I think it's a fabulous profession. You can up and move. You can travel. You can go to Alaska. You can do so many things and so many specialties; it's much broader than maybe people think. It's not just in the hospital any more. It's out in the community. It's in business. It's in industry. There are a lot of options and I think they should be prepared for a journey and really a search inside themselves in terms of what is their passion? So I think it is a fabulous choice for someone who is ready to take on that task.

**Lorraine Frazier** I would say the sky is the limit. I've been funded by NIH for millions of dollars, traveled around the world, met the most incredible people, never been bored, always been challenged, never want to quit, wish I had five more lifetimes to do it again. I think it's been wonderful. It has been a great career.

I can't imagine not being a nurse. Never. So I would say go for it. Quickly. And study hard and all the other things.

**Jacquelyn Wilkerson** It's such a blessing to be a servant. I really feel like it's a calling so I would say to them, "Why would you be interested in going?" I've talked to many new grads and I'll ask them, "Why do you want to be a nurse?" and they answer, "I don't really know." I tell them, "If you've got the heart and compassion it's such a reward. You can hold someone's hand and you can cry with them, sing with them at night." One of my favorite memories was sitting with a gentleman at night and we sang hymns. The next day he coded and passed away and to be with him through that transition in life, but also working OB and seeing a miracle happen in a birth, you go through so many emotions. It can be such a blessing, the highs and the lows, and diversity, but go in it for the right reasons. It's not just a job. I would never do anything else. But I think you have a purpose, that you are called to it.

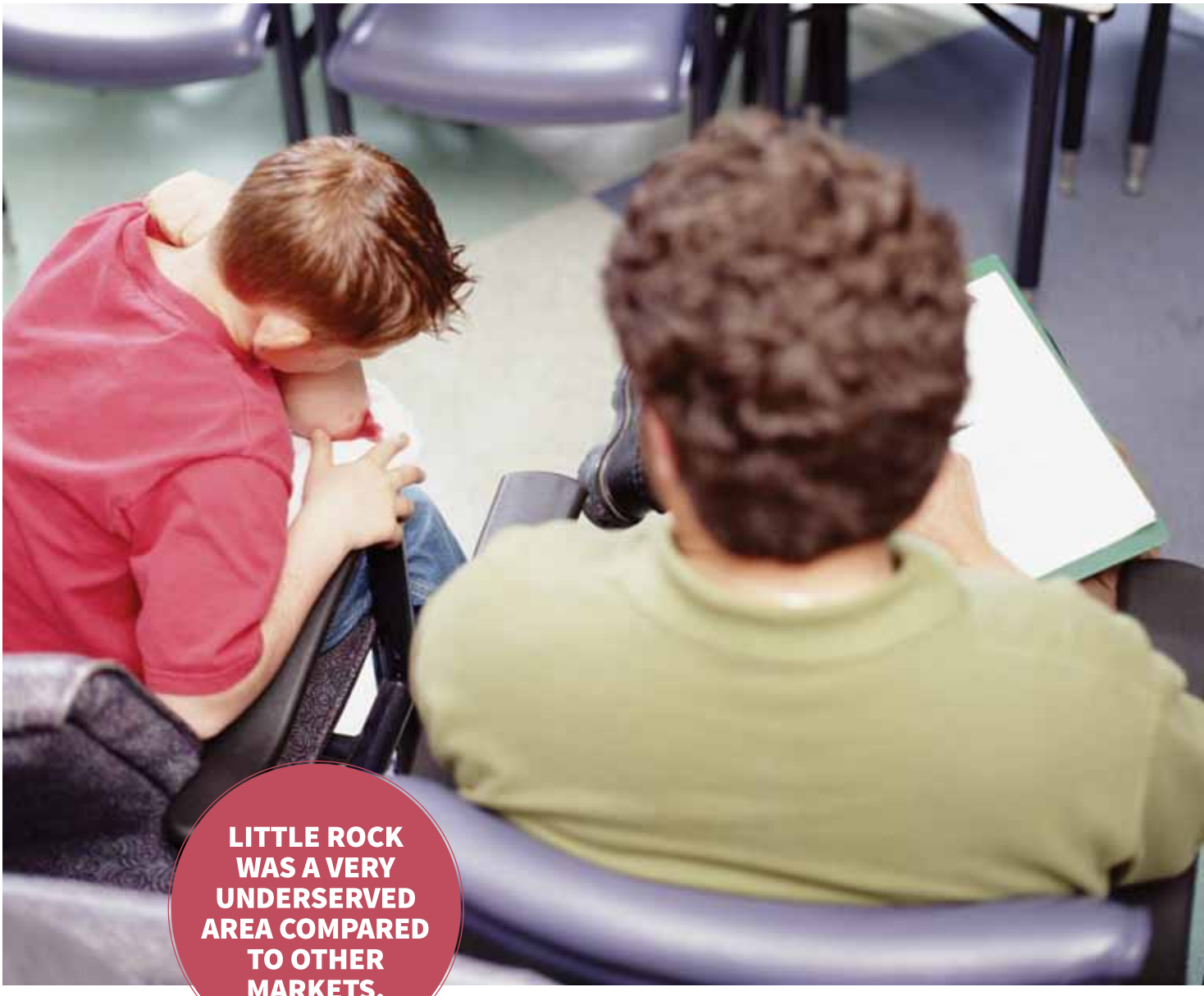
**Carolynn Whitley** I would say to the young nurse or the young person going into nursing that they are about to embark on one of the most exciting times of their life. When I was young I wanted to be a criminal lawyer. I was going to live in Houston, Texas and carry a big old gun, and go into court. But my dad changed my mind that that's not who I was and not who I wanted to be. I am so glad he did. I would tell anyone, and I have told my own daughters, healthcare and nursing is the only profession that you can ever go into that has so many different areas. You can choose from birth to death, wherever you want to be. It's ever-changing. You are always learning so if you have a thirst to learn this is where you need to be. If you have a thirst to make a difference in people's lives and in your life as well. I went into nursing when I was quite young and I've been able to be there to tell a young mother that she was pregnant finally. I have been there with mothers when they have delivered their first child. I've gone to med/surg. I've been a prison nurse. I was able to be with a young man who had never seen a doctor before and was terrified. I have seen things that others have only been able to read about in textbooks. I've seen scurvy. I've seen rickets. And I've been able to teach people. You are not going to be able to find that anywhere else, where you make that much of a difference in people's lives.

**I HAVE SEEN THINGS THAT OTHERS HAVE ONLY BEEN ABLE TO READ ABOUT IN TEXTBOOKS**

**Peggy Henderson** I listened to you when you stated that you asked nurses, "Why did you become a nurse?" and they say they don't know. Well, I didn't know either. My mom was a nurse and she encouraged me. After I graduated from high school I went straight into nursing school and needless to say, I am probably the oldest person in this room. I have been a nurse many, many years, and I always wanted to be a glamour girl when I was younger. I thought about that even while nursing. I thought, "I am going to quit this. I hate nursing." But I stayed and I stayed and I stayed. Now that I grow close to retirement I think, "What am I going to do? They can't do without me." Every time I think about it I think, "They are not going to get anyone like me. I have been here forever."

**Carolynn Whitley** And they won't either. At the end of the career, you've also been there for the last breath and it's the most precious breath. The first and the last breath. I got to experience that. You don't get to experience that in banking or teaching. It is a phenomenal career. ■

# Urgent Care
## FILLS PRESSING NEED



**LITTLE ROCK WAS A VERY UNDERSERVED AREA COMPARED TO OTHER MARKETS.**

By **Cynthia Hicks**

Urgent care centers seem to have become the place where many Little Rock residents go for healthcare, especially on weekends or evenings when their primary care physicians don't have office hours. Several have opened in the past year alone, including family owned and operated Central Arkansas Urgent Care, which opened its doors on January 27th of this year.


Heath Nay, MD, and wife, Heather Nay, with Central Arkansas Urgent Care

"During his residency, my husband, Dr. Heath Nay saw a need in this community. That was in 2007 and there were no urgent care centers in Little Rock," said Heather Nay, Central Arkansas Urgent Care Office Manager. "We started researching again in 2011 and there was only one. That is when we decided that this is what we wanted to do."

Dr. Nay did his residency at the University of Arkansas for Medical Sciences (UAMS) in Little Rock. The opening of his business follows a national trend that has seen a large increase in the number of urgent care centers nationwide. Dr. Franz Ritucc, the Director of the American Academy of Urgent Care (AAUC), says there are two main reasons for the increase.

"There is a decrease in the number of family practice doctors graduating, so there are fewer doctors available to treat patients," said Ritucc. "That, combined with the millions of additional people who have healthcare as a result of the Affordable Care Act."

R.T. Fendley, the Associate Vice Chancellor and Chief Strategy Officer for UAMS, says in the Little Rock area, the push to open urgent care centers, along with after-hours walk-in clinics, is driven primarily by the Affordable Care Act. "Folks with an insurance card will

seek help faster than folks without an insurance card," said Fendley.

It is hard to track exactly how many centers have opened because there is currently no mandate on who can open a center, and it is something that is not tracked by any government entity. But, Ritucc says, the number of centers accredited through the AAUC has increased fourfold over the past ten years. That growth is expected to increase even faster this year as the Affordable Care Act starts to bring healthcare coverage to as many as 30 million Americans, many of whom do not have regular doctors.

R.T. Fendley

John Soud, MD

**"Probably half of the cases that come into our ER could be taken care of in a less costly environment. They need treatment, but not necessarily in a high-cost, level-one trauma center."**

*R.T. Fendley, Associate Vice Chancellor and Chief Strategy Officer, UAMS*

"If you don't already have a doctor, it is hard to find one," said Nay. "We take most insurances and this is a way to get your health needs covered, without waiting months to get in to see a primary care physician as a new patient."

At most urgent care centers patients can often see a doctor in an hour or less, compared to a multi-hour wait time in some emergency departments. Moreover, urgent care centers offer imaging and other services not found in many primary care offices.

"Our society is the 'McDonald's society,'" said Ritucc. "We want things when we want it and we want it now. When people are injured or ill they don't want to wait in an ER when they can't get into their doctor's office."

Ritucc says the urgent care centers, like all of the new ones in Little Rock, are designed

Velocity Care Urgent Treatment Center

**"Having the ability to look back over 12 years of working in the emergency room, it is frustrating to see patients sit in the ER for hours for a sore throat. The ER is not efficient or effective in treating people with a non-emergency."**

*John Soud, MD, Owner, Velocity Care Urgent Treatment Centers*

**EMERGENCY ROOMS NEED TO BE FOR EMERGENCIES, NOT FOR ROUTINE ILLNESSES.**

to see more patients than a primary care physician's office, offering rapid care in an efficient manner. After they are treated by urgent care, patients are referred back to their primary doctors for follow up and long term care, something Fendley agrees is key.

"We believe every person should have a primary care physician," said Fendley. "But even folks who have a primary care physician are going to find it convenient to go to an urgent care setting."

Many centers are busiest in the evenings and on weekends, when most doctors' offices are closed. Central Arkansas Urgent Care is open seven days a week and until 8 p.m. on weekdays. "People don't want to go to the ER after five or on the weekends," said Nay. "It could take hours to get a cast at an ER, while it could take an hour here."

In the past, at least some of the patients who now go to urgent care centers would have ended up in a hospital emergency room. A 2010 Rand Corp. study found that almost one in five visits to hospital emergency rooms could be treated at urgent care centers, potentially saving $4.4 billion annually in healthcare costs. Nay agrees, saying she personally sees a significant savings to patients in Little Rock.

"It is at least 60 to 70 percent less out-of-pocket to come to an urgent care center than it is to go to the emergency room," said Nay. "Insurance companies charge a lower co-pay. For example, our average copay is around $40, where in an ER it could be as much as $250."

The lower costs have drawn the attention of insurers. Many have added urgent care centers to their provider networks, and one has gone a step further. Humana, in 2010, purchased Concentra. There are currently two Concentra urgent care centers in the Little Rock area

Velocity Care Urgent Treatment Centers also expanded into the Little Rock market, less than a year ago, from Shreveport, La. The owner, Dr. John Soud, says a few years ago one of his partners got a call from his brother. His son was sick and he wanted to know if there were any urgent care centers in the Little Rock area to take him to. After a search on the internet, Soud's partner discovered that there were none. Upon doing actual market analysis, Soud came to the same conclusion that the Nays had.

**"It is to offer a level of service that, up to this point, has really not been offered. We feel like there is a sizable number of patients in Little Rock who need this type of service. It helps alleviate the pressure on emergency rooms, and in almost every instance it would be at a lower price."**

*Greg Stubblefield, Vice President of Clinical Services, Baptist Health*

Greg Stubblefield

"Little Rock was a very underserved area compared to other markets," said Soud. "Having the ability to look back over 12 years of working in the emergency room, it is frustrating to see patients sit in the ER for hours for a sore throat. The ER is not efficient or effective in treating people with a non-emergency."

Soud says Velocity Care is also filling the gap where traditional medicine has not kept up with the changing needs of Little Rock patients. On the Velocity Care website it says these changing needs are due to lack of access to healthcare providers and the increased use of the emergency room for non-emergencies, which has overwhelmed the hospital systems.

This is one of the reasons hospitals across the country and in Little Rock are also jumping into the urgent care clinic business, adding their own centers. The Baptist Health After Hours Express Care Clinic was opened in January of 2013 and takes patients until 11 p.m. during the week and on Saturday mornings. Greg Stubblefield, Vice President of Clinical Services for Baptist Health, says it is all about fulfilling a need in the community which is part of the mission of the Baptist Health System.

"It is pretty well documented that here in Arkansas and across the south there is a shortage of doctors. People are looking for a physician and can't find one," said Stubblefield. "Because of this they will seek out the emergency department for their primary care."

In fact, Stubblefield says that 30 to 35 percent of patients seen in the Baptist Health emergency room are for nonemergency reasons. Fendley says at the UAMC emergency department that number is higher. "Probably half of the cases that come into our ER could be taken care of in a less costly environment," said Fendley. "They need treatment, but not necessarily in a high-cost, level-one trauma center."

UAMS does not currently have an after-hours clinic, but Fendley says they are looking into opening one. Nay believes this is where urgent care centers step into the picture, stating that, "Emergency rooms need to be for emergencies, not for routine illnesses." Stubblefield agrees and says, for this reason and others, Baptist is currently evaluating opening additional clinics at some of its other sites too.

"It is to offer a level of service that, up to this point, has really not been offered," said Stubblefield. "We feel like there is a sizable number of patients in Little Rock who need this type of service. It helps alleviate the pressure on emergency rooms, and in almost every instance it would be at a lower price." ■

# One on One

## Scot Davis, CEO Arkansas Urology

E. Scot Davis joined Arkansas Urology as Chief Executive Officer in May, 2013. He has more than 20 years of physician practice management experience serving in a variety of roles. Before moving to Little Rock, Davis served as Chief Financial Officer of Baptist Medical Group based in Memphis and prior to that he was the Chief Financial Officer of Northeast Arkansas Clinic in Jonesboro, also serving in an interim Chief Operating Officer capacity.

Davis is a member of the Arkansas Medical Group Management Association and the American Medical Group Association. In 1999 he received the Certified Medical Practice Executive (CMPE) designation from the American College of Medical Practice Executives.

Davis has been active in leadership and community organizations across Arkansas and Tennessee and is a 2002 graduate of Leadership Jonesboro. He recently served on the Board of Directors of the Jonesboro Baseball Boosters, the Craighead County Community Foundation, and the Greater Jonesboro Chamber of Commerce. While in Jonesboro, he was a member of the Rotary Club, serving on various committees and receiving the Paul Harris Fellowship. Davis is currently a member of Rotary Club of Little Rock – Club 99.

