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with

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President & CEO
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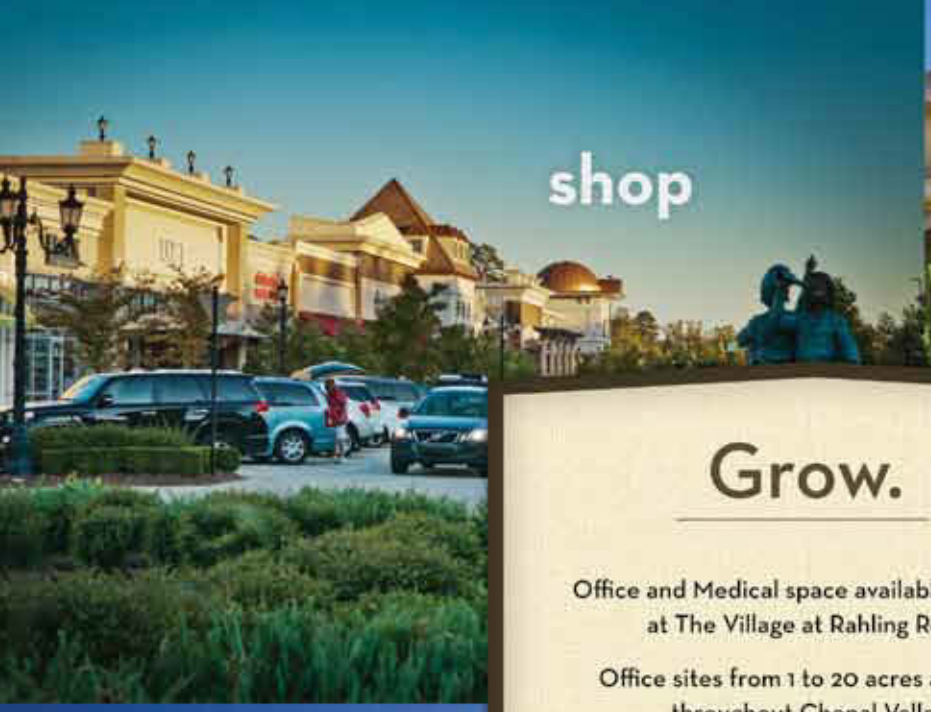

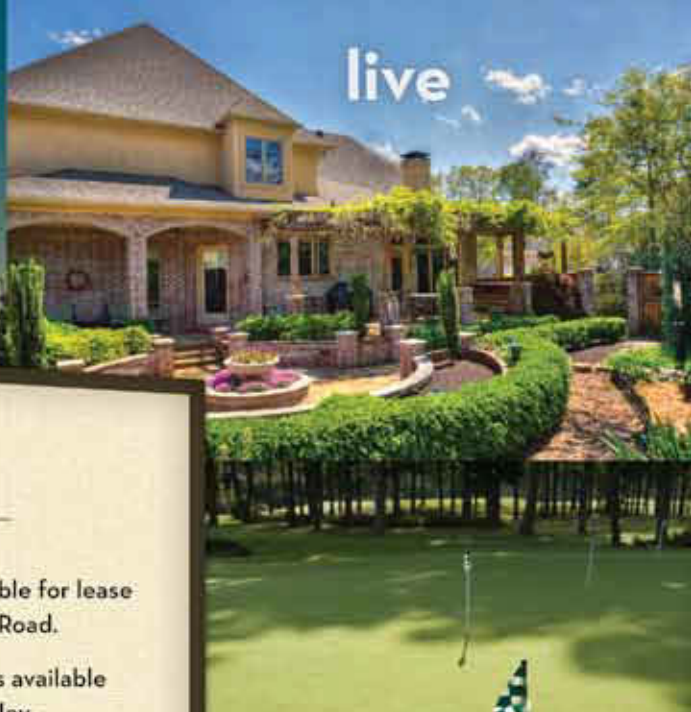

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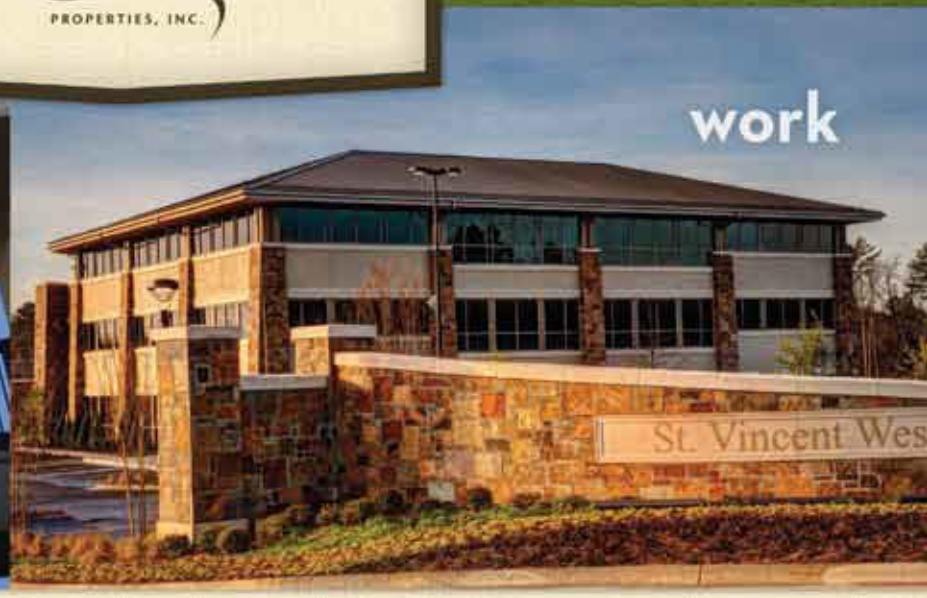

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Contents

March / April 2014 | Vol. 1, No. 3

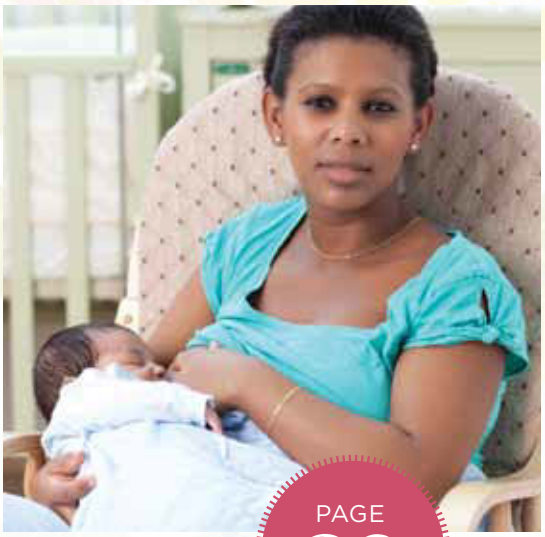
one on one

with **Marcy Doderer**
President & CEO
Arkansas Children's Hospital
page 18

COVER AND STORY PHOTOS BY KELLEY COOPER

HJLR

PAGE 12



PAGE 32

Features

Departments

Correspondents

PAGE 28

What I dream of is an art of balance.