A native of Memphis, Tennessee, Davis received a Bachelor of Arts in Political Science and a Master of Public Administration from Memphis State University and a Master of Business Administration from Christian Brothers University.

**I WILL TELL YOU FOR PHYSICIANS, MEDICINE IS BOTH AN ART AND A SCIENCE**

**Chief Editor Smith W. Hartley: At the beginning of the year Arkansas Urology acquired Epoch Health brand and opened a clinic in North Little Rock. What need did you see to do that and what other acquisition plans might you have in the future?**

**Scot Davis:** I think in the marketplace right now there's a real difference between what people perceive as men's health and what men's health truly is. I think there's a sense that men's health is being touted as testosterone clinics. In reality, men's health is much more encompassing. Women have been going to OB docs since they started their menstrual cycles and men have been left out. At the end of the day, men as they age, they get hormonal imbalances as well. So when you look at men's hormones, it's not just testosterone. Men have estrogen, men have LH, luteinizing hormones, so when you look at all of those together it's part of just one piece of men's health.

So when we start talking about overall men's health what we do that's very unique,

and I am not saying it doesn't happen other places, but unique for us, is that we offer a free screening for men on their first visit. And when we screen we are going to look at cholesterol, HDL, LDL, triglycerides, blood sugar. We do what's called a comprehensive metabolic profile where we are going to look at kidney functions through a urinalysis, we are going to look at Vitamin D, iron, B 12. So when we talk about men's health it just isn't testosterone. I think that's what a lot of people think.

There's a proliferation of testosterone out there. There are creams, gels, pills, and all these other things. So what we are trying to do is change the mindset and the culture of men to say, "If you were experiencing these symptoms—you are tired, lethargic, low energy, lack of focus, gaining weight, all of those things, it may be something other than testosterone." Although that's what everybody's trying to tell you because they are going to make money off the pills, the drugs, the creams, the injections, whatever. We want men to come in and do a full blood panel, let's do a full workup and let's find out what's going on with you. And then we are either going to refer you to a specialist or your primary care doctor, or treat the things that we can as urologists. We focus on kidney health, prostate health, hormone health for men, all of those things. So I think that's what makes it a little bit different for us and I think that's what makes men's health the way that we're doing it, very different.

The other thing I think is very relevant is that urologists across the country are all dealing with this issue. Here's what's happening. Urology practice is predominantly a male-dominated specialty, 70% of our patients are men. There have been these "shotboxes" that have opened up in markets and urologists are seeing their traditional patients leave their clinical settings and go to these retail type clinics. Why are they going? Because it is convenient, it's discreet, they don't tell their doctor about it, and they are going because they are thinking they are going to get testosterone. We are basically saying, "Come in and see us. We'll treat you free of charge and find out all the things that are going on, but at the end of the day if there is something urolological going on, and it may be, we're going to refer you to Arkansas Urology or treat the things we can within our Men's Health clinics." So that's what is very unique. This isn't just unique to Little Rock this is a national and even world trend when it comes to men's health and testosterone.

**Editor Would you say men's health is sort of the change in urology services that's come on over time? The increase in testosterone and other sort of treatments?**

**Scot Davis** I think what's driven urology more towards men's health is the fact that within marketplaces such as Little Rock and others, there is an opportunity for clinics to go out and basically administer testosterone. What has changed in the urology market is that it isn't necessarily best practice and it isn't best medicine. Testosterone at the end of the day is a drug that's being put into someone's body. You have to clinically manage that either through the labs or physical examinations and other things. Part of our process is that we are going to make sure those blood levels are checked on a regular basis, make sure there isn't anything else going on. I think providing the true clinical and thorough evaluation and examination during that process is what makes it different for urologists.

**Editor Where are your primary referrals coming from?**

**Scot Davis** Urology is such a reactive specialty. In other words, if you are having problems urinating or symptoms of pain in your kidney or bladder or those kinds of things you might go to your primary care doctor, so most likely we are going to see referrals from primary care physicians and we get a lot of our own self-referrals. What's important to us is our relationship with our primary care referring doctors. We've actually gone out and strengthened those relationships and let them know we are here to provide a whole bevy of services. At the end of the day our bread and butter is really probably prostate health and kidney health and kidney stones. That's a lot of what we do for men. But 30% of our patients are females so we do a lot of female incontinence, stress incontinence, sexual health for women. Again it's part of our whole panel of services that we offer.

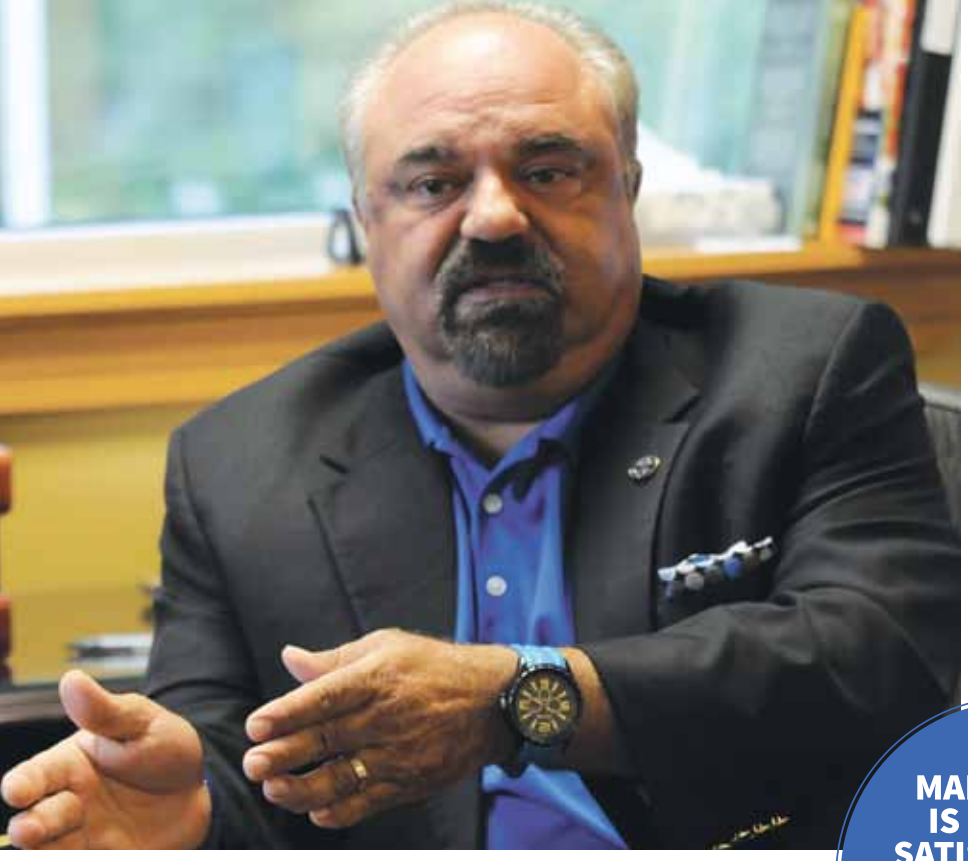
**Editor How did Arkansas Urology start to come together and where are you positioned in the market landscape?**

**Scot Davis** The formation of Arkansas Urology was several different groups that came together in the late 80s and 90s and formed themselves into a group in the mid-90s. In 2001 they came together and built this facility and those separate practices then came into one location. So we've actually been in this facility right at 13 years. In terms of the marketplace, within the Central Arkansas area we're the largest group. There are some independent doctors and a small group in Conway and a small group in Hot Springs, but we are the largest group within probably 200 miles of Little Rock.

**Editor Are there some partnerships that you are working on?**

**Scot Davis** I've been in healthcare practice management for 20 plus years, and I think you always look for potential partnerships. With the way that the healthcare landscape is evolving it's always good to explore opportunities for partnerships, whether it's with hospitals, with insurance payers, with other groups or other specialties, there's always ways we can look at that. For us strategically, it's also looking at if there are independent physicians that want to become part of a large group and want to remain independent as urologists, then we certainly would welcome those opportunities and we're exploring some of those as well.

With the way that payment systems are evolving in this country, we obviously want to look at relationships with payers and the hospitals as well. We work with both Baptist and St. Vincent right now in their clinically integrated networks and we are excited about the opportunity to bring value, access, and quality to those facilities. Also partnering with other specialists that are complementary, whether it's gastroenterology or cardiology. When you think about it there is so much



**OUR MAIN FOCUS IS PATIENT SATISFACTION. THAT'S WHAT WE ARE REALLY WORKING ON RIGHT NOW**

within the body that's connected. We're one piece of that and it's interesting, as specialists they treat one system or maybe some system and a complementary system, but having the ability to integrate and communicate is really where healthcare is going. Whether it's in a health system where all those physicians are employed or whether it's a clinically integrated network where they work together or whether it's just a quasi partnership and communication. I say partnership, but really just good communication. To me the structure really doesn't matter as long as doctors are talking to each other about the outcomes for those patients.

**Editor Have you noticed that happening more? The communication increasing though technology. Is it coming or is it here?**

**Scot Davis** I think it's both. I think it's evolving. For now, I think the ability to have EMR systems that can talk to each other is important. Part of clinical integration is sharing our data with hospitals and to a central repository so that data can then be analyzed and we can look at best practices and best outcomes and basically look at population management. The reality is I think everybody has got the intent. When you look at healthcare there are three things that are really critical: quality, good outcomes; access for patients; and cost. There are a myriad of ways in this country that we are trying to solve those three things. If you think about Obamacare, what Obamacare has done is created access. It has basically said there is a population of people that don't have insurance so let's provide access. Now I think most physicians, and quite frankly, most hospitals, if people need care they are going to get it, regardless of their ability to pay. I think in terms of quality, I think that's more of that communication, the use of the EMR to coordinate care, to have population health, to have best outcomes.

From those two things, when you create access and you provide quality, then you start managing cost, because you are not duplicating services. You are not doing unnecessary tests. You are looking at the best algorithms to treat a certain disease category. It becomes somewhat standardized, but I will tell you for physicians, medicine is both an art and a science. The science is yes, you've got specific outcomes and specific ways to do things. The art is knowing how that individual patient's systems work together. So you may not necessarily say this is how to treat it based on an algorithm, doctor's have to use their experience. And they think in their own repository, their brain, and say, "A while back I had a patient similar to this and this is how we treated it." When you are in a large group of urologists you get that. Even within our group, we have the ability to confer and I've seen that. Doctors will get together and have lunch and say, "Well I've got this patient and this is what's going on and what would you do?" So they are within their own specialty trying to get best outcomes.

**Editor What does your payer mix look like? Is there a lot of Medicare?**

**Scot Davis** We're about 50% Medicare. And then about 50% commercial and a little self-pay worker's comp. I think for most specialists you are going to see that. Some specialties may have a little bit higher mix of Medicare. The average age of our patients is about 55. We have patients that are still working and obviously with doing vasectomies and sexual health and ED and testosterone, you are going to get patients who are not quite in their 60s or 70s, who are your traditional Medicare patients.

**Editor It's a beautiful facility by the way.**

**Scot Davis** Actually we are in the process of trying to do some renovations. Our focus right now in terms of culture and where we are moving forward is to make it more patient-centric and more retail focused. So some of the technology things that we are looking at is the ability for our patients to go online and enter information that will feed directly into our electronic medical records system. That allows those patients to come in and have a seamless check-in. If you were to walk into one of our Epoch Health clinics that is very much a retail, no wait, walk-in clinic. It's difficult with the kind of volume we have here to offer an open access, "come on in, we'll take care of you" setting. What we are trying to do though, is create the atmosphere of a very friendly open-air, retail type environment, but having the ability to schedule appointments and work somewhat within a scheduling system.

**I think we have great staff, great doctors and great nurses, but the minute we say we can't improve then we are moving backwards. It's a continuous improvement on processes, workflows, and patient satisfaction. Very much patient-centric.**

**Editor Has Arkansas Urology been working on any operational changes?**

**Scot Davis** There is so much transformation in healthcare right now. Our main focus is patient satisfaction. So we've created a patient advocate program where if patients are having issues with their experience from start to finish, scheduling their appointment, a billing problem, a problem with their visit, we have the ability for them to call and talk to someone about their experience. And quite frankly we love to hear about the good experiences, too. A lot of times patient advocates are seen as the one you call when you have a problem, but we'd love for patients to call when they have a great experience. We can share that with our staff.

So internally patient satisfaction is a major priority for us. And that includes the appearance of the building, and a retooling of the entrance and the pods, check-in and check-out. But also intense training with our staff, nurses and front desk staff. I think we have great staff, great doctors and great nurses, but the minute we say we can't improve then we are moving backwards. It's a continuous improvement on processes, workflows, and patient satisfaction. Very much patient-centric.

We are still looking at cost and ways that we can bring a lot of value to our patients. Reimbursement continues to decline for physician practices, for hospitals, for everybody. So we, as an industry, have to find more effective and efficient ways to do things. So we are looking at better technology, whether it's EMR, check-in, patient convenience types of technologies, but also emerging technologies in care. We are partnering with the hospitals that are acquiring technologies that make access and outcomes better. We do a lot of prostate examination and biopsies and one of the emerging technologies is the ability to use an MRI and fuse that to an ultrasound, so you have a much better image of the prostate and you can pinpoint specifically where you might have a cancer cell. It becomes more focal therapy where we can define where cancer is and once we can identify that we can treat more aggressive cancers and we can catch the less aggressive or maybe some benign stuff that really in the past we've just done surveillance on. We can have a better understanding of whether that person has cancer, the degree of cancer, and the best treatment we can provide. So that's a technology that we are about to launch and share with our patients.

I would say the other big thing that we are working on is communicating with our patients and the public about our centers of excellence. We are looking at eight centers where we are going to target and specifically focus on, "these are the things that we do." Our new tagline is "We do you better." Along with that we do kidney care better, we do prostate health better, we do all of these things and it will focus on education, preventive care, and in partnership with our foundation, which is Swings for Screens, we will bring about awareness to the public.

We are really excited about becoming less reactive and more proactive and I think that really is the future for our specialty. Understanding that we've got to go out and become more focused on preventing urological issues. The fact is they are still going to happen. If you don't drink enough water, you have a bad diet, you are going to develop kidney stones, but part of our center for kidney health is going to focus on dehydration and proper diet and the things that will cause kidney stones. If you do have one, then we are the specialists and we are the experts to treat it. And we are going to create access for those patients so they will have one number to call and we are going to take care of the problem.

**Editor Will the centers of excellence be free-standing or within other facilities?**

**Scot Davis** A little of both. Our center of excellence for men's health will be our Epoch strategy. Our center for kidney health will be a combination because we have three lithotripsy machines—one at St. Vincent, one at Baptist, and one that's mobile—so we have actually talked to the hospitals about how to market and brand those. We'll have a center of women's and pelvic health, which will be here. Like I said, 30% of our patients are female. Dr. Brizzolara is probably one of the best when it comes to women's sexual health or stress incontinence or bladder health. Doctors around here know, "Go see Dr. Brizzolara." We have our prostate cancer center right next door. So our center for prostate and cancer health will be a combination. We'll do some treatment and therapy here and we'll do a lot of our radiation therapy next door.

So a little bit of everything, but you asked a good question about partnerships. I have a meeting today with several specialty groups where we are talking about how we can collaborate. It is timely. I know you interviewed Jan Burford last issue and we've talked to CARTI about partnership opportunities. In this day and age you don't discount anything in the marketplace as to opportunities. When I got my MBA I had a professor say, "Marketing is like swimming like a whale. You swim with your mouth open and absorb everything. The water flushes out through the gills and what's left is the food." That's kind of what you have to do. I am running around like a chicken with its head cut off because I am looking at all these opportunities out there. ■

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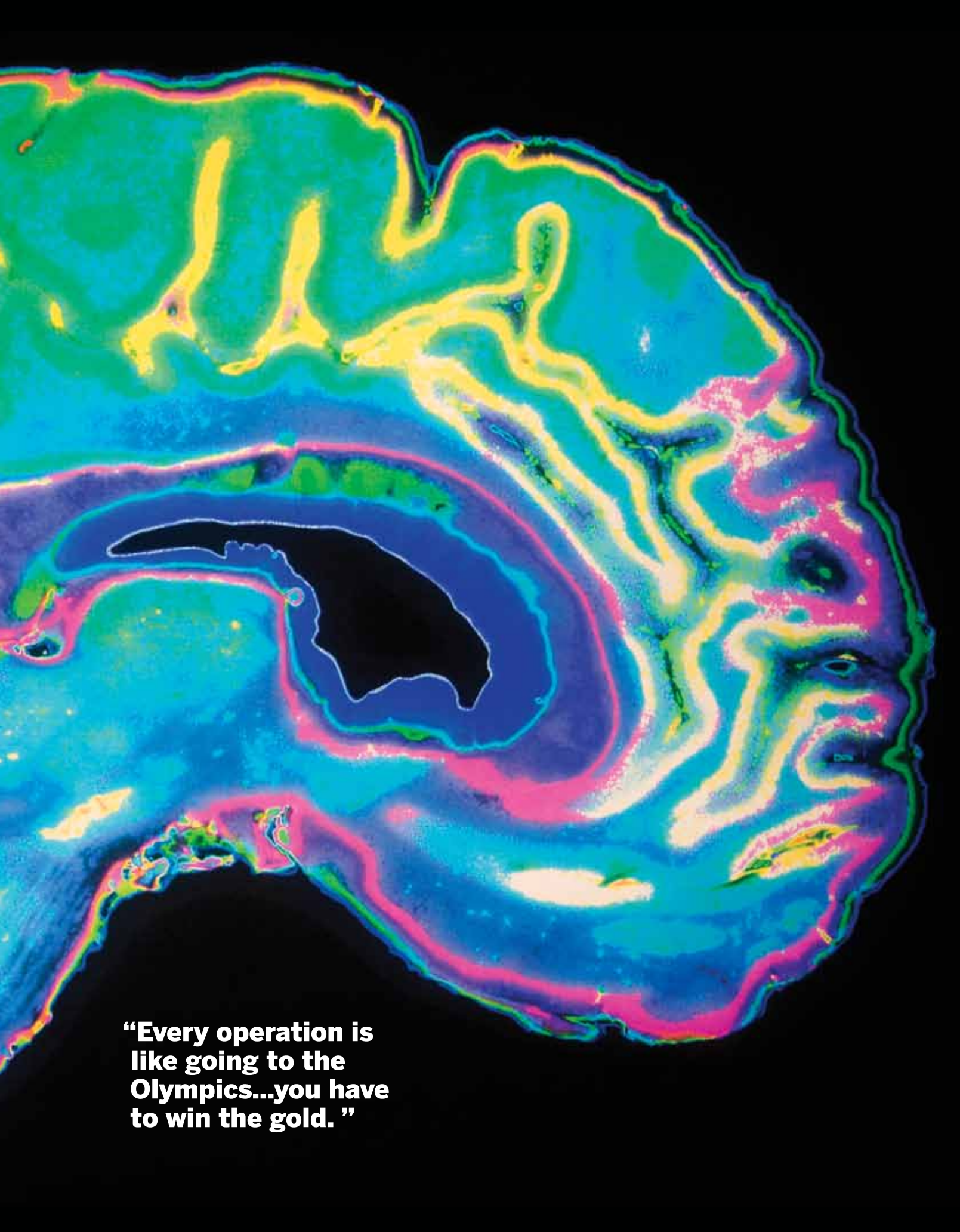
# THE "OLYMPICS" OF neurosurgery

By **Margo Pierce**

## As told by one of its pros



**“Every operation is like going to the Olympics...you have to win the gold. ”**

When doctors want the best neurosurgical training, many of them go to Dr. Ali Krisht, FACS. And when he meets them, he tells them he's not going to teach them surgical technique. He's going to teach them to be better people. Mentored by two of the most renowned neurosurgeons, Krisht became one himself during his 29 years of study and practice. He shares his expertise by offering surgical training in foreign countries, but Krisht also offers one-on-one training at the facility he runs right here in Little Rock, the Arkansas Neuroscience Institute (ANI) with the St. Vincent Health System. And his students hail from all over the world.


Dr. Ali Krisht

**CALLING ANY NEUROSURGERY "ROUTINE" SHOULD BE ALARMING.**

"When my Fellows come to me I don't tell them, 'You are going to come and learn my technique.' I say, 'If you think you will learn technical skills or tricks so you can become a better neurosurgeon, you're in the wrong place,'" he says. "I like to think I teach them character, how to really care in such depth that (they) are going to be better surgeons. When you want to do a good job, you're going to pursue it (as) a lifetime learning experience, you want to improve on yourself every day.

"I make sure they live a healthy life. They cannot drink, stay up, and go operate. You have to be rested and in shape. You have to have the stamina. If you have a good body and (are) healthy, then everything becomes possible. If you want to do very long hours in surgery, sometimes 16 to 18 hours – the longest I've managed is 26 – you have to be fit. Your stamina has to be at the level when, in the last minute of the operation, you are as sharp as the first minute of it."

Krisht says he believes he can always do better. That motivation and drive are what he tries to teach all surgeons. But that only comes with a kind of self-knowledge that isn't taught in medical school.

"I usually teach my colleagues, physicians: You have to watch yourself and be aware of where and how you can improve yourself," Krisht says. "You need to know what it is that you need to perform. The second half of the technique is to be dedicated to improvement, which means to see how

DERO SANFORD

JASON MASTERS

Arkansas Neuroscience Institute (ANI) neurosurgeon Emad T. Aboud, MD demonstrates his groundbreaking "Aboud Model" which circulates a blood-like perfusent throughout a cadaver to simulate life-like conditions during surgery. The "Aboud Model" allows physicians, fellows and residents from around the world to train in a safe, state-of-the-art lab setting at ANI in Little Rock.

somebody does it and to try and simulate it.

"That's something I learned from my mentors; something that I've seen in most people who have done a good job in what they do. It's a combination of really caring about your patient and wanting to improve on every procedure you've done. That's really the core or the essence of how to become a specialist, (to) technically improve."

This understanding of all aspects of neurosurgery is why Krisht was named among the top 1 percent of neurosurgeons in the country by the physician ratings firm Castle Connolly. But Krisht is always critical of his performance and worries that other physicians are becoming complacent. Calling any neurosurgery "routine" should be alarming.

"It shouldn't be like that. The value of somebody trusting you with their brain, their life, it's a big deal. This is why I cannot relax," he says. "Even though I feel like this is a 'piece of cake' surgery – I've done it so many times – it's not that for the patient.

"I joke sometimes. I say, 'My training is more like rehab.' They finish their training and they come and they get what is missing."

A connection to the patient is one of those things that's missing. Krisht would prefer every surgeon consider the most important person in her life and the kind of operation she'd like for that person to have. Then transfer that feeling of concern for and connection to the patient undergoing the procedure to heighten awareness and conscientiousness. Considering how unique each person is, how the circumstances of each surgery can be different, eliminates the impulse to take surgical competence for granted. Being careless can result in death.

"Every operation is like going to the Olympics...you have to win the gold," Krisht says. "The success is how you prepare for it. It's (developing) the ability for the person who trusts in you. This is something we have to nurture and instill in a lot of physicians."

The sporting reference is more than an analogy for Dr. Krisht. Once on the career path of a professional soccer player, he was sidelined with a broken leg. That injury, combined with acceptance to medical school, gave him an opportunity to consider a way to bring together his interest in neuroscience with his preference for hands-on activity. A career in neurosurgery took him from medical school at the American University of Beirut, Lebanon, to Atlanta, Georgia, for his residency training at Emory University.

This was followed by what he calls "a golden opportunity to be sandwiched between two of the giants of our field." Krisht worked with professors Dr. Ossama Al-Mefty and Dr. Mahmut Gazi Yasargil as a staff member in the Department of Neurosurgery at the University of Arkansas for Medical Sciences. He credits both men, his mentors, and their generous teaching as

**"Most surgeons will finish their training, and they might not have encountered the bleeding aneurism. This way you can simulate 10 or 15 aneurisms in one cadaver – make them bleed one after the other – and they gain experience, which is amazing."**

the foundation of his success. In addition to being promoted to associate then professor of neurosurgery, Krisht was the vice chair and professor of neurosurgery until September 2009.

During that time Krisht learned a great deal from Yasargil, who is frequently called the "Father of Neurosurgery." With pride he easily cites a few of Yasargil's accomplishments: Dr. Yasargil introduced and developed the use of the operating microscope for neurosurgery and developed the Yasargil vascular clips used to treat brain aneurysms, which are the mainstay of brain aneurysm treatment today. Yasargil was also named Neurosurgery's Man of the Century 1950-1999 by the Congress of Neurological Surgeons.

In 2009 Drs. Krisht and Al-Mefty co-founded the Arkansas Neuroscience Institute (ANI). Al-Mefty has since joined Brigham and Women's Hospital at Harvard Medical School. Krisht currently serves as the institute's director and the director of the Cerebrovascular and Neuroendocrine Clinics.

"Mentors are important," he says. "We can do more good by teaching more people. We used to be trained in a rigorous way. We needed to achieve certain skills, but at the same time we (were) being watched by our mentors in how we acted and reacted to patients, how we reacted to our failures. We (were) being always put under the gun to achieve more and better. The level of knowledge and experience is shrinking over time."

Krisht likens medical training today to following a recipe in a cookbook – a list of steps to be followed with the expectation of the same outcome every time. The ability to deal with unusual circumstances, unique needs, and the ability to think and act under pressure isn't part of the "didactic" approach currently used by most medical colleges.

Combined with a reduction in the working hours and exposure to open surgery for medical students, neurosurgeons need to augment their training outside school. Alternative ways to learn various approaches to surgical treatment for things such as cerebral aneurysms and how to handle unforeseen neurovascular emergencies in the operating room is essential, according to Krisht.

To experience operating room-like conditions, participants in Krisht's program are trained with the Aboud Model, which circulates a blood-like perfusant throughout the veins of the cadaver to simulate real-life conditions. Residents are first taught by one of the ANI neurosurgeons. Wearing 3-D glasses, they watch the surgical instruction on a large screen. Then they perform the procedures in a life-like setting. The objective is to give residents and younger neurosurgeons more experience and allow them to learn how to handle surgical emergencies in a safe environment. The U.S. Department of Defense's Physicians Committee for Responsible Medicine recognizes the Aboud Model as an effective training tool.

"Most surgeons will finish their training, and they might not have encountered the bleeding aneurism," Krisht says. "This way you can simulate 10 or 15 aneurisms in one cadaver – make them bleed one after the other – and they gain experience, which is amazing. It's kind of like what pilots do with simulation when they fly a plane.

"Operating on the brain, you have to have the highest level of skill to do it. To do that you have to have the highest level of training. One of the missions of our institute is to complement that part of the training, which is not being done as well as it should be done."

Once those basic skills become engrained, Krisht believes surgeons should learn other ways to improve performance. On the physical side, that's learning breathing techniques and how to move the body during surgery in ways that enhance performance.

"Like a professional basketball player, you have to find out what's the best way to improve on your shot (so) that you can score every time," Krisht says. "You have to find out that, if you are in front of the basket, you're going to score better than when you're on the side. You have to always position yourself in the front, and you do it so many times that it becomes part of you, (like) breathing."

He understands that the discipline required to focus on improving performance over time requires a level of maturity that young physicians might not have. This is why he believes mentors are critical for guidance. And until medical schools stress the importance of this issue, Krisht believes healthcare will suffer.

"The certain level of maturity and curiosity you would want medical students to have is not always present," he says. "You have a young population, they have lots on their minds. It's only (a) few who will be able to achieve that level of maturity. The rest of them, if the system is not strong enough... may be ill prepared." ■

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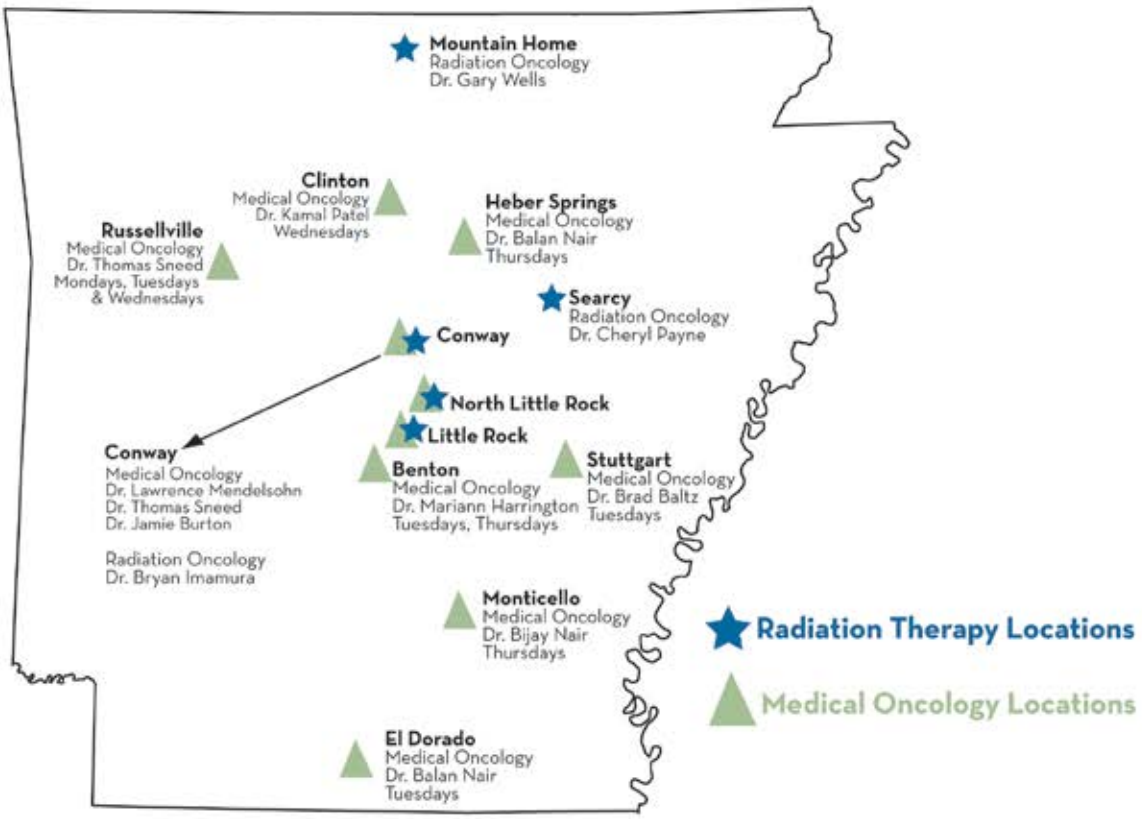


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# A Stitch in Time

By **Melina Druga**

## Stroke research aims to increase treatment window

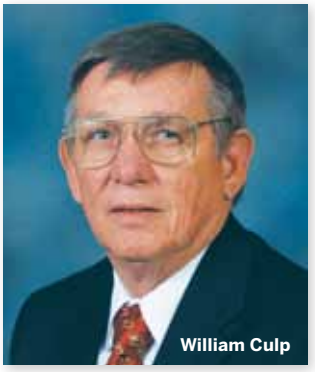
Excited and hopeful are two words used to describe the stroke research Dr. William Culp, an interventional radiologist, and Dr. Robert Skinner, a neurobiologist, are conducting at the University of Arkansas for Medical Sciences. The doctors are working on two treatments, the result of 14 years of work, which would extend the amount of time doctors have to react when a patient has a stroke.