— HENRI MATISSE (1869-1954)

The challenge in healthcare is not an inability to achieve a single objective. A single objective can be quite simple to achieve with unselfish people. The challenge in healthcare is finding a proper balance among oftentimes competing interests

Balancing the highest levels of optimal care while containing costs is always at the forefront of the healthcare discussion and always will be. To further complicate the equation, we are continually tweaking a macro system, while most healthcare decisions exist at the individual patient level. As patients, we're just not all created the same.

I was asked the other day, "You interview all these healthcare people, what's the right answer?" My answer is the right answer is always changing. Finding balance means continually altering something that often gets out of balance. Sometimes physicians and other providers need more help, sometimes it's hospitals and facilities, sometimes it's the expense of it all, sometimes it's patient access, sometimes it's quality objectives, and most times it's our philosophical notions of providing healthcare.

Healthcare is forever changing and evolving. We may never settle into the perfect answer for everyone. It's important that we openly embrace the constant change of our healthcare system and our ideas about health. But, I hope we can all agree that the pursuit of optimal health can be our guiding light.

Optimal health has less to do with our healthcare system and more to do with our life system. Optimal health is more about nourishing our bodies, minds, and spirits. It's about an infrastructure of encouraging uplifting relationships, well being, and hope. I always respect those working to improve the lives of others. It's the noblest pursuit.

Working to improve the health of others means a pursuit of balance. We may not have all the right answers. But, with the right intentions, the right answers may begin to reveal themselves.

Smith Hartley
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"I wanted to be a good husband and dad and a better doctor to my patients."

–Mark Williams, MD

THE CASE FOR Concierge Medicine

By ***John Mitchell***

Mark Williams, Amy Beard, and Torin Gray might just be some of the happiest doctors in healthcare.

Each of the Arkansas primary care physicians has recently converted their practice to a version of what is commonly called concierge medicine. In this emerging model, which has its roots in both physician and patient frustration, patients pay a monthly or yearly subscription fee to join a physician practice. In exchange for the fee, patients get 24/7 access to their doctor via phone and email, same day appointments that can last hours, and a relationship in which the doctor's and the patient's interest are closely aligned.

"I love it. I couldn't see myself going back to fee-for-service, which I practiced for 16 years." *–Torin Gray, MD*

Torin Gray, MD

Matt Priddy, MD

According to the American Medical Association there are approximately 246,000 primary care physicians practicing in the U.S. [1]. Approximately 40 percent are employed [2] mostly by health systems and hospitals. That leaves approximately 148,000 primary care doctors in private practice. According to Michael Tetreault, Editor of *Concierge Today*, a leading trade source, there are 5,500 doctors practicing concierge medicine and that rate is expected to grow by 15 percent a year. While the current numbers are small, the doctors who have made the transition are turning into the biggest advocates.

"I love it," said Torin Gray, MD, a Little Rock board certified Internal Medicine and Pediatric physician. "I couldn't see myself going back to fee-for-service, which I practiced for 16 years."

Dr. Gray is part of a group of four physicians, but the only one who has so far deployed the concierge model. He converted to a concierge practice just about a year ago with the help of MDVIP. According to Chris Lillich, Chief Marketing Officer, MDVIP is the largest concierge medicine consulting company in the nation with more than 700 physician members and more than 200,000 patients in 42 states. MDVIP is a hybrid model. Lillich said that MDVIP's product is a comprehensive wellness screening that becomes the foundation for the doctor-patient relationship. He noted that MDVIP accepts insurance, including Medicare, and that 94% of patients renew with affiliated physicians.

On an average day, Dr. Gray sees between 10-12 patients. He carries a current patient panel of 400 patients, about 10 percent of his former patient load. He receives about $140 a month from each patient and he sees the children of patients at no charge.

"I didn't go into medicine to shuffle paper. This allows me to take care of patients without being dependent upon what the insurance company wants," Dr. Gray said. He said he sees his partners rushing from exam room to exam room to see twice as many patients, frustrated that they cannot deal with a patient's problem in one visit. He also reports that because he has the time to take more detailed and thorough notes, when he does have to work with an insurance company to get a referral for specialty testing or care, he is now more successful for his patients because his documentation is better.

"It is so fulfilling to get off the treadmill," he added. "Today I had an elderly patient who was having a problem. She just walked

"Now, for example, I can spend an hour or more with a patient who is having an emotional or psychiatric problem rather than trying to figure it out in five minutes. It's just better care."

—Matt Priddy, MD

in and I was able to take care of her."

Mark Williams, MD, who is located a few hours north of Little Rock in Mountain Home, has carried the concierge model to its extreme. He does not participate in any insurance plans, carries an active panel of only 125 patients, and has equipped his car with advanced testing equipment he needs to make house calls. About 10 percent of his patients live in and around the Little Rock area. He is a member of the American Academy of Private Physicians (AAPP), a nonprofit group which works with its members to build sustainable concierge medicine practices.

"I was probably in the top five percent of income for primary care doctors, but I wasn't very happy. The stress was really getting to me," he recalled. "I wanted to be a good husband and dad and a better doctor to my patients." He opened in May of 2011 between a pharmacy and dental practice. On his first day, he was sitting in his barren office when a former patient recognized his Jeep parked out front and walked in.

"When I explained the concierge model to him, he asked me how much I was going to charge. I told him I hadn't figured that out yet and he said, "How about $2,000 a year?" I went home that night and told my wife, "I need our furniture, I've got my first patient," said Dr. Williams with a laugh. He also has made arrangements for his patients to receive lab and imaging tests for about 10 percent of the cost providers bill insurance companies. Dr. Williams bases his fee on the wants and needs of the patient and his yearly fee typically ranges from $750-$4,500 (for 100% home visits) a year. He has even designed his own medical records program to support his practice.