A stroke occurs when a blood vessel leading to the brain bursts or when the blood supply to the brain is cut off by a clot. They can strike at any age, but are more common in people older than 65.

The first treatment, an ultrasound device patented by Cerevast Therapeutics, was developed at the university. The device works by delivering low levels of ultrasound to the blood vessels feeding the brain, helping to dissolve blood clots.

It is in the sixth month of a two year, phase three clinical trial. The device is being tested in 67 hospitals worldwide as part of

**SO FAR, 40 PERCENT OF THE PATIENTS USING THE DEVICE HAVE SEEN IMPROVEMENT**



William Culp

## The symptoms of stroke include:

- A sudden, severe headache without a known cause.
- Sudden vision changes.
- A sudden loss of balance or coordination, trouble walking or dizziness.
- Sudden confusion, difficulty understanding or speaking.
- Sudden numbness or weakness, especially on one side of the body.

If a person experiences any of these symptoms, call 911 and get the individual to a hospital immediately.

the CLOTBUST-ER.trial. The University of Arkansas has 200 patients participating in the trial, but will be expanding to 600 soon. It is the only hospital in the region participating.

Phase three trials seek to answer the question, "Does this treatment work in a large population?" If successful, it will gain FDA approval and worldwide distribution. "It's coming," Culp says. "We hope." So far, 40 percent of the patients using the device have seen improvement, he says.

The second treatment is a drug called dodecafluoropentane or DDFPe which would increase the window of time doctors have to save a patient's brain capacity. The Federal Drug Administration has approved a drug which can be used in the first three hours after a stroke, although Culp says some patients can still benefit as late as 4.5 hours after a stroke.

DDFPe, a neuroprotective, nano droplet, works by helping transport oxygen through arteries, even those with poor blood flow. It is in the animal-testing stage. It can be used for up to 24 hours after a stroke in animals and reduces the effects of stroke by 83 percent "which is huge," Culp says.

The next step would be human testing which is already being conducted in Australia, but the University of Arkansas would be the first U.S. hospital to perform clinical trials. The university hopes to begin the trial later this year, Culp says.

If the treatments are approved, it will be significant for the more than 795,000 Americans who suffer strokes each year. Stroke is the fourth leading cause of death in the United States, killing 130,000 each year, and is the top cause of long-term disability, according to the Centers for Disease Control and Prevention. ■

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## Arkansas Competes in 2014 Text4baby Contest

The Arkansas Department of Health (ADH) has announced its participation in the 2014 Text-4baby State Enrollment Contest, a national competition to provide pregnant and new moms with important information they need for their health and that of their babies.

The Text4baby State Enrollment Contest was established in 2011 and this year's contest runs from May 11 to Nov. 1, 2014. During this time, states will compete to enroll as many participants as possible in the free health and safety service designed for pregnant women and new moms. Text4baby is a service of the nonprofit National Healthy Mothers, Healthy Babies Coalition and is sponsored by Johnson & Johnson. Last year the contest reached more than 1,900 Arkansans with free health and safety information.

Through the text4baby service, Women who text "BABY" (or "BEBE" for Spanish) to 511411 receive three free text messages a week, timed to their due date or their baby's birth date, through pregnancy and up until the baby's first birthday. Text4baby messages will include information on immunizations, appointments, resources, and other health and safety information that leads to better health for moms and their babies. Studies show that women who use text4baby feel more prepared for motherhood because they are armed with the knowledge that leads to better health for them and their babies.

Arkansas won the medium state category in the 2013 contest due to an innovative media campaign with news releases, billboards, media tour, and a grassroots effort through the ADH Sisters United program.

# HEALTHCAREBRIEFS

## STATE

### Some Private Option Clients Lose Coverage

The Arkansas Department of Human Services (DHS) notified 4,798 individuals that their Health Care Independence Program/Private Option coverage would end on May 31 because the federal government incorrectly included their information among applications of eligible individuals.

While reviewing application information from the federal government, DHS Division of County Operations (DCO) staff noticed missing information and income levels that would exclude people from Health Care Independence Program coverage. After questions were raised by DCO staff, the federal government notified DHS that the state had been sent data for people whose applications were "pending verification." Arkansas should only receive applications for people who have been determined eligible and that have been fully verified.

Some of the people who received letters may in fact be eligible, but must go to www.healthcare.gov and provide any information needed to complete the verification process. Others may instead be eligible for coverage through the Federally Facilitated Marketplace and should return to www.healthcare.gov. Loss of Health Care Independence Program coverage is a qualifying event that will allow people to return to www.healthcare.gov even though the open enrollment period has ended.

Individuals who complete the application process and are determined eligible for the Health Care Independence Program will receive retroactive Medicaid coverage and, therefore, will not have a gap in services.

### Allison Leaves State Medicaid Post

Arkansas Medicaid Director Andy Allison left his position on June 1st to pursue other opportunities outside state government. Allison began serving as Arkansas Department of Human Services Division of Medical Services (DMS) and Medicaid Director in November 2011. He said he valued his experiences working for the State of Arkansas "more than any other time in my career."

Dawn Zekis, Medicaid's director of Health Care Innovation since April 2012, will serve as interim Medicaid director while DHS conducts a national search for a new director. Zekis previously served as the DHS Director of Policy and Planning starting in April 2008, and currently oversees Medicaid's payment transformation efforts, called the Arkansas Health Care Payment Improvement Initiative. She has a bachelor's degree in biology and social work from the University of South Dakota, a master's degree from the University of Arkansas's Clinton School of Public Service and is completing her doctorate of public health at the University of Arkansas for Medical Sciences.

### WellCare Names Diaz Medical Director for Five States

WellCare Health Plans, Inc. has named Dr. Victor A. Diaz medical director for its health plan operations in Arkansas, Louisiana, Mississippi, Tennessee, and Texas. He is responsible for overseeing the clinical direction of medical services and quality functions. He also provides medical leadership for the effective care integration of pharmacy operations, utilization/case/disease management activities, and quality improvement activities. He reports to Frank Heyliger, WellCare's region president for Arkansas, Louisiana, Mississippi, Tennessee, and Texas.

### Telehealth Center Forms Multi-State Advisory Council

The Advisory Council of the South Central Telehealth Resource Center, newly established and composed of 18 members from Arkansas, Tennessee, and Mississippi, met for the first time in May. The University of Arkansas for Medical Sciences (UAMS) Center for Distance Health serves as the telehealth resource center for the south central region of the United States.

In late 2013, the Department of Health and Human Services Health Resources and Services Administration renewed grant funding for the center for $975,000 over three years. It funded it for the same amount starting in 2010 when it also designated the UAMS Center for Distance Health as a telehealth resource center.

Representing Arkansas on the Advisory Council are Ray Hanley of Little Rock, president of the Arkansas Foundation for Medical Care; Katie Burns of Little Rock, government and regulatory affairs director for CenturyLink; Sip Mouden of Little Rock, CEO of Community Health Center; Luke Kramer, director of Birch Tree Communities in Benton; Jodiane Tritt of Little Rock, vice president of government relations for the Arkansas Hospital Association; and G. Bradley Schaefer, MD, of Little Rock, chief of the UAMS Division of Genetics.

Six members also serve from Tennessee and six from Mississippi. Members represent telecommunications, primary care associations, mental health services, academic and non-academic hospitals, and rural healthcare organizations.

### Elkins' Clinic Joins Baptist Health Family

Dr. John Elkins' practice, formerly Arkadelphia Women's Clinic, is now Baptist Health Women's Clinic-Arkadelphia. The clinic, located at 312 Professional Park Drive, will continue to serve its current patients. For 30 years, Dr. Elkins has provided obstetric and gynecological care to the women of southwest Arkansas. He is board certified from the American College of Obstetricians and Gynecologists. Dr. Elkins has served as chief of staff at Baptist Health Medical Center-Arkadelphia, as well as chief of surgery.

### Private Option Budget on Target

Actuaries hired to analyze the cost of the Private Option confirmed that spending on health insurance premiums remains in line with the budget approved in the state's federal waiver and will not exceed budget targets after allowable adjustments are made.

Optumas, which worked with the Department of Human Services on the original budget projections for the waiver, used actual enrollment data from the first four months of the Private Option to complete the new analysis. It showed that participants are approximately two years older than the projection used as a baseline for the state's approved


Victor A. Diaz, MD


John Elkins, MD

waiver budget cap, said Optumas founder Steve Schramm.

Because the Private Option is a new program with no historic budget data, the federal government established a standard process for adjusting caps if demographic factors used to create budgets, such as age, turn out to be different than expected.

Optumas found that the increase in age for actual enrollees added $24 dollars to the average premium paid in the first four months of the program, Schramm explained.

### St. Vincent Medical Clinic Opens in Scott

An open house was held at St. Vincent Medical Clinic Scott in celebration of a newly built permanent facility. The 6700 square foot clinic, at 15111 Highway 165 South, is next door to the original temporary clinic that opened in 2011.

The new clinic has nine patient exam rooms compared to the three rooms in the prior facility. There are three physician offices and a larger laboratory. Digital x - rays, with much clearer images, are also now available. For convenience patients can be dropped off at the front door sheltered by the covered driveway.

### Nearly 70% of Eligible Citizens Choose Private Option

The Arkansas Dept. of Human Services reported that nearly 70% of Arkansans eligible for the program (155,567 of the estimated 225,000) signed up for the Private Option in the first six months, surpassing expectations of the level of acceptance in the program's first year. Demographics show most enrollees likely would not have had insurance without the new program.

An analysis of demographic information of those in the Private Option showed that most – 82 percent – had incomes too low to qualify for insurance through the Health Insurance Marketplace.

Statewide, 61 percent of Arkansans in the program are women and 64 percent are ages 19 to 44 years old, a somewhat younger population than those getting coverage through the federal insurance marketplaces, said former Arkansas Medicaid Director Andy Allison. "The average age and sheer number of people in the Private Option will have a significant impact on competiveness and strength of the state's insurance market moving forward," Allison said.

Unlike the Health Insurance Marketplace, which has an open enrollment period that ended March 31, people who are eligible for the Private Option can apply at any time throughout the year.

## LOCAL

### UAMS Chancellor's Circle Awards 10 Grants

University of Arkansas for Medical Sciences (UAMS) Chancellor Dan Rahn, MD awarded 10 grants to UAMS programs at the annual Chancellor's Circle Awards Reception, including one named in honor of longtime fundraiser Sue Williamson.

Announcing that Williamson would retire June 30 after 30 years at UAMS, Rahn said UAMS will establish the Sue Williamson UAMS Medical Center Endowment and that gifts to the endowment would be matched by a $50,000 Chancellor's Circle Matching Grant.

The other nine grants Rahn distributed will allow UAMS educational programs, clinical services, and research projects to fund new projects. The following 10 programs were chosen to receive grants starting at $25,000:

**UAMS Center for Dental Education** – William Slagle, MD, director of the UAMS Center for Dental Education, and Douglas Murphy, PhD, dean of the UAMS College of Health Professions. Kevin Crass, chair of the UAMS Foundation Fund Board and Chancellor's Circle member, presented the award.

**UAMS Physical Therapy Program at UAMS Northwest** – Murphy and Peter Kohler, MD, vice chancellor of UAMS Northwest. Lee Ronnel, lifetime member of the Chancellor's Circle, immediate past chair of the UAMS Foundation Fund Board and current chair of the University of Arkansas Foundation Inc. Board of Directors, presented the award.

**UAMS 12th Street Health and Wellness Center/ Interprofessional Education** – Jeanne Heard, MD, PhD, provost, and Stephanie Gardner, MD, dean of the UAMS College of Pharmacy. Don Munro, member of the Foundation Fund Board and Chancellor's Circle, presented the award.

**Doctor of Nursing Practice Degree Program** – Lorraine Frazier, PhD, dean of the UAMS College of Nursing. Jim Darr, vice chair of the Foundation Fund board, presented the award.

**Precision Medicine Dean's Society Innovation Fund** – Richard Smith, MD, dean of the UAMS College of Medicine. Patti Bailey, corporate roundtable member of the Chancellor's Circle, presented the award.

**Mosquito Control Research** – Helen Benes, PhD, and Larry Cornett, PhD, vice chancellor for research. Sandra Connor, vice chair of philanthropy and Foundation Fund Board member, presented the award.

**UAMS Health Literacy Program** – Kristie Hadden, director of the UAMS Health Literacy Program, and Mark Mengel, MD, PhD, vice chancellor for regional programs. Dick Williams, co-chair of the Volunteer Boards Development Committee of the Foundation Fund Board, presented the award.

**Cord Blood Bank of Arkansas** – Michele Fox, MD, medical director of the cord blood bank, professor of pathology, and director of cell therapy and transfusion. Cindy Pugh, chair of the philanthropy committee of the Foundation Fund Board, and Connor, presented the award.

**Healing Arts Acquisition Project** – Roxane

# HEALTHCAREBRIEFS

Susie Akin

Rhonda Horton

Carol Cassil

Tim Dockery

Townsend, MD, CEO of UAMS Medical Center, and Erin Gray, director of Volunteer Services and Auxiliary. Floyd Kyser, member of the Chancellor's Circle and past member of the Foundation Fund Board, presented the award.

The Chancellor's Circle raises more than $350,000 every year and has raised more than $7 million to date.

## Akin Named Arkansas Hospice Program Director

Arkansas Hospice has named Susie Akin as its program director for Russellville and Conway. Akin, who lives in Pottsville, had previously served as area manager for Arkansas Hospice's Conway office. In her new position, Akin oversees operations in Johnson, Pope, Logan, Yell, Perry, Conway, Faulkner, and Van Buren counties as well as portions of Newton, Searcy, Stone and Cleburne counties.

Akin replaces Rhonda Horton, a Russellville resident who was recently named Arkansas Hospice's director of education and quality. Both Akin and Horton are registered nurses who have bachelor's degrees in nursing as well as master's degrees in business administration.

## UAMS Graduates 931 New Healthcare Professionals

The University of Arkansas for Medical Sciences (UAMS) awarded certificates and degrees this spring to 931 graduates of its five colleges and graduate school during its commencement ceremony at Verizon Arena in North Little Rock.

Diplomas were presented to 161 in the College of Medicine; 214 in the College of Nursing; 125 in the College of Pharmacy; 50 in the Fay W. Boozman College of Public Health; 124 in the Graduate School and 225 from the 21 academic programs that make up the College of Health Professions.

During commencement, degrees and certificates conferred include the doctor of philosophy, doctor of medicine, doctor of pharmacy, master of science, master of nursing science, bachelor of science in nursing, master of public health, doctor of public health, certificate in clinical and translational science, master of health services administration, post baccalaureate certificate in public health and a variety of degrees in allied health disciplines including certificates, associate and bachelor of science degrees, post-baccalaureate certificates, the master of imaging science, and doctor of audiology.

## Cassil Named AFMC Communications Director

Carol Cassil, APR, has recently returned to the Arkansas Foundation for Medical Care (AFMC) to take on the role of communications director. She was previously a senior specialist in the AFMC strategic development department from 2009-12.

Cassil received a Bachelor of Arts degree in journalism from the University of Arkansas at Little Rock, as well as a graduate certificate in nonprofit management. Before rejoining AFMC, she was a vice president for account management and public relations for Thoma Thoma, a Little Rock communications firm.

## UAMS Names Dockery as Director of Planned Giving

Tim Dockery has been named director of planned giving in the University of Arkansas for Medical Sciences (UAMS) Division of Institutional Advancement. He will work with donors who are considering or making planned gifts, will provide counsel and education about planned giving opportunities to the advancement team and continue stewardship of the legacy of donors who include the university in their estate plans.

Before coming to UAMS, Dockery served as general counsel of the Arkansas Baptist Foundation where he helped hundreds of individuals achieve their philanthropic goals through deferred giving and was the lead attorney for a team that helped individuals plan more than $50 million in deferred gifts during his tenure.

## Pre-K Teachers Participate in Health/Science Workshops

Pre-K teachers from central Arkansas learned interactive skills to teach their students how blood flows through the body; how smoking affects the lungs; and how carbon monoxide from tobacco

**A Pre-K teacher listens to her heart through a stethoscope during the workshop "Healthy Hearts and Lungs" at the Centre at University Park.**

smoke affects the heart and increases the risk for heart attack at two interactive workshops hosted by the University of Arkansas for Medical Sciences (UAMS) Partners in Health Sciences Program.

The interactive workshops, "Healthy Hearts" and "Healthy Lungs," were led by Bob Burns, PhD, professor in the Department of Neurobiology & Developmental Sciences in the UAMS College of Medicine. The teachers learned how to actively engage their students in health science concepts and received a training kit with supplies to take back to their classrooms.

The event was sponsored by a grant from the Division of Child Care & Early Childhood Education in the Arkansas Department of Human Services.

## UCA Nursing Department Awards Scholarships

The Department of Nursing at the University of Central Arkansas recently announced scholarships to undergraduate and graduate students.

*Elizabeth Beck*, of Solgohachia, has been selected as the recipient of the Barbara Harpe Nabholz Nursing Scholarship for the 2014-2015 academic year. This scholarship endowment was established by the children and family of Nabholz in her memory. The recognition is awarded to a junior or senior nursing student who is a single parent. The student must be enrolled full-time in required nursing courses and in good academic standing.

*Deanna Allen*, of New Boston, Texas, has been selected as the recipient of the Betty Martin Nursing Scholarship for the 2014-2015 academic year. This scholarship was established in memory of Dr. Betty Martin who was chair of UCA Department of Nursing for a number of years. The scholarship is for a junior or senior nursing student who is enrolled full time in required nursing courses, in good academic standing, and demonstrates high academic and professional standards.

*Sundi Scott* of North Little Rock, has been selected as the recipient of the Clara M. Forsberg Nursing Scholarship for the 2014-2015 academic year. The scholarship is for a junior or senior nursing student, enrolled full-time in required nursing courses, in good academic standing and who demonstrates high professional standards. This scholarship endowment was established by the estate of Carl and Clara Forsberg. Clara Forsberg was a faculty member in the Department of Nursing when the program was first established. She was a woman of high professional standards and expected her students to exemplify those standards.

*Rachel Choate* of Conway, has been selected as the 2014 recipient of the Department of Nursing Graduate Clinical Excellence Award. The recognition is awarded to the graduate nursing student who faculty believe demonstrates exceptional clinical performance.

*Tammy Johnson* of Guy, has been selected as the recipient of the Johnelle Hunt Nursing Scholarship for the 2014-2015 academic year. This scholarship is for a graduate nursing student, enrolled in the nurse educator track and who serves as part-time clinical faculty member within the UCA Department of Nursing. The recipient must be enrolled in the nurse educator track and in good academic standing.

*Olivia Davis* of Beebe, is the 2014-2015 recipient of the University of Central Arkansas, Lauretta Koenigseder Nursing Scholarship Award. The scholarship is for a junior or senior nursing student, enrolled full-time in required nursing courses, in good academic standing and who demonstrates quality nursing care and professionalism.

*Laura Gillis* of Conway, is the 2014 recipient of the Department of Nursing Outstanding Graduate Student Award. The recognition is awarded annually by the faculty to the graduate nursing student who best exemplifies the achievement of program objectives, demonstrates a high level of scholarship, and evidences the advanced professional nursing role.

*Elizabeth Craig* of Little Rock, is the 2014 recipient of the Department of Nursing Outstanding Undergraduate Student Award. The recognition is awarded to the senior nursing student who faculty and other seniors believe has assumed leadership roles and demonstrates the greatest potential for becoming a leader within professional nursing.

*Meghan Mallett* of Conway, has been selected as the recipient of the Suzanne Harvey Graduate Nursing Scholarship for the 2014-2015 academic year. This scholarship endowment was established in memory of Suzanne Harvey by her husband, Dr. David Harvey, and her family. Mrs. Harvey was a graduate of the first UCA nurse practitioner class and was a nurse practitioner for a number of years before her death.

*Katelyn Noland*, of Morrilton, is the 2014 recipient of the Department of Nursing Undergraduate Academic Excellence Award. It is presented annually to the senior nursing student with the highest cumulative grade point average.

The Undergraduate Clinical Excellence Award is awarded to a Level III and a Level IV nursing student whom faculty believes demonstrates exceptional clinical performance. *Sarah Larson*, of Greenbrier, is the 2014 Level III recipient. *Austin Wilson*, of Conway, is the 2014 Level IV recipient.

## Gentry Appointed Chair of UAMS Anesthesiology

William Brooks Gentry, MD, has been appointed chair of the Department of Anesthesiology in the College of Medicine at the University of Arkansas for Medical Sciences (UAMS). Gentry takes the

# HEALTHCAREBRIEFS


William Brooks Gentry, MD


Nelda New


Joseph Bates, MD

position July 1 after the retirement of Carmelita Pablo, MD, who has been in the department 33 years and chair for 13 years.

Gentry has been on faculty at UAMS for two decades as professor in both the Department of Anesthesiology and the Department of Pharmacology and Toxicology. He also served as vice chair for research since 2002. He chaired the UAMS Committee on Clinical Research from 2009 to 2013, and has special clinical interests in ambulatory and trauma anesthesiology.

## New Dietetic Internship Class Announced

The University of Central Arkansas has announced its 2014-2015 Dietetic Internship (DI) Class. The DI is a post-baccalaureate, supervised practice program designed to allow students to complete requirements for both the DI and a master's degree in 15 months. This 15-month program begins in May and concludes in August the following year. The UCA DI is one of only two in Arkansas.

Graduates of the DI receive a verification statement and are eligible to sit for the national exam for registered dietitians. Interns selected for the UCA DI program enroll as graduate students.

The following persons started the DI at UCA in May:

- Rebecca Blaylock
- Candace Casebier
- Hayley Chappell
- Alicia Courtway
- Brenda Green
- Chris Henson
- Amanda Hines
- Rachel Sanders
- Daniela Utrera
- Erica Watson

## UCA Professor Named AANP Fellow

Nelda New, assistant professor, has been selected as a 2014 Fellow in the American Academy of Nurse Practitioners. New was inducted at the organization's annual meeting in Nashville, Tenn., in June. Upon induction, New became the sixth Arkansas nurse practitioner (NP) recognized as an AANP Fellow from a total of 416 nationally.

New's sponsoring fellows focused on her commitment to education and clinical practice. They named her contributions to the conversion of UCA's master of science program for NP to online delivery which resulted in a 400 percent increase in enrollment for the track. New also participated in the development of the doctor of nursing practice.

In clinical practice, the sponsoring fellows highlighted New's work with the Maumelle Medical Clinic as a place where nurse practitioners could practice on a part-time basis. Her work with developing the UCA Student Health Clinic into a full service health care clinic with nurse practitioners and physician providers was also presented and her ongoing clinical practice.

## Joseph Bates Honored by Arkansas Medical Society

Joseph Bates MD, professor of epidemiology and associate dean for public health practice in the UAMS College of Public Health, was recently awarded the Asklepion Award by the Arkansas Medical Society for his contributions to healthcare in Arkansas. Bates is also deputy state health officer and chief science officer for the Arkansas Health Department.

## McDaniel Announces Medicaid Fraud Arrests

Attorney General Dustin McDaniel announced that two Pulaski County women have been arrested for allegedly bilking the Arkansas Medicaid program out of more than $41,000.

Darann Bright Harrison, 57, and her daughter, Tamecia Dion Bright, 34, both of Little Rock, were arrested following an investigation by the Attorney General's Medicaid Fraud Control Unit. Both are charged with Medicaid Fraud, a Class B felony. Both were released from the Pulaski County Detention Center after each posted a $2,500 bond.

The two operate a Little Rock-based day treatment center. Both had already been barred from participating in the state Medicaid program because of previous actions. According to investigators, between Dec. 14, 2011, and at least until Sept. 14, 2012, they sought reimbursement from the program to bank accounts that were not listed under their names, but that were under their control.

Harrison, also known as Diane Bright Harrison, and Bright are accused of forging prescriptions in the name of a Little Rock physician and billing Medicaid for reimbursement. In addition, they are accused of both overbilling for services that were provided by employees or ex-employees and billing for services that were never rendered by employees or ex-employees.

The total amount alleged to have been fraudulently obtained from Medicaid is $41,400. Charges are merely accusations and a defendant is presumed innocent unless and until proven guilty.

## UAMS Researchers Receive NIDA Grant

A team of University of Arkansas for Medical Sciences (UAMS) researchers has received a grant worth $1.45 million from the National Institute on Drug Abuse (NIDA) to study the effects of trauma on adolescent girls in hopes of establishing a direct connection to substance abuse in adult women. Clint Kilts, PhD, director of the Helen L. Porter and James T. Dyke Brain Imaging Research Center at UAMS, is the lead investigator for the study.

The study seeks to understand how physical or emotional trauma in adolescent girls may alter


brain function to result in risky drug use behaviors. The project will also study the relationship of brain function, childhood trauma, and drug dependence in adult women to understand why young girls who have experienced some form of trauma are more likely to develop drug use disorders later in life.

## UCA Health and Behavioral Sciences Dean Named

The University of Central Arkansas announced the appointment of Dr. Jimmy H. Ishee as dean of the College of Health and Behavioral Sciences, effective July 1, 2014.

Prior to TWU, Ishee served as dean of the School of Health Science at Georgia College & State University in Milledgeville, Georgia.

## Doctorate of Nursing Practice Inaugural Class Introduced

Twelve students have been accepted to the University of Central Arkansas' inaugural class for the Doctor of Nursing Practice. The university was approved for the 36-hour practice-focused program in 2013. The program is offered as a post-master's degree. All coursework will be offered online, and students will engage in advanced clinical training and capstone scholarly projects at practice sites.

The following students make up the first cohort class of students:

- Callie Fisher of Sherwood
- Patricia Griffith of Sherwood
- Laura Hall of Maumelle
- Stacy Harris of Conway
- Leah Martin of Russellville
- Rachel Myers of Lafayette, Louisiana
- Lacie Pettito of Little Rock
- Erma Storay of Sherwood
- Amy Ramick of Lonoke
- Frances Stueben of Lafayette, Louisiana
- Lucy Wisemon of Little Rock
- Shannon Woods of Tallahassee, Florida

## Osteoporosis Research Findings Published

A University of Arkansas for Medical Sciences (UAMS) research team has found that reducing the levels of reactive oxygen chemicals in certain cells can increase bone mass and eventually may lead to new treatments for osteoporosis.

Findings from a research effort led by Maria Almeida, PhD, an associate professor and researcher in the UAMS Center for Osteoporosis and Metabolic Bone Diseases, are published in the April edition of the scientific journal *Nature Communications*.

## UAMS Researcher Lands NIH Grant

A surprise discovery that could lead to new treatments for herpes viruses that infect more than 90 percent of the world's adult population has led to a $1.8 million grant to the University of Arkansas for Medical Sciences (UAMS) from the National Cancer Institute (NCI) at the National Institutes of Health (NIH).

UAMS researcher Craig Forrest, PhD, an assistant professor in the UAMS College of Medicine's Department of Microbiology and Immunology, found that a certain protein may suppress the herpes virus and possibly several cancers that are caused by related herpes viruses.

The five-year NCI grant will allow Forrest and collaborating researchers to use innovative genetics techniques to manipulate the herpes virus and its genes as they test the protein (p53), which is known for suppressing cancer.

## Arkansas Hospice Receives Elite Award

Arkansas Hospice has been named as a recipient of the Hospice Honors Elite Award given by Deyta, a data-gathering company that partners with thousands of hospice, home health, human services and other healthcare organizations. The award recognizes hospice agencies that continuously provide the highest level of satisfaction through their care as measured from the caregiver's point of view. Receiving the honor places Arkansas Hospice in the top 2 percent of 1,700 hospices across the nation that use Deyta's services.

## UCA Professor Named Distinguished Scholar and Fellow

The National Academies of Practice announced the election of Julie B. Meaux, Department of Nursing professor, as a Distinguished Scholar and Fellow member of the NAP. Meaux was inducted at a Gala Membership Banquet in Alexandria, Virginia. New members were inducted following a forum on "One Team – One Health."

Membership in the NAP is an honor extended to those who have excelled in their profession and are dedicated to furthering practice, scholarship and policy in support of interprofessional care. ■

# Electronic Cigarettes, Electronic Nicotine Delivery Systems (ENDS)

## and Other Vapor Products Can Have Serious Health Consequences

In the last several years, Electronic Nicotine Delivery Systems (ENDS) have begun to penetrate the Arkansas environment. These devices, also known as e-cigarettes, e-cigars, vaping devices, e-hookahs, etc., usually have some type of nicotine base in a suspension (such as propylene glycol or glycerin) often mixed with flavorings including menthol. Since these are relatively new products, there is a lot of uncertainty and misinformation surrounding them. There are many reasons why ENDS should be avoided.

ENDS contain nicotine, a tobacco product under current definitions, and are not a therapeutic product. Unofficially, they have been promoted as cessation aids with claims of reduced harm and safety in the public space. The FDA, under the Tobacco Control Act and subsequent judicial decisions, has the authority to regulate ENDS and has begun the process of approving regulatory documents. Because of the extensive process and anticipated pushback from the ENDS industry, FDA regulations are likely to take several years to fully implement.

Among the public health concerns related to the use of these products is nicotine poisoning. Since January 1, 2014, there have been 30 calls to the Poison Control Hotline in Arkansas related to poisoning from the liquid nicotine (so-called "e-juice") used to fill ENDS cartridges. Seventeen of those 30 were for children under the age of five. Liquid contained or used in e-cigarettes or vapor devices should not be accessible to children. Parents should not allow children to play with electronic cigarettes or similar devices. These contain batteries and liquid chemicals which, if swallowed, could cause serious health complications. Bottles of e-juice, used in e-cigarettes, are a poison risk for small children and pets. In addition, ENDS vapor has been reported to condense in the environment, and residue can be found on carpet, glass and other surfaces, creating a risk for crawling infants and pets and ultimately creating a toxic dust.

For those who use ENDS, there is clear ongoing exposure to nicotine. Because ENDS are currently unregulated, there are wide variations in product concentrations of nicotine. Nicotine is toxic and highly addictive and affects the nervous system and heart. It can be absorbed into the body through inhalation, ingestion, and skin contact. The Health Consequences of Smoking–50 Years of Progress: A Report of the Surgeon General (2014) notes that the evidence is sufficient to infer that nicotine activates multiple biological pathways through which smoking increases risk for adult onset diseases, including atherosclerosis, coronary heart disease, type 2 diabetes, obesity, and cancer.

Nicotine may also adversely affect pregnancy outcomes and fetal development, and pregnant women should avoid using ENDS. Nicotine crosses the placenta and can damage the lungs, heart, and central nervous system of the developing fetus. Pregnant women should be informed that exposure to nicotine in conventional cigarettes or ENDS may cause miscarriages or low birth weight; affect their unborn baby's blood flow, heart rate,

**Nathaniel Smith, MD, MPH**
Director and State Health Officer,
Arkansas Department of Health

**BECAUSE ENDS ARE CURRENTLY UNREGULATED, THERE ARE WIDE VARIATIONS IN PRODUCT CONCENTRATIONS OF NICOTINE**

and breathing; contribute to sudden infant death syndrome (SIDS); and create significant health challenges for their babies.