Before Amy Beard, MD, who practices in and around Conway, went to medical school at the age of 32 she had been a registered dietician who had been around hospitals and healthcare.

"I became a doctor because I couldn't get anyone to listen to me when I was a dietician," she said, half serious. While working ER shifts in her third year of residency, she realized that 70% of the patients she was seeing did not have a medical emergency. Most came to the ER because they could not get in to see their doctor for a week or two. As she neared completion of medical school, she had offers to go to work for hospitals.

"I didn't want to see 30-40 patients a day because I don't think that is good medicine. I considered the concierge model for a long time. I studied other practices and talked to friends and family about the concept. I got good feedback from them, so I decided that was the way I wanted to go," she explained. As with Dr. Williams, she does not participate in any insurance plans.

She opened her practice in November and already has a panel of 50 patients. She reports that patients are "shocked" by the

Patient Angela Cate and Amy Beard, MD

"I studied other practices and talked to friends and family about the concept. I got good feedback from them, so I decided that was the way I wanted to go."

–Amy Beard, MD

one to two hours she spends with them. This includes Angela Cate, who relied on home birth for the last two of her five children. She and her husband own a graphic design firm and are both fitness instructors. She has not carried health insurance on herself, although her kids are covered.

"I had not been to a doctor in five years. After my last baby, I went to a GYN about some issues I was having. I had two pages of notes and the doctor spent five minutes with me and didn't listen to what I had to say. And for that I got a bill for $600," Cate said. Cate said that her relationship with "Dr. Amy" is the best she's ever had with a physician.

"Dr. Amy calls me and texts me and sends me articles to read, it's really great to be her patient," said Cate.

Dr. Beard charges by age group, from $39 to $125 a month. She does not screen her patients on medical condition, but in attitude. "I've declined to accept a few patients who seem more interested in how many prescriptions I would write for them. I'm not a pill pusher. I want patients who want to work with me to manage their health," she said. Dr. Beard is already planning to expand her patient census and is in talks with a colleague who wants to join her practice.

There are concerns about the concierge model. According to John Rother, a policy expert at the American Association of Retired Persons (AARP), those who can afford to pay a monthly fee will get better healthcare than those who cannot [3]. He indicated that Medicare patients, who have lower incomes, are at a disadvantage under such an evolving two-tiered health system. Also, with more insured patients coming into the system under the auspices of the Affordable Care Act (ACA) the current projected shortage of doctors will be exacerbated if primary care doctors increasingly see fewer patients. A recent study by the *Annals of Family Medicine* projects there will be a shortage of more than 50,000 primary care doctors by 2025. [1]

Many people balk at the idea of paying a monthly or annual fee to see their doctor. Dr. Matt Priddy, who is the current sitting practicing physician president of the AAPP (with which Dr. Williams is affiliated) notes there is a lot of patient education involved about this relatively new model.

"Concierge medicine is not an insurance plan. But once patients understand how much we can manage their care with better access to keep them healthy, they usually sign up," he said. The concierge model, he said, allows doctor and patients to spend more time together.

"Somewhere along the line primary care evolved away from time spent with a patient to how many patients doctors can see and how many procedures can be done in an hour," said Dr. Priddy. "Now, for example, I can spend an hour or more with a patient who is having an emotional or psychiatric problem rather than trying to figure it out in five minutes. It's just better care."

1 - http://annfammed.org/content/10/6/503.full
2 - http://www.healthcarejournallr.com/the-journal/hjlr-contents-index/features/402-md-for-hire
3 - http://www.cbsnews.com/news/concierge-medicine-a-threat-to-medicare-users/

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one on one

MARCY DODERER, FACHE
President & CEO, Arkansas Children's Hospital

PHOTOS BY KELLEY COOPER

We believe the work we are doing here warrants national attention. Our ultimate vision is to be a top tier children's hospital that stands national recognition and can influence the care of children across our country, not just across the state of Arkansas.

After an extensive national search, Marcella (Marcy) L. Doderer, FACHE, was named president and chief executive officer for Arkansas Children's Hospital (ACH) in May, 2013. Doderer took the helm of ACH on July 15, 2013, following the June 30 retirement of former President & CEO Dr. Jonathan Bates.

A Little Rock native, Doderer has 20 years of healthcare management experience in a variety of hospital settings. Most recently, she served as Vice President and Administrator of the Children's Hospital of San Antonio, part of the CHRISTUS Santa Rosa Health System.

Doderer was instrumental in leading the transformation from a multi-use downtown hospital campus into the freestanding, separately licensed children's hospital. The new campus will be fully transformed by late 2014. Doderer was responsible for facilitating the transition of academic partners from the University of Texas Health Science Center San Antonio (UTHSCSA) to Baylor College of Medicine and in partnership with Texas Children's Hospital.

From 2002-2008, Doderer held the position of Vice President/Associate Administrator for CHRISTUS Santa Rosa Children's Hospital. Prior to CHRISTUS Santa Rosa Children's, she served as Vice President for CHRISTUS St. Joseph's Health System in Paris, Texas; director, ancillary and support services for Texas Health Resources/McCuistion Regional Medical Center in Paris, Texas; and leadership positions from 1994-1999 at Presbyterian Hospital of Dallas.

Doderer holds a Master of Arts in hospital and health administration from the University of Iowa. She received her Bachelor of Science in finance from Trinity University in San Antonio, Texas. Doderer serves on the boards of Children's Hospital Association, Children's Hospital Association of Texas, and South Texas Blood and Tissue Center's Foundation. She is a member of the Texas Hospital Association's Council on Policy Development and is a Fellow, American College of Healthcare Executives (FACHE).

Chief Editor Smith W. Hartley *You were in San Antonio, I believe for 12 years, at the Children's Hospital there. What brought you to Arkansas Children's Hospital?*

Marcy Doderer It was one of those opportunities I really couldn't pass up. I am originally from Little Rock. I grew up around Arkansas Children's Hospital as a junior volunteer and that kind of thing. At that point in my career in San Antonio I was leading a 200-bed children's hospital within a health system and was really interested in being part of a freestanding children's hospital– a place where everybody comes to work every day just to take care of kids. So when the position became available it seemed very symmetrical to apply for a position that was in a freestanding children's hospital in a community where I had grown up and was very fond of.