Confusion has developed in environments where clean indoor air laws apply because ENDS are often misidentified as cigarettes. ENDS are re-normalizing smoking behaviors and threaten to reverse clean indoor air gains. Further, secondhand vapor contains chemicals that can be inhaled by non-users. Bystanders can absorb nicotine, propylene glycol, and tobacco-related contaminants, such as formaldehyde, acetaldehyde, and acrolein. Blood levels of nicotine in non-smoking people exposed to ENDS vapor have been documented. ENDS have also been adapted for use with other non-tobacco substances such as marijuana, cocaine, and methamphetamine solutions.

According to a preliminary report in North Carolina, heavy promotion and misunderstanding of ENDS has led some healthcare providers to promote these products. In one survey, two of three physicians believed that ENDS helped with smoking cessation, and one in three prescribed ENDS for their patients. In reality, it is illegal for ENDS to be marketed as smoking cessation aids, and a number of electronic cigarette companies have received warning letters from the FDA for making such claims. ENDS have not been proven effective for smoking cessation, nor have they been shown to be superior to current safe and effective FDA-approved nicotine replacement therapies. In fact, some studies suggest decreased effectiveness of cessation treatments when clients are using ENDS.

Arkansas Act 1188 of 2013 prohibits distribution of "alternative nicotine products" directly, indirectly by an agent or employee, or through vending machines to minors under the age of 18. "Alternative nicotine products" includes both e-cigarettes and any product containing nicotine that is intended for human consumption. The age of the individual purchasing these products must be verified using a photographic identification card, or if purchased online, verification must be performed through an independent, third-party age verification service. Pending approval, FDA will restrict sales to children at the federal level.

Despite these restrictions, parents should be aware that electronic cigarettes and similar ENDS are available in a variety of flavors such as bubble gum, strawberry, chocolate, and mint, which may be attractive to children and adolescents. Of note, e-cigarette use among middle school and high school students in the U.S. doubled to 1.78 million students from 2011 to 2012, according to the U.S. Centers for Disease Control and Prevention (CDC).

For the reasons outlined above, the Arkansas Department of Health recently issued a Public Health Advisory to consumers concerning e-cigarettes and other ENDS. These devices contain and emit harmful chemicals, are currently unregulated, and pose known and unknown health risks to users and non-users alike. ■

# Let's not lose ground in our war against childhood obesity

Something often said by health researchers really resonates with me as both a father and a pediatrician; this generation of children may be the first in U.S. history to live shorter, less healthy lives than their parents. The primary culprit in this is childhood obesity resulting from **improper nutrition** and a **lack of physical activity**.

As Congress works to pass agriculture appropriations, the U.S. House of Representatives has included in its bill a waiver to allow schools to opt out of complying with all school meal standards if they show any decline in revenue over six months in the previous year—regardless of the reason for the decline. While this legislative issue may be resolved one way or the other by the time this article is published, it represents a renewed call to action for Arkansans to ensure that we do not lose hard-won ground in our war against childhood obesity.

Despite significant progress made on many fronts, and a leveling-off of the upward trajectory that obesity rates have taken over the past few decades, one of every three children in Arkansas is overweight or obese. Further, Arkansas has been ranked as the most physically inactive state in the nation in a recent report by the Trust for America's Health. Why do we have this problem? It is the unintended result of progress and convenience that has created communities that do not support healthy lifestyles. Too many of the foods we have convenient access to are unhealthy. Because of land use decisions that have limited access to sidewalks and parks, along with safety concerns, physical activities like walking and riding a bike are no longer a routine part of our lives. Lack of access to affordable nutritious foods and safe places for physical activity is an even greater problem in poor communities and in communities of color that have been hardest hit by the obesity epidemic.

Roughly one-third of the meals consumed by our children each year are provided at school, making schools an undeniable stakeholder in child nutrition and in teaching children how to eat healthy. This is especially meaningful in Arkansas, where nearly 28 percent of our children—28 percent!—suffer food insecurity, meaning that food is not always available to them on a regular basis. For far too many kids, school meals are the only ones they can count on receiving. We must stay the course in making these meals optimally nutritious.

From a strictly economic perspective, it is short-sighted to think of saving money at the expense of making sure that the meals provided to children during the school day are healthy. While school resources are stretched thinly across the state, it is important to note that obese children often remain obese as adults. Health care costs are far greater for those who are obese than for healthy weight individuals, and those costs only increase as people age. Today one of every five dollars of our economy is spent on health care. If we don't continue to push forward to reduce childhood obesity, we will not be able to afford the avalanche of health care costs headed our way. Early improvement of eating habits using tools provided to schools through Arkansas Act 1220 of 2003 and the national Healthy, Hunger-Free Kids Act passed in 2010 is a significant part of the solution.

Arkansas led the nation in efforts to combat childhood obesity with Act 1220 of 2003. In fact, many of the child wellness standards included in the federal Healthy, Hunger-Free Kids Act of 2010 and the proposed rules recently announced by the White House and the U.S. Department of Agriculture are similar to what was established in Arkansas as a result of Act 1220. The Act mandated establishment of school district wellness committees with membership composition requirements inline with currently proposed federal rule. Additionally, the Act established a Child Health Advisory Committee tasked with developing and recommending standards to the Board of Education. As a result, the board adopted the following rules in 2005:

- Local wellness policies are included in school food assessments submitted to the Arkansas Department of Education (ADE) and are part of child nutrition performance reviews.
- All public school districts are to include in their annual report to the community the total revenue they receive from food and beverage contracts and how they have spent that money.

**Joseph W. Thompson, MD, MPH**
Arkansas Surgeon General and Director,
Arkansas Center for Health Improvement

• ADE is charged with the monitoring and evaluation of all nutrition and physical activity standards.

• ADE is required to promote grade-appropriate nutrition education as part of a broad-based integrated health education program.

Within its responsibilities as outlined in Act 1220, the Child Health Advisory Committee created an allowable competitive foods/beverage maximum portion size list, which is updated annually. For several years, the approved foods/beverages have had to meet nutrition criteria that are just now coming under the federal rules. This includes zero grams of trans-fat; caffeine maximum limits; only low fat or non-fat milk; 100% juice; unflavored, unsweetened water and diet carbonated/non-carbonated beverages; and portion size limits on beverages.

Criteria have been established for on-campus fundraisers limiting unhealthy food sales to off-campus.

In addition, Arkansas Act 2285 of 2005 requires school district child nutrition directors to provide their menus to the district wellness committee for review. More recently, the Child Health Advisory Committee has developed recommendations for food marketing that have been sent to ADE for review and submittal to the Board of Education. The Little Rock School District has had these marketing limitations on their vending machines since 2006.

Regardless of what happens at the federal level, we here in Arkansas have come too far to stop now. More than that, we need to step-up our efforts.

As health care professionals, we have new opportunities to make a positive difference for our patients facing the health risks associated with childhood obesity. Through patient-centered medical homes, we can use our teams to help counsel families on proper nutrition and physical activity. We can refer patients for intensive behavioral counseling, which is now reimbursable as a result of the Patient Protection and Affordable Care Act. And, we can take the battle outside of our offices and join the effort to intentionally create environments where the healthy choice is the easy choice for families. Over the years, many health care professionals have joined educators, mayors, students, and others in stepping up to make meaningful changes that create healthier school and community environments. The majority of our schools are successfully meeting the updated nutrition standards and kids are eating more fruits and vegetables and fewer non-nutritious, calorie-laden foods and beverages. And there are significant pockets of success. For example, a recent evaluation of the Fresh Fruits and Vegetables Program in Arkansas public schools conducted in partnership between investigators at the University of Arkansas (Rodolfo Nayga and colleagues) and the Arkansas Center for Health Improvement found that students attending public schools with the program evidence a four percentile point reduction in body mass index (BMI) percentile compared to students in schools without the program in place. This is particularly promising in light of the fact that the cost of the program is estimated to be only 50-75 dollars per student per year.

**ARKANSAS LED THE NATION IN EFFORTS TO COMBAT CHILDHOOD OBESITY WITH ACT 1220 OF 2003**

The most successful efforts are led by champions who refuse to accept "we can't," and instead set out to prove that we can. If you haven't done so already, I encourage you to enlist in the war on childhood obesity. Just a couple of hours a month can make a huge difference. Join your school district's wellness committee, get involved with a school-based wellness center, have lunch with the child nutrition director or principal of a local school to discuss needs and offer to help, or contact the Arkansas Coalition for Obesity Prevention at www.arkansasobesity.org for other ways to get involved. There are many online resources available to help guide you in finding a way to engage, including www.LetsMove.gov. The National Institute for Children's Health Quality also provides some great resources, including a strategy guide and online obesity prevention advocacy training at www.nichq.org/advocacy.

The negative social and economic impact of childhood obesity affects us all in one way or another. We need all hands on deck to reverse this deadly epidemic. Are you on board? ■

# Current Trends: Patient Engagement

## Involve Patients for Better Health Care Lower Costs

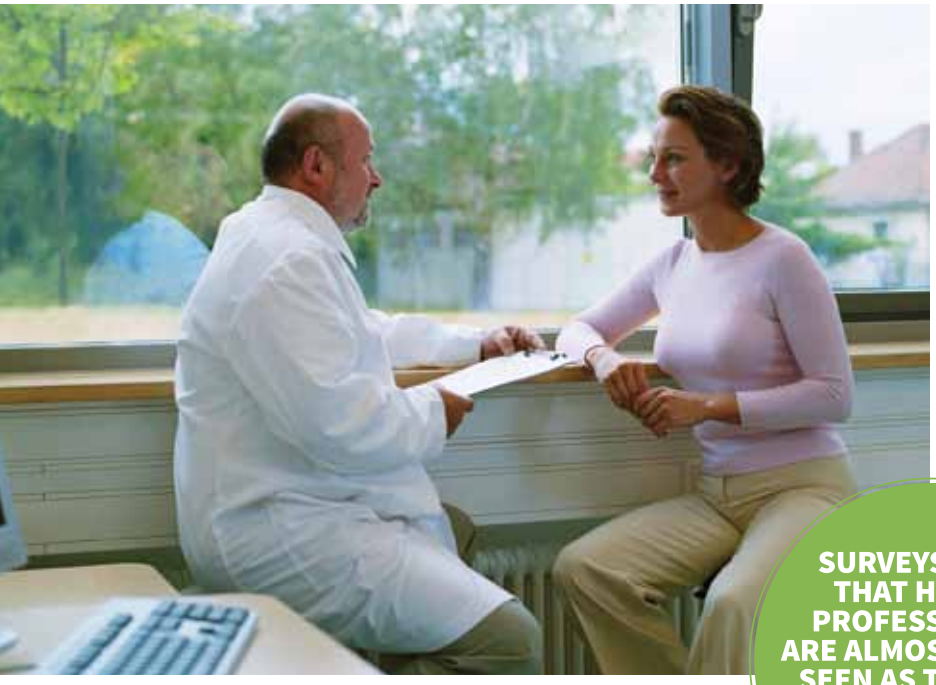
The latest "hot trend" in health care is patient and family engagement – an ongoing and constructive dialog between the patient, patient's family, and provider with the aim of improving the patient's overall health. It is touted by every health care organization working to improve quality and reduce costs. The Centers for Medicare and Medicaid Services (CMS) has made patient engagement a cornerstone of several initiatives, including patient-centered medical home (PCMH) and Stage 2 of Meaningful Use.

There is solid data behind this trend. A growing body of evidence demonstrates that patients who are more actively involved in their health care will experience better health outcomes and incur lower costs. One study found patients with lower "patient activation scores" (a component of patient engagement) had 21 percent higher health care costs the following year when compared with patients with higher patient activation scores.[1] Patient engagement also affects how a provider is perceived. A study conducted by the National Research Corporation[2] shows a direct correlation between patient experience and an organization's reputation. According to the study, "hospitals with low patient experience scores are four times more likely to have poor reputation scores."

While many patients turn to the Internet and other sources, surveys show that health professionals are almost always seen as the main source of health information and support.

Providers can use a variety of options to connect with their patients on an ongoing basis. To foster effective engagement, look for opportunities outside of usual business hours. Fortunately, modern technology makes this relatively simple for most providers.

**Ray Hanley**
President and CEO,
Arkansas Foundation
for Medical Care



**SURVEYS SHOW THAT HEALTH PROFESSIONALS ARE ALMOST ALWAYS SEEN AS THE MAIN SOURCE OF HEALTH INFORMATION AND SUPPORT**

A good way to engage patients is through an online web-based connection called a patient portal. The portal allows patients to access their personal health information securely and reliably from their personal computer. These portals also connect the patient and provider through secure messaging that is encrypted and HIPAA-compliant. Patients and providers can quickly exchange information, send health information to another provider, give patients quick and easy access to lab results, current medications, hospital discharge instructions, and other information – without an in-office visit or phone call. Meaningful Use Stage 2 requires two-directional, secure messaging with patients so a provider and patient can connect and exchange information in a secure and convenient format. About 40 percent of office-based physicians currently have a portal through their electronic health records.

Social media provide an array of options. Many Arkansans use Facebook and other social media sites like Twitter, YouTube, and Instagram. Providers can use these channels to address general health issues and topics without increasing their overhead. The Center for Social Media at the Mayo Clinic reports zero cost for the Mayo Clinic's social media (Facebook, YouTube, and Twitter) and $75 annually for a customized blog. More than 1,300 physicians have joined twitterdoctor.net, a site that bills itself as a directory of the most influential doctors on Twitter. The number is indicative of a new generation of physicians using social media to comment on health and medical issues. It is important to note that no social media site should be used to dispense medical advice or comment on a patient.

If you decide to use Facebook to connect with patients, it's important to set up a separate Facebook page for patients to serve as your public persona. This is separate from your personal profile which should not be accessible to your patients. Your comments on the patient page should never include patient information and should always be professional. Ideas for page content include information on health screenings, weight management tips, update on changes to clinic hours, and relevant blog posts. The Institute for Health Technology Transformation recommends patient reminders, instructions, and educational information about their diagnosis and treatment options. You will be most effective on social media by using plain language in your content and encouraging user interaction.

Most people want to know what they can do to help themselves. Patients are more likely to make positive health changes when they take responsibility for their health and feel invested in their health care services. The more a patient understands, the more likely he or she is to ask questions, learn, and obtain the care that meets his or her specific needs. Providers can encourage this by teaming up with their patients, encouraging and enabling them to take responsibility for their health and quality of life. ■

[1] Hibbard J. Greene J. Overton V. Patients With Lower Activation Associated With Higher Costs. *Health Affairs*, February 2013 vol. 32 no. 2 216-222

[2] Davies E. Cleary D. Hearing the patient's voice? Factors affecting the use of patient survey data in quality improvement. *Quality and Safety in Health Care* 2005; 14: 428-432


Type 1 diabetes (T1D) is an autoimmune disease, unrelated to diet or lifestyle, that creates a lifelong dependence on injected insulin. Affecting both children and adults, it carries the constant burden of life-threatening complications and never-ending management.

But JDRF has a plan to change all that. As the largest non-profit funder of T1D research in the world, we're working to deliver life-improving therapies until we can put an end to T1D entirely. But we need your help.

Together, we will create a world without type 1 diabetes.

Join us now at jdrf.org/theplan

JDRF IMPROVING LIVES. CURING TYPE 1 DIABETES.


## UT Cyclists Roll Through Cancer Institute

About 30 University of Texas students participating in Texas 4000, the longest charity bike ride in the world, stopped at the UAMS Winthrop P. Rockefeller Cancer Institute as they passed through Little Rock on their way from Austin, Texas to Anchorage, Alaska. The students will be on the road for 70 days

This is the second year for the Texas 4000 cyclists to stop at the UAMS Cancer Institute. As part of their participation in the program, the students raise money for cancer research and patient support services and visit cancer centers across the country.

During their stop at the UAMS Winthrop P. Rockefeller Cancer Institute, they got to visit with both doctors and patients. Many of the riders have a connection to the cause, riding in honor of family members and friends affected by cancer.

# HOSPITAL ROUNDS

Gareth Morgan, MD, PhD

## Morgan to Lead UAMS Myeloma Institute

World-renowned multiple myeloma researcher and clinician Gareth Morgan, MD, PhD, has been named director of the University of Arkansas for Medical Sciences (UAMS) Myeloma Institute for Research and Therapy (MIRT).

Morgan, who is currently a clinician and researcher with the Myeloma UK Research Centre at the Institute of Cancer Research in London, will begin at UAMS on a full-time basis in July. He is a director of Myeloma UK, a respected patient organization, as well as a member of the Scientific Board of the International Myeloma Foundation, Scientific Secretary for the UK Myeloma Forum, and founding director of the European Myeloma Network.

Morgan succeeds Bart Barlogie, MD, PhD, the institute's founder who has chosen to step down as director, but who will remain to focus on clinical care and research.

In support of the Myeloma Institute and Morgan's recruitment, Gov. Mike Beebe has provided $5 million from General Improvement Funds. In a $3-for-every-$1 match, philanthropic contributions raised by UAMS have provided another $15 million for a total of $20 million. Goldman Sachs Philanthropy Fund, at the recommendation of Carol A. Ammon, chair of the Myeloma Institute Advisory Board, and her spouse Marie Pinizzotto, MD, made the first matching gift of $5 million. The $20 million will help pay for the construction of new laboratories and the institute's research program.

Founded in 1989, the myeloma program at UAMS has seen more than 11,000 patients from every state in the United States and more than 50 foreign countries and has performed more than 9,000 peripheral blood stem cell transplants. Barlogie and his colleagues fundamentally have changed the course of the disease and its effects through new diagnostic procedures and novel therapeutic interventions.

The work Morgan proposes to develop is already in progress at the Myeloma Institute through the application of commercially available drugs that target unique oncogene mutations. Morgan holds more than $10 million of research grant funding from various governmental and private philanthropic sources.

Morgan received his doctorate on the genetics of leukemia from the University of London in 1991 and his bachelor of medicine in 1981 from the Welsh National School of Medicine. Since 2003, he has served as a professor of Hematology and director of the Centre for Myeloma Research at the Royal Marsden NHS Foundation Trust and The Institute of Cancer Research in London, Europe's largest comprehensive cancer institute. Morgan is a director of Myeloma UK, the UK's respected patient organization, as well as a member of the Scientific Board of the International Myeloma Foundation and Scientific Secretary for the UK Myeloma Forum. He is also a founding director of the European Myeloma Network.

## Ultracyclist Racing for Methodist Family Health

Kurt Searvogel of Sheridan, and cycling buddy Joel Sothern, competed in the Race Across America, a 3,000-mile nonstop competition billed as the world's toughest bike race, in support of Methodist Family Health. Searvogel and Sothern's "Team Flying" will have nine days to complete the journey from west to east coast.

Team Flying has selected Methodist Family Health as its charity of choice and recipient of a portion of their sponsorship proceeds. Searvogel and his wife Trish have been friends and supporters of Methodist Family Health since 2006, when they learned about the historic Methodist Children's Home and other programs managed by MFH at their church, First United Methodist in Sheridan.

The team races to raise money for and to showcase "the great work of the Methodist Children's Home," according to their web site, www.kashweb.com, and to focus on "living a balanced, happy and healthy lifestyle that promotes respect for all beings everywhere."

Cyclasana Balanced Fitness, a Sheridan yoga studio, assisted Team Flying by recruiting sponsors for portions of the route the cyclists traveled during the Race Across America. Sponsors received team T-shirts and jerseys, depending on sponsorship level. The Methodist Children's Home will receive 75 percent of the net proceeds of the sponsorships.

## UAMS Joins AROK Purchasing Coalition, LLC

VHA Inc. has announced that the University of Arkansas for Medical Sciences (UAMS) has joined the AROK Purchasing Coalition, LLC. The AROK Purchasing Coalition, a VHA supply network, includes more than 50 healthcare organizations across Arkansas and Oklahoma. Their members collaborate to increase efficiencies and reduce expenses by establishing contracting strategies that meet unique needs and aggregate spend across the supply chain.

UAMS is Arkansas' only academic health sciences university. UAMS Medical Center has 430 beds and staff physicians treat hundreds of thousands on an outpatient basis each year. UAMS also provides care through eight regional medical centers and a comprehensive Rural Hospital Program. It's Myeloma Institute for Research & Therapy has treated more than 10,000 patients from every state in the U.S. and more than 50 countries.

"By joining AROK, UAMS will be able to access resources to quickly improve supply chain performance as well as collaborate with a network of our peers to foster innovation and improvements that will benefit our patients and the communities we serve," said Roxane Townsend, MD, UAMS Medical Center CEO and vice chancellor for clinical programs.

The AROK Purchasing Coalition was established in 2008 to stabilize and drive down non-salary expenses of the member organizations for supplies, pharmaceuticals, equipment, new

technology, and purchased services. AROK transacts over $705 million annually in member purchases and has saved members approximately $50 million since its inception.

## Retailers Raise Funds for Children's Hospital

From May 1 through June 11, Walmart customers and Sam's Club members had the opportunity to change children's lives by making a donation of $1 or more to Arkansas Children's Hospital (ACH), the regional Children's Miracle Network Hospital. Walmart and Sam's Club locations across Arkansas, eastern Texas, northern Louisiana, and eastern Oklahoma raised funds for ACH during the six-week period.

100 percent of donations flowed directly to ACH. Donations provided each year — with most given $1 at a time — have had a significant impact on improving children's health in Arkansas.

In 2013, Walmart and Sam's Club raised more than $1.3 million for ACH, which is the only pediatric hospital in the state. The funds raised through Walmart and Sam's Club help thousands of children each year, including kids like 6-year-old Anna from Jonesboro, who was born prematurely; 4-year-old Dyer from Rogers who woke up one morning with a dislocated neck; and 2-year-old Kenzie Ford from Hope, who was born with dwarfism.

All funds raised during the Walmart and Sam's Club campaign will be celebrated as part of a larger fundraising effort. Arkansas Children's Hospital is currently in the midst of the Century of Possibility Campaign, which will raise $160 million in support of pediatric care, research, education, and prevention programs at the hospital. The campaign has already raised $149 million and will conclude in December 2014.

Since 1987, Walmart and Sam's Club fundraising across North America has provided more than $700 million for pediatric care. Funds are used by the community hospital to meet the greatest need — helping to provide necessary charitable care, establish critical care wings, introduce therapy programs, and fund specialized, life-saving treatment and equipment.

UAMS Chancellor Dan Rahn introduces the 11 members in the first group to complete the UAMS Project SEARCH internship program.

## First Interns Graduate Project SEARCH

The celebration proved emotional and joyous as the first group of interns in the University of Arkansas for Medical Sciences' (UAMS) Project SEARCH program for young adults with disabilities completed the yearlong internship with all 11 ready to move on to employment. Each of the young adults in the first group to complete the UAMS Project SEARCH internship program took a moment after receiving their certificate at the May 30 graduation ceremony to offer thanks and celebrate what they had learned in the past nine months.

The interns in UAMS Project SEARCH — a partnership between UAMS, ACCESS, and Arkansas Rehabilitation Services — started last August at UAMS, working jobs in patient transport, nutrition services, central supply, the mailroom, human resources, and other areas.

Hollis Carter, whose daughter — intern Becky Carter — had been talking about the graduation "non-stop" for three weeks said, "Her mother and I worried that when she left school, her world might get smaller, not larger. This program has expanded her world. Thank you to the three organizations who had the great vision to start this program in Little Rock."

Arkansas first lady Ginger Beebe joined UAMS Chancellor Dan Rahn, MD, and leaders from ACCESS and Arkansas Rehabilitation Services to celebrate their graduation from the program and the program's success in helping prepare them for employment.

UAMS Project SEARCH, the first program of its kind at an Arkansas university and the only in central Arkansas, was modeled after the internationally successful Project SEARCH program started at the Children's Hospital Medical Center in Cincinnati, Ohio.

Ten of the 11 interns have found employment so far with companies and organizations that include the city of Little Rock, Crothall Healthcare, Dillard's, Maverick Transportation, Developmental Disabilities Council, St. Vincent Health System, and UAMS.

UAMS served as the host business for the program, providing entry-level work experiences that match each intern's skills. ACCESS advisors met the interns daily for vocational instruction, job coaching and lessons in independent living skills. Arkansas Rehabilitation Services provided financial support for the program, applied directly to vocational education and career development. The goal was to help participants build competitive, marketable and transferable skills and enable them to apply for a related job upon completion of the internship.

# HOSPITAL ROUNDS

Founded in 1996, Project SEARCH has grown to an international one-year internship program for individuals with developmental disabilities who desire sustainable, competitive employment. Its proven training and employment model spans more than 200 licensed programs across the United States, five countries, and multiple industries.

UAMS Project SEARCH interns were selected for the program following interviews with a selection committee made up of representatives from the three organizations. Eligibility criteria include having an intellectual disability, developmental disability, and/or a referral from Arkansas Rehabilitation Services; a high school diploma, GED or certificate of completion; appropriate social, communication, and independent living skills for participation in a work program; and reliable transportation to and from work. The interns also met UAMS employment requirements such as immunizations, the ability to observe patient privacy rules, pre-employment drug screening, and background checks.

A group of 12 interns has been accepted for the 2014-2015 UAMS Project SEARCH program. They will begin their internship experience this summer.

## UAMS, UAF Offering Grants to Spur Telehealth

The University of Arkansas for Medical Sciences (UAMS) Translational Research Institute and the University of Arkansas, Fayetteville (UAF) are offering pilot grants to study the state's nationally leading telehealth programs, a relatively new practice that allows doctors to reach patients in distant locations.

The one-year Translational Research Institute Pilot Research Awards will fund as many as four telehealth projects at up to $15,000, with an additional $5,000 available to projects that involve a UAF collaborator.

Telehealth uses two-way interactive video and imaging devices to deliver specialized medical services, from emergency stroke treatment to the care of premature infants. Arkansas ranks second nationally in telehealth availability, and it has the lowest ratio of rural residents to telehealth sites, according to the National Telehealth Resource Centers Report.

UAMS has more than 40 pioneering clinical telehealth programs that utilize the state's infrastructure, but many of the programs lack the data needed to promote broader adoption, said Laura James, MD, director of the UAMS Translational Research Institute.

The institutions' leaders said the collaborative funding initiative is designed to foster research between physicians engaged in telehealth programs and researchers.

"We expect to see research that tests the clinical outcomes, cost effectiveness, and comparative effectiveness of these programs so that they can be more broadly adopted to meet the health care needs of Arkansans," said Cynthia L. Sagers, PhD, associate vice provost for Research and Economic Development at UAF. "Collaborations between UAMS and UAF enhance our research capacity, our reputation and our service to the state."

Every county in Arkansas has at least one telehealth site and most counties have several. All UAMS Regional Centers, most of the state's hospitals, Federally Qualified Health Centers, and county health departments are linked through telehealth. Arkansas has 945 telehealth endpoints, 421 anchor health care institutions, and 495 interactive video units.

The UAMS Translational Research Institute's mission is to help accelerate research that will improve the health and healthcare of people in Arkansas and across the country. TRI is one of 62 recipients of a National Institutes of Health (NIH) National Center for Advancing Translational Sciences (NCATS) Clinical and Translational Science Award (CTSA).

## Pavlas Named to Baptist Health Foundation Board

Jerry Pavlas, Onebanc president and CEO, was recently named as the newest member of the Baptist Health Foundation's Board of Trustees. Pavlas, who began serving in May, will continue his board duties until December 2020.

Pavlas began his 40 plus year career after receiving his accounting degree from Cleveland State University. During that time, he has accumulated an extensive background in lending, strategic growth initiatives, market expansions, risk management, re-capitalizations, and acquisitions. Prior to joining Onebanc in 2012, Pavlas served as CEO of Southwest Securities in Dallas, Texas. In addition to his work, Pavlas is committed to helping his community through the Cystic Fibrosis Foundation and now the Baptist Health Foundation Board of Trustees.

## St. Vincent Morrilton Begins ED Renovation

A groundbreaking ceremony was held at St. Vincent Morrilton recently to mark the start of construction to renovate, expand, and relocate the emergency department to the east side of the hospital campus. The current emergency department location and operation will not be impacted by the renovation. It will remain on the west side of the hospital.

This is more than a renovation, it is also an expansion. When completed, St. Vincent Morrilton will have more than double the number of emergency exam rooms. The square footage of the emergency department will increase from 2,800 to 7,000 square feet. Total cost of the project is $1.5 million.

St. Vincent Auxiliary President Deloris Hartman presented a $60,000 check on behalf of the Auxiliary to help pay for the renovation and expansion. Auxiliary members raised the money with fundraisers throughout the last two years with bake sales, silent auctions, raffles, drawings, and the sales of breakfast and lunch at St. Vincent Morrilton Grill – the employee cafeteria.

The renovations are scheduled to be completed by Nov. 1, 2014. Architects for the project are Wittenberg Delony & Davidson Architects. Western Millwright is the contractor.

## Physicians' Donations Help Further Medical Education

The Conway Regional Health Foundation awarded scholarships to 14 area students recently, totaling $25,800. All the scholarship recipients are pursuing education in an advanced healthcare related field. The students received scholarships based on grade point average, leadership ability,

**St. Vincent Morrilton Begins ED Renovation**
L-R: Kevin Johnson, Administrative Director, Facilities, St. Vincent; Stewart Nelson, Mayor, Morrilton; Ed Peek, Architect, Wittenberg Delony & Davidson, Architects Tom Miller, Contractor Western Millwright; Chad Aduddell, President St. Vincent Infirmary; Leslie 'Bubba' Arnold, President St. Vincent Morrilton; Sharlene Mourot, Nurse Manager, St. Vincent Morrilton; Charles Penick, Chairman, St. Vincent Morrilton Board of Directors; Angie Longing, BSN, MHSM, RN, NE-BC, Executive Director of Nursing; Jimmy Hart, Judge, Conway County: Delores Hartman, President St. Vincent Morrilton Auxiliary

activities, and financial need. Scholarship recipients and their families were recognized during a reception in the Conway Regional Auditorium.

The scholarships are funded by private donations to the Health Foundation. During the reception, Conway Regional President and CEO Jim Lambert recognized the support of the medical staff which donated funds for seven of the scholarships as well as several private scholarship donors. The medical staff scholarships totaled $11,900.

This year's group of scholarship recipients includes students who aspire to become doctors, nurses, therapists, and radiology technologists. These students come from a variety of public and private school backgrounds and have been accepted or are currently pursuing higher education at the University of Arkansas for Medicine Sciences, University of Central Arkansas, University of Arkansas at Fayetteville, and Arkansas State University in Jonesboro.

Physicians on the Conway Regional medical staff make an annual donation to fund scholarships. The six Conway Regional Medical Staff recipients are:

• Joshua Ryan Blaylock of Little Rock is a student in the UAMS College of Medicine. Blaylock holds a bachelor's degree from the University of Arkansas at Fayetteville. He is a graduate of Conway High School.

• Kaitlyn Brickey of Greenbrier will pursue a bachelor's degree in Pre-medicine at the University of Arkansas in Fayetteville. She is scheduled to graduate from Greenbrier High School.