Editor *What are some of the main differences between a freestanding hospital and a hospital within a hospital?*

Marcy Doderer As a freestanding children's hospital we are a private, non-profit organization, which means we have our own governing board and we are able to lead an organization, govern an organization, and drive change within an organization that is solely dedicated to the care of children. That isn't necessarily better than a children's hospital within a hospital or a health system, it's just very different.

The children's hospital in San Antonio is part of Christus Health, a large, Catholic health system. It has somewhere around 40 acute care hospitals and several other books of business. They have hospitals across the Southeast as well as in Mexico and Santiago, Chile, and being the only children's hospital within that large health system, care of the child was not always the highest priority. It is a big $4.5 billion business looking at healthcare across many states and several countries. Sometimes it is a challenge to advocate for resources as only one hospital out of 40.

Coming to a freestanding children's hospital where your resources are there solely to improve the health of children it's a little more liberating and a little more fun.

Editor *You've been at the helm for about eight months. When you arrived at Arkansas Children's Hospital what did you find were some of the most pressing issues?*

Marcy Doderer I was very lucky to come to an organization that is not in the middle of a financial crisis. That doesn't answer your question directly, but I think it's important to note. At so many hospitals across the country the revenue pressures are pretty extreme and pretty intense, causing somewhat of a financial crisis and I don't face that today at Arkansas Children's Hospital. We are very financially stable and really thriving in our current environment.

The issues that are more pressing are what I would maybe define as cultural as opposed to operational, meaning we really need to continue to step up our game around a culture of safety. How do we ensure that everything we do every day is the right thing for the child to ensure we do no harm? Somewhere close to a 100,000 people are injured or harmed in hospitals across our country every year and hospitals are hard at work to eliminate that harm. Arkansas Children's Hospital had already started efforts to reduce harm and that's one of the things I've really focused on in my first seven months– how do we provide a culture of safety to really get to zero harm.

The other cultural opportunity that I am working on is really one of accountability. It's probably a word thrown out there too often in management textbooks or theory, but what I mean by accountability is when you say you are going to do something you do it. And you do the right thing right. So it is trying to ensure that people follow through on commitments, that we abide by policy, that we abide by evidence-based standards

in the delivery of clinical care, that we are accountable to our community for use of funds and the care of the children in the communities we serve.

Editor *What are some of the quality initiatives that you are working on?*

Marcy Doderer We participate in a national consortium of children's hospitals called the Children's Hospital Solution for Patient Safety so we are tracking a number of very specific types of events. The global work is on what are called serious safety events—tracking when, through the course of care for a patient, the teams deviate from standard practice or the approved process or protocol and harm happens to the patient. Sometimes serious harm, sometimes moderate harm, but the outcome is not what was anticipated had you followed all the practices.

Beyond serious safety events we are also looking very specifically at different hospital acquired infections and conditions—the patient came into the hospital to get care for one issue and actually, as a result of the hospital stay, had another issue evolve. These are things like catheter-associated and central line infections, bloodstream infections, medication events, adverse drug events, patient falls. There are eleven of those that we track every day and we are becoming much more transparent in our work around eliminating errors in those eleven categories. For instance we count how many days it's been since our last infection or fall or adverse drug event. We are really trying to drive that conversation to, "How can we get to zero?"

Editor *How important is technology in measuring quality and how do you manage people towards these quality objectives?*

Marcy Doderer That's a great question and not one that's easily answered. We believe in something that is often called a "just culture" meaning we really do believe most errors occur not because a person came to work today and said, "I think I am just not going to pay attention to my job and if a kid gets hurt who cares?" We don't believe that at all. We believe systems actually promote an opportunity for errors to occur and that's where we can use technology to really help try to "error-proof" our work. So whether it's alarm systems that ensure if a patient's using a certain kind of equipment, like a ventilator for example, you have a good way of having those alarms sound not just in the patient room but at the nurse's station.

We also use technology in our documentation process. For example, trying to reduce the medication error rate by really standardizing physician order sets. You take some of the pretext and prehand thinking about medication management out and put

> **"WE ARE MAKING SURE WE HAVE GOT THE TOPNOTCH SCIENCE APPLIED TO THE KIDS THAT COME HERE FOR CARE.**

it in more of an algorithm or a protocol that drives a person to the right answer versus forcing them to have to remember all those steps on their own.

So we try to use technology to create systems to help avoid errors. But because there are people involved every step of the way what we don't want to ever do, and this is where it becomes a balancing act, we don't want to eliminate the critical thinking that our team brings to the table every day. Because every child is different and they might have the same disease, but their path to healing or to cure is going to be slightly different because they are a different person. It's important to still have that art of medicine where the critical thinking skill of your team is partnered well with advanced technology so that you get the best outcomes possible for the individual child. We don't want to put technology in place so people quit thinking.

Editor *Shifting gears a little bit, how do you plan for the future knowing that reimbursement is going down and that traditional hospital revenue is going to be more dependent on outpatient care instead of inpatient care?*

Marcy Doderer You've got to plan for it. You cannot just wander into the future in a willy nilly way without some kind of plan. So we have a group of senior leaders who spend time together every month in a strategic thinking group, not just a strategic planning process, and not just a tactical plan, but really trying to bring information from the outside–what external forces are affecting our world of healthcare, outside forces at the federal or national level as well as within? And then have some really good information about what other hospitals are doing, what do we need to do to impact the public policy arena at the state and the national level to not just protect an income stream, but actually to partner with our elected officials to develop new ways to pay for healthcare?

At the same time we also have that internal list. Where do we have opportunities to take cost out of the system? What are we doing from a facility standpoint to better manage the patients who come to us for care? You are right that there is a real shift to outpatient. There's also a shift to get care as close to home as makes sense and is feasible. So when we think about Arkansas Children's Hospital, the physical plant and our footprint, it's no longer just dreaming about big new buildings on a 30-square-block campus, it's really how do we use the inpatient beds that we have to the best of our abilities, and a lot more thinking into how do

"Being a teaching hospital cultivates a culture of innovation and investigation that helps us continue to improve the kind of care that can be delivered."