• Antonia Michelle Byrd of Conway is pursuing a bachelor's degree in Radiography at UCA. She is a graduate of Conway High School.

• Andrea Eades of Conway is working toward a bachelor's degree in Pre-medicine from the University of Arkansas at Fayetteville. She is a graduate of St. Joseph High School.

• Emily Jean Smithson of Little Rock is pursuing a master's degree in Occupational Therapy from UCA. She holds a bachelor's degree in Allied Health from Hendrix College. She is a graduate of Conway High School.

• Morgan Danielle Sweere of Conway will pursue a bachelor's degree in Biology at UCA. She is scheduled to graduate from Conway High School.

The seventh scholarship is in honor of William Furlow, MD, a retired Conway physician who helped establish the first CCU in Conway. The recipient this year is Kaleb Brent Smithson of Little Rock, who is working toward a medical degree at UAMS. He plans to become an Orthopedic Surgeon. Smithson holds a bachelor's degree in Chemistry from UCA. He is a graduate of Greenbrier High School.

Two students received scholarships given in memory of the late James S. Garrison, MD, a physician who founded the Conway Regional Radiology Department:

• Wilson M. Alobuia of Little Rock is pursuing a medical degree from UAMS. He holds a biology degree from UCA. He is a native of Ghana.

• Kelsey Davidson of Conway is pursuing a doctorate in Physical Therapy at UCA. She holds a bachelor's degree in Health Sciences from UCA and is a graduate of St. Joseph High School.

The Garrison scholarships are funded by private donations and totaled $5,400.

## Conway to Discuss Affiliation with St. Vincent

The Conway Regional Health System Board of Directors announced it plans to enter into exclusive strategic affiliation discussions with St. Vincent Health System of Little Rock, an affiliate of Catholic Health Initiatives. While it is expected to take several months of further discussions and negotiations before a final agreement can be reached on the details of the specific structure of this relationship, it is anticipated that the organizations will form a partnership to strengthen their market presence, enhance quality, and create the platform for improved efficiencies. This will not be a sale or acquisition. Both St. Vincent and Conway Regional will retain their autonomy, individual identities and separate corporate governance structures. The affiliation is intended to be structured in a way that will bring value to both organizations and the communities they serve.

In October of 2013, the Conway Regional Health System board announced its intention to explore strategic affiliation proposals from various health care organizations. Proposals were presented

# HOSPITAL ROUNDS

from numerous organizations and after months of review, the vision and structure of St. Vincent's proposal was considered to be the most aligned with the needs and vision of Conway Regional.

## St. Vincent North Names New ED Medical Director

Charles Corey Scott, MD, PhD is the new medical director of the emergency department at St. Vincent North in Sherwood. Scott began his duties April 1, 2014. Prior to joining St. Vincent, he practiced at hospitals in North Carolina and Virginia.

Scott is a member of the American College of Emergency Physicians Arkansas Chapter and is American Board of Emergency Medicine certified. He completed his emergency medicine residency at the University of North Carolina at Chapel Hill. The university is one of the largest referral centers in North Carolina, seeing some of the highest acuity patients in the state. These settings allowed Scott to gain extensive clinical experience in a high volume, fast paced, Level I Trauma setting.

Scott earned a Doctorate of Medicine at Baylor College of Medicine Houston, where he rotated through nine hospital settings. He completed his undergraduate studies at the University of Texas Austin in mechanical engineering. Scott then went on to complete his Master of Science in Mechanical Engineering at Stanford University in California. He was also in the Medical Scientist Training Program during medical school, which included completing a PhD in Bioengineering at Rice University.

Scott is accompanied by his wife, who is currently working on completing a Developmental Pediatrics Fellowship at UAMS.

## Prince Tribute Band Headlines RockStar Lounge

Prince tribute band Vince & the Revelation headlined the annual RockStar Lounge event to benefit research at the University of Arkansas for Medical Sciences (UAMS) Winthrop P. Rockefeller Cancer Institute.

Based in Tulsa, Okla., Vince & the Revelation features Vince Gibbs, a singer who regularly performs Prince tribute concerts across the country.

RockStar Lounge is hosted by the Envoys, an advocacy group of the Winthrop P. Rockefeller Cancer Institute Foundation, whose mission is to advance the outreach efforts of the Cancer Institute by promoting its physicians, scientists, programs, and vision. Membership is free, and volunteering hours are flexible. For information or to become an Envoy, visit www.cancer.uams.edu/envoys.

Charles Corey Scott, MD, PhD

## Physicians' Specialty Hospital Recognized for Orthopedics

Physicians' Specialty Hospital has been named a Women's Choice Award® recipient as an America's Best Hospital for Orthopedics. The award is based on robust criteria that include patient satisfaction measurements as well as consideration of areas of clinical excellence.

Physicians' Specialty Hospital qualifies for this highly selective annual list based on an in-depth proprietary scoring process. The scoring utilizes data reported by the Centers for Medicare and Medicaid Services. The selection process identifies

**LEFT** UAMS Cancer Institute scientists and doctors served as bartenders, raising about $1,000 in tips for cancer research. **BELOW** Prince tribute band Vince and the Revelation helped raise about $70,000 for research programs at UAMS Cancer Institute's RockStar Lounge event.

**TOP LEFT** UAMS Medical Center CEO Roxane Townsend, MD, greets 500th ARSAVES patient Dustin Martinez and his family at the May 13 Strike Out Stroke event.
**TOP RIGHT** Free Strike Out Stroke night T-shirts were handed out to guests at Dickey-Stephens Park in North Little Rock.
**LEFT** UAMS Medical Center CEO Roxane Townsend, MD, throws out the first pitch during a pregame ceremony.

those hospitals that provide comprehensive orthopedic services, and that meet criteria for patient satisfaction and surgical excellence based on female needs and preferences.

The Women's Choice Award program provides women with a trusted third party endorsement based on hospital experiences by patients in their community and back that with clinical data. By carrying the Women's Choice Award seal, Physicians' Specialty Hospital has joined an elite network of hospitals committed to a global mission to empower women to make smart healthcare choices.

## Survivors Hurl Strikes Against Stroke

On May 13, Dustin Martinez, the 500th stroke patient to receive a blood-clot dissolving agent through the UAMS-led AR SAVES program, and Roxane Townsend, MD, UAMS Medical Center CEO, threw their strikes against stroke at the AR SAVES Strike Out Stroke Night during a pregame ceremony at an Arkansas Travelers game against the Northwest Arkansas Naturals at Dickey-Stephens Park in North Little Rock.

On April 10, survivors did the same at Arvest Park in Springdale before a game pitting the Northwest Arkansas Naturals against the Frisco, Texas Rough Riders – both games featuring teams from Minor League Baseball's Class AA Texas League.

A helicopter delivered the baseball at Arvest Park for the survivors to use, but weather forced the helicopter to be canceled at Dickey-Stephens Park.

Volunteers from AR SAVES sites around the state worked at stroke education booths at the ballparks to distribute informational materials and answer questions. Brain-shaped stress toys were thrown into the stands.

The AR SAVES program is a partnership between the UAMS Center for Distance Health, the state Department of Human Services, Sparks Regional Health System in Fort Smith, and 42 Arkansas hospitals. The program uses a high-speed video communications system to help provide immediate, life-saving treatments to stroke patients 24 hours a day. The real-time video communication enables a stroke neurologist to evaluate whether emergency room physicians should use t-PA, a powerful blood-clot dissolving agent, within the critical three-hour period following the first signs of stroke.

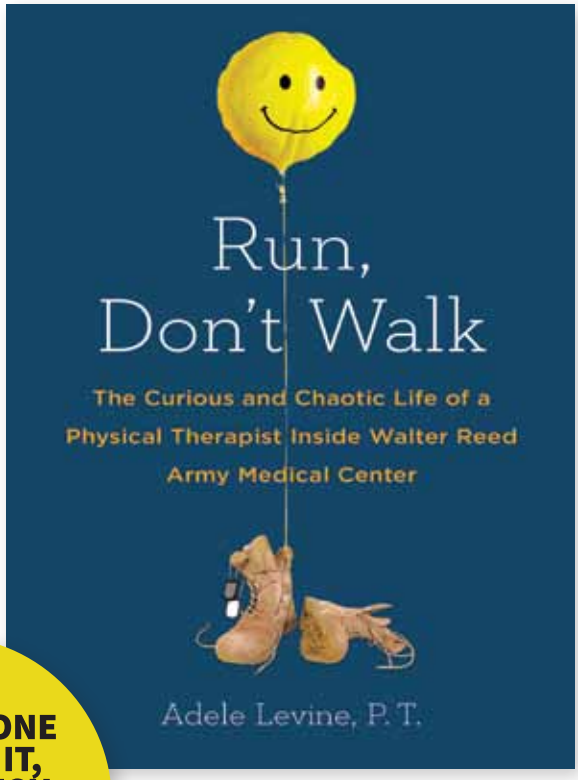
Arkansas, which ranks first in the nation in stroke death rates, had 1,560 stroke-related deaths in 2011, according to the national Centers for Disease Control and Prevention. Since the program began Nov. 1, 2008, more than 2,038 patients have received stroke consults through AR SAVES and 575 patients have received t-PA. ■

# bookcorner

REVIEWS BY THE BOOKWORM

**It all starts with baby steps.**

**Baby steps, with arm-waving balance and shaky testing of foot on floor. You held onto the fingers of someone bigger and more experienced at that sort of thing, one foot in front of the other before you finally got the hang of it all.**




by **Adele Levine, PT**
c.2014, Avery

You probably don't remember your first steps – unless it's your second chance to learn how to make them. In the new book "Run, Don't Walk" by Adele Levine, PT, you'll see how that can happen.

The call came at 0600. Sure that someone was dead (isn't it always the case with calls like that?) Adele Levine answered the phone and learned that she was being granted an interview for a job as a physical therapist in the amputee clinic at Walter Reed Army Medical Center.

Levine had gone to PT school because of "several depressing rounds of unemployment." PT had never been her "calling," and she didn't have big plans, other than to find a job close to her apartment. She figured that Walter Reed would be a temporary gig.

As it turned out, she loved the amputee clinic, and stayed for several years.

**WHEN YOU'RE DONE READING IT, YOU'LL WISH YOU COULD READ IT AGAIN FOR THE FIRST TIME**

Surrounded by glass walls "The Fishbowl" was complete chaos, a "nonstop party" with visitors, cookies, and bent rules. Double- and triple-amputees worked with therapists to learn to be ambulatory with new prosthetic devices, and other patients hung around as support. Because of the glass, visitors could see what went on but Levine says that the soldiers barely noticed. They were too busy meeting new challenges.

Sometimes, the challenges were Levine's.

Patients occasionally didn't cooperate with their treatment, and needed warnings, encouragement, or just more understanding. Others really didn't want to get better, finding the role of victim more appealing. Like most of her co-workers, Levine tried to create unusual ways to keep everyone – staff and patients alike – occupied, to keep them working on getting better, to keep them healthy in mind and body.

They did this, through personality clashes. They did it, while the injured never stopped coming. And they did it, though their clinic was closing in less than a year...

With a sense of irony, a dose of humor, and beaming pride, author Adele Levine gives readers entertainment and lessons that are both sweet and sad. Her anecdotes are peopled by soldiers whose lives have been forever altered, therapists who show them that those lives aren't over yet, and officers who offer support to both sides. This isn't necessarily some sunny, feel-good book, though: Levine is plain about pain, roadside bombs, f-bombs, frustrations, injury, and death.

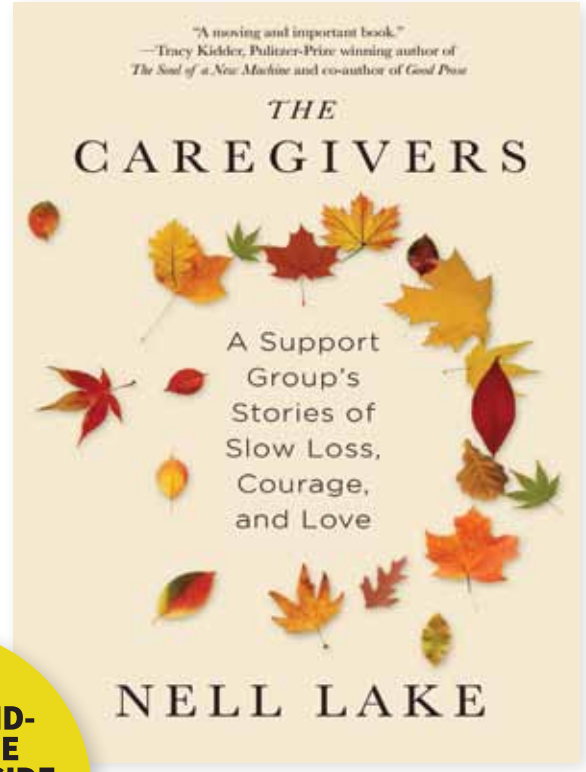
This is one of those true stories that, when you're done reading, you'll wish you could read it again for the first time. And how could you resist a book like that?

Really – you can't, so "Run, Don't Walk" is a book you should take steps to find. ■

**For better, for worse.**

**You promised that once, and you meant it. For richer, for poorer was okay, too; you'd do it together. And over the years, that's how it happened... until you got to the last part.**

**In sickness and in health.**




by **Nell Lake**
c.2014, Scribner

You hoped it would be more of the last part, less of the first, but life doesn't turn out like that. And in the new book "The Caregivers" by Nell Lake, you'll see how one group of spouses (and children) dealt with it.

Though her grandmother had never been demonstrative, Nell Lake knew the woman loved her. Hildegard was "elegant, German, unadorned, restrained," independent, strong-willed, and active. And when she found out that some pain she was having "could mean" cancer, she committed suicide.

Hildegard possessed dignity and grace while alive, Lake says, but she missed "the intimacy that may come with tending and being tended to" while dying. Fear of "the shadow part of life" followed Lake, too, so she decided to immerse herself in a "group of people living in that shadow." She joined a support group for caregivers of those with dementia and Alzheimer's.

**ADVICE THAT'S SOLID-BUT-SUBTLE WRAPPED INSIDE ONE OF THE MORE POWERFUL STORIES YOU'LL EVER READ**

Eighty-eight-year-old Daniel suffered from recurring cancer while caring for his much younger wife; she was depressed, bi-polar, and had myriad other severe health issues. William married the love of his life shortly after World War II, then watched as she was overtaken by dementia. Liz struggled with guilt for putting her abusive husband in a veteran's home due to his Alzheimer's. Inga, who'd cared for and lost a daughter, aunts, and both parents, was caretaker for her partner, Louise, who was recovering from multiple surgeries. Rufus tended a friend who'd died, but kept returning to the group anyhow. And Penny, who's featured most in this book, cared for her mother with humor, good-natured teasing, frustration, and the sometimes-surprising support of her siblings.

Throughout the year, there was sadness and loss but "Moments of loveliness arise," too. Taboo subjects were tackled, and friendships formed. And through it all, group members learned to grieve someone who was gone, but who was still around...

I struggle with what to say about "The Caregivers" because, truthfully, it made me so profoundly sad.

And yet, I know there's comfort in what author Nell Lake has to say, as well as advice that's solid-but-subtle wrapped inside one of the more powerful stories you'll ever read. Lake brings each of her pseudonymous subjects alive so well that when they're stricken, we're also stricken - and there's a lot of that in this book.

What made me stick with it, though, I think, is the compassionately wistful sweetness mixed with resigned, gotta-keep-moving outrage that's here. Lake's ability to repeatedly remind us of the former is like a gentle slap. The latter, however, is why you'll keep reading.

For Boomers who are squinting into the future, or anyone who's already in a caregiving position, bring tissues and find this book. I'm not sure I'd call it light reading, but "The Caregivers" might make you feel better. ■

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