Editor *Arkansas Children's Hospital is in a good financial position, but with lower Medicaid rates and lower reimbursement rates, do you attribute that to cost containment or is it more of a foundation type of revenue? Typically children's hospitals can't survive on their own from just traditional reimbursement.*

Marcy Doderer About 60 percent of the patients we take care of are on government funding, either through traditional Medicaid or ARKids, which is Arkansas's answer to the Children's Health Insurance Program (CHIP) that came out of the federal government in the 90s. We have to manage a significant portion of our patient population that is funded through the government and we work very closely with Arkansas Medicaid and our legislature to ensure that the reimbursement is at a reasonable level. We've got 35 to 40 percent of our patients that are insured through other means such as managed care companies. There are only a small number of kids in Arkansas that are completely uninsured. I believe it's around two percent of our business that is actually uncompensated, because Arkansas Medicaid and ARKids ensure that kids can get coverage. Those go up to 200 percent of the poverty level, which covers most kids if they don't have insurance through their family.

> **"YOU CANNOT JUST WANDER INTO THE FUTURE IN A WILLY NILLY WAY WITHOUT SOME KIND OF PLAN**

we creatively address care for kids closer to home so the kids from Arkansas don't have to drive three hours into Little Rock? So it's about building and operating outpatient facilities in Northwest Arkansas, for example in Lowell, in Northeast Arkansas in Jonesboro, and looking at a regional strategy for Southwest Arkansas. So we are really trying to understand how you help kids get the care they need, particularly in an outpatient setting, across the state and not just on our campus.

On this campus, we treat around 1500 kids a day in our clinic system. We are trying to help children who are outside of central Arkansas have that same level of access to care.

We've got the critical revenue piece, but we want to influence public policy closely to capture what revenue we can. We also, as all children's hospitals do, have a very active foundation and philanthropic support from individuals and corporations to underwrite programs that don't have a revenue stream tied to them. When you look at some of our community benefit and community outreach programs such as our dental sealant program, where we take vans out across the state and help kids get good oral care, we partner with the Blue and You Foundation for a Healthier Arkansas, which is the foundation arm of Blue Cross Blue Shield of Arkansas. We've had support from the Ronald McDonald House charities to fund some of those programs. So we rely on philanthropy to support non-revenue generating programs, but programs that we believe are essential to improving the health of children in Arkansas. It's a balancing act.

Editor *What are some of the things that, as a children's hospital, you can do to be proactive with children's health in the community?*

Marcy Doderer There are a couple of things. Prevention is absolutely key to long term health of children so for example, we have an outpatient clinic that's solely dedicated to ensuring timely immunization for children, particularly children on Medicaid, to make sure the parents know what the schedule for immunizations needs to be, particularly in those early childhood years. And we have nurse practitioners that all they do all day is bring those young babies, young families in, and get them immunized on time, on the schedule that's been well prescribed by the American Academy of Pediatrics.

We also know that oral health issues are the leading cause of absenteeism in schools, which is why we've invested in a large dental health program and our dental sealant program. If you can keep kids' teeth healthy they stay healthier. It's an interesting and pretty easy solution. So helping push pediatric dental care out across the state keeps kids in school. That actually has a great downstream economic impact as well. Public schools get their funding based on attendance. More kids in school means more funding to support the public school system which then is an economic driver in those smaller communities.

We are actually looking at a wide range of public health type indicators that speak to the health of children and are trying to ensure we have very targeted programs in the right locations around the state to truly improve those children's health. We

are actually going to start measuring the effectiveness of those programs by using the Annie E. Casey Foundation Kids Count report. It comes out every year and it ranks all 50 states in order as healthy states for children. They score each state on four different domains. One is specifically a health domain. Overall Arkansas ranks 40 out of 50 states. For the health domain, I believe in the last report we were number 30. As a senior team we have said by 2020 we want that needle to move to where we are at least at 25 out of 50 states. We've got to at least get to the middle in the next five to seven years. So we are really trying to hold ourselves accountable for improving health for kids in Arkansas.

Editor *How big of a problem is childhood obesity in Arkansas and are you doing anything proactively?*

Marcy Doderer It is a very big challenge in our state. I think it's an epidemic across our country unfortunately. We have a series of different treatment programs today, some weight management programs, eating disorder clinics, diabetes programs, for kids who are already suffering the ill effects of obesity. But with our work through the Arkansas Children's Research Institute and the Arkansas Children's Nutrition Center, we have a large, federally funded grant program that's really tapping into human nutrition issues and finding the molecular, genetic level causes of obesity through clinical and bench research. The goal is to use that research to then influence behaviors to hopefully prevent obesity rather than just have to treat obesity. It's a long term process and it will take a generation or two to actually stem that tide, but we've got millions of dollars funding research to address nutrition type issues that lead to childhood obesity.

Editor *I understand your hematology/oncology unit has received some accolades. What makes it so wonderful?*

Marcy Doderer We do have an amazing hematology and oncology program here in partnership with the physicians and other providers at UAMS. We are able to take care of a broad spectrum of hematologic and oncologic diseases and disorders for the kids in our state. I think what makes it wonderful is multi-factorial. The first is we are active participants in COG, the Children's Oncology Group. That is a group of some of the finest minds in pediatric hematology and oncology that really drive the research protocols we use to treat kids with different blood disorders and cancers. It's cutting edge therapy and we participate in that international forum to make sure we're using the latest chemo protocols, for example. We are making sure we have got the topnotch science applied to the kids that come here for care.

The other piece I think is a little softer side and goes back to that art of medicine that makes our program very special. It truly is a multi-disciplinary team. It's not just a physician taking care of a sick child; we have skilled and certified nurses, child life specialists, laboratory technicians, pharmacists, physicians, nurse practitioners, who all come together in a team environment to really map the course of care for that particular child. And then we put the child and the family in an environment that's really focused on healing. We have a separate healing garden in the outpatient chemotherapy division so that families can actually step outside on pretty days and enjoy a little peace, get the

> **It's important to still have that art of medicine where the critical thinking skill of your team is partnered well with advanced technology so that you get the best outcomes possible for the individual child.**

healing aspect of nature, as part of their course of care. We have a dedicated inpatient unit so when children come back for frequent admission because of chemotherapy or illness, it's the same group of nurses each time. The families know who the caregivers are and the caregivers know the families. The really holistic approach to taking care of the child and the family through the course of the cancer or the blood disorder journey makes it a very special place.

Editor *What does it mean for the community for Arkansas Children's Hospital to be a teaching hospital? How does the community benefit from having a teaching component to the children's hospital?*

Marcy Doderer Academic medical centers and teaching hospitals bring a couple of things to the community. The first is we absolutely need an outstanding training ground for the next generation of physicians. As young people are in medical school today and thinking about becoming a pediatrician, we want Arkansas Children's Hospital to be a top choice for where those young medical students would seek their pediatric residency programs. With that being a priority of ours, it's a key part of our mission to be an education center, a teaching hospital. We can help produce really strong physicians for that next generation.

That also translates into helping train enough subspecialists. There are not enough pediatric subspecialists in our country for the population of kids we have. We have certain subspecialties that because there are so few of them it might take six or eight or ten weeks to get in to see a subspecialist—just because the physician supply is so low. In being a training site we focus on not just training good general pediatricians who can go out in the community to have good access to care in the communities, but also training enough subspecialists so that we have a good pipeline of subspecialists coming out in the future. It's a very direct benefit to the community; we are the ones training those physicians who are going to practice and take care of the community.

I think there is an indirect benefit to communities as well. If you go back to the hematology and oncology program and participation in the Children's Oncology Group, that takes a university affiliation to participate. You want academic physicians who have this interest in furthering care, pushing the envelope and testing how we can take treatment standards to the next level. Being a teaching hospital cultivates a culture of innovation and investigation that helps us continue to improve the kind of care that can be delivered. And that care then gets translated well beyond the walls of a teaching hospital so we don't just keep that knowledge to ourselves and provide it to the children we take care of, but we publish those results and we present at national conferences and we provide weekly conferences here to local pediatricians so they can also learn what we have learned and then apply it in their own practice settings. The community then benefits indirectly by having that kind of knowledge and science perpetuated and pushed out to practicing physicians all over the state.

Editor *What's next for Arkansas Children's Hospital? What are you working on and what do you see in the future for the health of children in Arkansas?*

Marcy Doderer We are really refining a vision that we believe will help put us as a top tier children's hospital across the country. Arkansas Children's Hospital has an amazing hundred year history and I believe we've got an amazing future ahead of us, but we want to be very purposeful and take what we believe is a rightful place standing shoulder to shoulder with the other large children's hospitals across the country. We want to be able to tell our story beyond the borders of Arkansas. We want to be a top 20 children's hospital as ranked by someone like *US News & World Report* or Leapfrog or some of those other national rankings where Arkansas might sometimes be forgotten today. We believe the work we are doing here warrants national attention. Our ultimate vision is to be a top tier children's hospital that stands national recognition and can influence the care of children across our country, not just across the state of Arkansas. ■

And Conway Makes Nine

Baptist Health picks fast-growing Conway as latest location

By *Cynthia Hicks*

Conway, Arkansas is the seventh largest city in the state, with just under 60,000 residents. Local leaders say it has not only become a shopping and recreation destination for central Arkansas, but also a healthcare destination.

Now Baptist Health has purchased 37 acres in Conway with plans to build a new medical center there. A Baptist Health spokesman says they will break ground in late spring 2014 on the 200,000 square foot facility along the west side of Interstate 40 in Conway near exit 129. The new hospital will have 100 beds, seven operating rooms, and a Level III trauma-center emergency room.

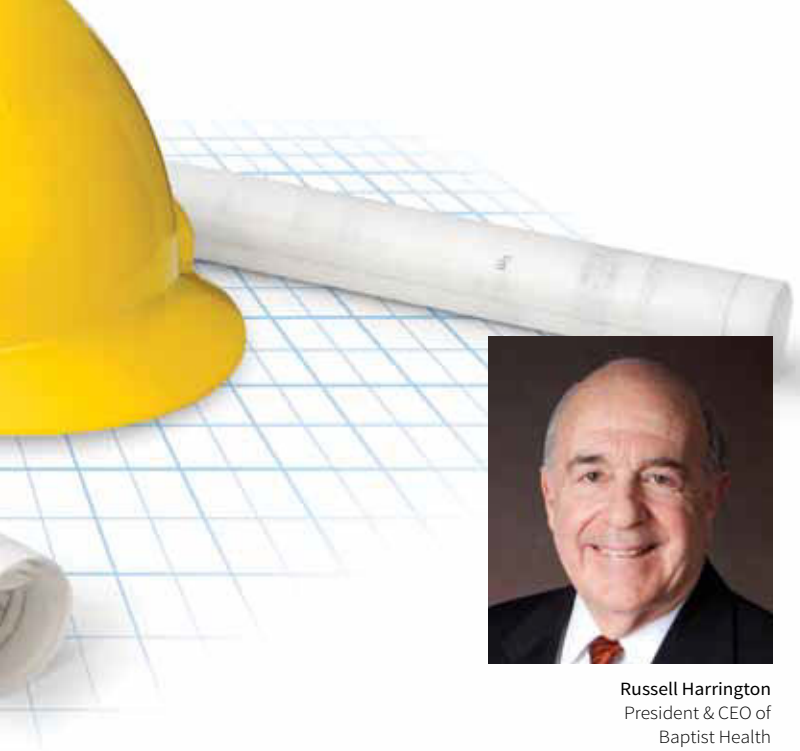
"The Baptist Health Medical Center-Conway will employ approximately 425 healthcare professionals and staff," said Russell Harrington, President and CEO of Baptist Health. "The facility will be led by an experienced leadership team working closely with Conway physicians committed to improving the health of the community."

Harrington says that Baptist Health was approached by more than 30 Conway-based physicians to develop and open the new Baptist Health Medical Center saying they want more direct input into the planning and operation of the hospital.

Dr. Benjamin Dodge of Conway, the chairman of a steering committee representing those physicians, says he sees this move as an excellent avenue for area doctors and Baptist Health to align their goals.

"Our collective goal is to create a hospital where the doctor is enabled and empowered to ensure their patients' care will be delivered by a compassionate team focused on superb clinical outcomes," said Dodge.

The Conway hospital will be the ninth hospital owned and operated by Baptist Health in the state. The company just opened its eighth Arkansas hospital, a 72-bed center in Malvern, at the end of December and Harrington says the company is working with other hospitals to reduce costs and improve quality of care and has plans to open more primary care clinics. All of this expansion comes despite hospitals nationwide facing millions of



Russell Harrington
President & CEO of
Baptist Health

Jim Lambert
President & CEO of Conway
Regional Health Center

Brad Lacy
President & CEO of Conway
Chamber of Commerce

dollars in lower healthcare reimbursements as a result of the Affordable Care Act.

"The lower Medicare reimbursements have already stung Baptist," said Harrington. 2014 may not be much better with the hospital expecting to lose another $6 million from the same federal budget sequestration that cost the company $5 million in 2013.

Another factor to consider is that Conway already has an existing 150-bed hospital. Baptist Health maintains that this new medical center will address the growing healthcare needs of Conway and the entire surrounding area. Jim Lambert, President and CEO of Conway Regional Health Center, which currently operates the only hospital in town, disagrees.

"While it is true that the population is growing in Conway, the demographics of that growth tend to be young–the average age according to the Conway Area Chamber of Commerce is 25.6," said Lambert. "Members of that age group aren't typically high users of hospital services."

Lambert also points out that in-patient volumes have been soft for the last several years in Arkansas and around the country and says there is no shortage of hospital beds in Conway.

"We believe Conway Regional has provided this community with high quality healthcare for the past 75 years, supporting the growth of this community and the health and wellbeing of the people who live here," said Lambert. "We are committed to continue to serve high quality compassionate healthcare regardless of what any other hospital plans to do."

But Harrington says he thinks Conway needs another hospital because about 15 percent of Baptist's patients already come from Faulkner County and the surrounding area.

"It's always been an important part of our market, and this gives us a chance to solidify that and hold on to it," he said. "We also see it as an opportunity to spread our area of service."

While Brad Lacy, President and CEO of the Conway Chamber of Commerce, couldn't comment on whether or not he thinks the area needs another medical center, he did confirm that his city has experienced substantial growth over the past few years in the healthcare industry.

"Conway isn't just providing healthcare for the city and Faulkner County, it has become a regional healthcare destination."

"Conway isn't just providing healthcare for the city and Faulkner County, it has become a regional healthcare destination," said Lacy. "This trend has had a significant impact on the local economy and has increased the number of people who hold local healthcare jobs."

Lacy says in 2005 the education and health services sector of the Conway economy employed 4,841 people. That had increased to nearly 6,100 people in 2013. A report from the University of Arkansas at Little Rock also shows the population of the Conway area has grown by over 35% in the past decade. Similar growth is projected by 2020.

This is a trend that has not escaped the notice of Harrington who says a local full-service hospital will enhance the potential for the area's economic growth by contributing to an increase in local employment and providing state-of-the-art health-care services that help attract new businesses.

"Baptist Health will bring, to the community of Conway and surrounding areas, an innovative and cooperative approach to providing the highest standards of clinical quality, a fully staffed emergency room, and a proven track record of long-term commitment to supporting Arkansas communities," said Harrington.

Final design, construction plans, financing, and legal review are expected to be completed in 2014 with construction to follow. The cost of the project has not been released, however Baptist did spend over $10 million to acquire the land in Conway. The new Baptist Health Medical Center-Conway is expected to open in 2016. ■

It's Medicine, naturall

BUT PERHAPS NOT SO IN ARKANSAS

By Carolyn Heneghan

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With rising healthcare costs and the proliferation of certain diseases, such as diabetes, cancer and heart disease, many people are seeking new forms of treatment to enhance and even replace their current healthcare regimen. Naturopathic medicine has arisen and recently gained traction as one alternative method of counsel and treatment. While Americans in the West have begun to turn to naturopathy, have Arkansas residents embraced this option?

What is Naturopathic Medicine?

Fayetteville naturopathic practitioner Dr. Tara Hickman, ND, is a graduate of the accredited Southwest College of Naturopathic Medicine in Tempe, Ariz., and is a naturopathic license-holder in the state of Arizona. She defines naturopathic medicine as, "a different way of viewing the patient, looking at them more from an individual perspective and trying to identify underlying causes for their illness rather than just treating the symptoms."

While treating the symptoms of a disease is important, particularly in the short term, long-term care often depends on identifying the root of the problem for that individual patient and treating the root issue as well. This is one of the primary tenets of naturopathic philosophy.

"We talk about obstacles to cure," says Dr. Hickman. "If you find obstacles that this person has either with their health or with their environment, if you take those away, and then just let the body do its own thing, you get much better results."

Naturopathic practitioners believe in the power and ability of the human body to naturally heal itself when given the right tools—tools which might not necessarily be medication. They take the time to evaluate their patients in areas of diet, exercise, stress, work and home environments, allergies, and so on, all with the intention of finding this root problem and advising natural ways to treat it. Another area of focus is the prevention of health issues by identifying potential factors for disease and taking action with treatments that can prevent such an occurrence from ever happening.

Oftentimes, these are treatments that the patients themselves have control over—such as restricting certain foods from their diets, drinking more water or taking certain vitamin or herbal supplements—and this method appears to have a special effect on patients.

"It empowers the patient, and they control their own health," says Dr. Hickman. "A lot of times patients feel like they don't have any say over their healthcare. They just have to go in and do exactly what the doctor says. They don't understand what's going on with them. And so whenever someone doesn't have control over their own healthcare, you don't seem to have the same outcome."

According to naturopathic philosophy, when you allow patients to treat the root cause of their diseases and to contribute to their own healing processes, it is not only empowering, but it is valuable education in proper care for themselves in their everyday lives.

"It's that old adage: give a guy a fish, feed him for a day. Teach him how to fish, feed him for a lifetime. That really is the underlying precept for naturopathic doctors," says executive director of the Association

Tara Hickman, ND

JoAnn Yanez, ND, MPH

"In a state like this where you can't accept insurance, a lot of people don't want to pay out of pocket for their healthcare. They're not used to doing that outside of their insurance, and so that prohibits a lot of people from doing naturopathic care too."

–Tara Hickman, ND

of Accredited Naturopathic Medical Colleges (AANMC) Dr. JoAnn Yanez, ND, MPH. "We're teaching people how to have healthy lifestyles so that hopefully they minimize their illness or get rid of it altogether. It's personal responsibility, it's personal awareness that are the tools to living a healthy lifestyle."

Is it catching on in Arkansas?

While this branch of medicine is popular in certain parts of the country, residents of Arkansas seem more hesitant to adapt and seek out this type of treatment.

Dr. Phillip Burbutes, an uncertified ND, appears to be the only remaining naturopathic practitioner in Little Rock. He laments the state of naturopathic medicine in the city.

"Little Rock has not been supportive to naturopathic medicine in general," says Dr. Burbutes. "This has been recently realized by two other NDs leaving Little Rock for Portland, Oregon. Their only reason for leaving was the total lack of support of the Little Rock community."

Dr. Hickman concurs. "In the South, it's a very strong religious place, so there's a lot of misconceptions that maybe naturopathic medicine is new age or that it's snake oil salesman type stuff."

These misconceptions may contribute to the lack of naturopathic practitioners in Little Rock. Another contributing factor is that few states actually license naturopathic doctors to practice and Arkansas is not among them. For this reason, insurance will not cover naturopathic care in the state.

"In a state like this where you can't accept insurance, a lot of people don't want to pay out of pocket for their healthcare. They're not used to doing that outside of their insurance, and so that prohibits a lot of people from doing naturopathic care too," said Dr. Hickman.

Naturopathic doctors stand firm in their position that natural, preventative, and patient-controlled care is key in alleviating many of the health problems seen in this country today. It remains to be seen, but it will be interesting and important to watch the effects that naturopathic medicine has on patients and to determine how viable an option it can be for widespread treatment.

"I am very passionate about prevention, and I really think that the key to addressing our healthcare crisis is preventing disease," says Dr. Yanez. "If we can focus more on the basics of health and what it takes to be a healthy person–good thoughts, good food, good water, good movement–in most cases, most of the illnesses that we see in this country wouldn't be there." ■

Phillip Burbutes

Efforts to Increase Breastfeeding in Arkansas Still Met With Resistance

feeding frenzy

By ***Claudia S. Copeland, PhD***

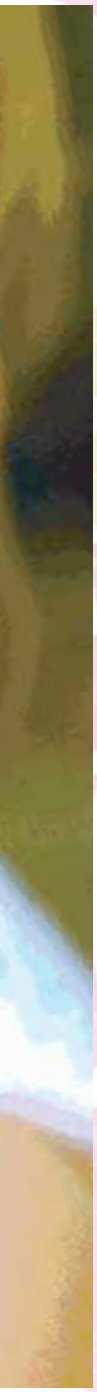


PHOTO BY RACHEL MULLER

When nursing mother Rachel Muller of Jacksonville, Arkansas, heard that her artwork was accepted into Small Works On Paper, a traveling art show sponsored by the Arkansas Arts Council, she was looking forward to showing the accepted photograph, a portrait of her baby breastfeeding. Soon, though, she received news that the first venue, the South Arkansas Arts Center, refused to hang her piece.

She contacted the director, and was told that the reason it was being excluded was that "this is an educational facility located across the street from an elementary school that frequently utilizes our building." She wrote to the director, informing him that health professionals recommend teaching children about breastfeeding. "By excluding my piece," she continued, "you are perpetuating the social norms of breastfeeding as something that should be concealed from adults and children. If you display my nursing photo, you will find that children are curious and want to learn about breastfeeding. Please, include my piece in the show." When her request was again denied, she started a petition, and posted a link to the Arkansas Arts Council Facebook page. For this, she was blocked from the page, a move upheld by the Arts Council executive director. After several dozen signatures on her petition, however, her piece was finally included.

The fact that Muller had to fight to get a portrait of a nursing baby in an art show provides a glimpse into the cultural stigma Arkansas women face for breastfeeding. The view that breastfeeding is somehow something to be hidden from view or done discreetly is not unique to Arkansas. It is, however, unique to our timepoint in history. The irony is that, while mothers in the past had little or no access to academic evidence supporting the benefits of breastfeeding, such evidence is abundantly available now. According to the World Health Organization, if every child was breastfed within an hour of birth, given only breast milk for their first six months of life, and continued breastfeeding up to the age of two years, about 220,000 child lives would be saved every year. Yet, as of July 2013, globally, less than 40% of infants under six months of age are exclusively breastfed.

Breastfeeding is associated with a broad range of benefits for babies, including lowered rates of respiratory tract infections, ear infections, gastrointestinal tract infections, necrotizing enterocolitis, clinical asthma, atopic dermatitis, eczema, inflammatory bowel disease, type 1 and type 2 diabetes, and childhood leukemia and lymphoma. Preterm infants who receive human milk while in the NICU exhibit improved neurodevelopmental outcomes and immune development. In addition, breastfeeding during infancy is significantly associated with positive outcomes later in life, including higher IQ and teacher ratings, and lower rates of childhood, adolescent, and adult obesity. According to meta-analyses cited by the American Academy of Pediatrics (AAP), breastfeeding is associated with a 36% reduced risk of sudden infant death syndrome (SIDS), independent of sleep position. The increased rate of SIDS in infants who were never breastfed accounts for 21%

of U.S. infant mortality, leading the AAP to conclude that more than 900 infant lives per year might be saved in the United States if 90% of mothers exclusively breastfed for 6 months. In light of all of these benefits, the AAP recommends "exclusive breastfeeding for about 6 months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant."

In addition to benefits to the baby, breastfeeding also confers significant benefits on the mother. These include immediate effects such as decreased postpartum blood loss, more rapid involution of the uterus, and decreased rates of postpartum depression, but also long-term effects, including decreased risk for diabetes, rheumatoid arthritis, cardiovascular disease, hypertension, and hyperlipidemia. Several studies have found associations with significantly lower rates of ovarian cancer and breast cancer in proportion to cumulative lifetime duration of breastfeeding. For breast cancer, this is particularly significant: each year of breastfeeding has been calculated to result in a 4.3% reduction in breast cancer risk.

Key to promoting breastfeeding is a good support network for nursing mothers. Whereas in the past, mothers were generally able to teach and help their daughters to breastfeed correctly, today, many breastfeeding mothers were never breastfed themselves. To help fill this need, the Arkansas Department of Health manages a Breastfeeding Peer Counselor Program. Peer counselors can be invaluable in helping new mothers with issues like pain and insufficient milk production by teaching their peers how to breastfeed correctly. The ADH is also addressing the issue of women not feeling comfortable breastfeeding in public. Through its Breastfeeding Welcome Here program, in which the ADH distributes signs with a symbol depicting a nursing mother and the words "Breastfeeding Welcome Here", the business community is included in the effort to encourage breastfeeding.

Support groups outside of government do much to promote breastfeeding in Arkansas. La Leche League groups can be found throughout the state, and are, as elsewhere in the U.S., a great resource for nursing mothers. Another non-profit organization dedicated to protecting and promoting breastfeeding is the Arkansas Breastfeeding Coalition. Besides providing a forum for members to share experiences and find support, they also actively sponsor events, such as a full-day annual lactation conference in Little Rock. This conference is co-sponsored by the Arkansas Department of Health and ANGELS (Antenatal and Neonatal Guidelines, Education, and Learning System), a consultative service of the University of Arkansas for Medical Science for Arkansas physicians. (This year's conference is tentatively scheduled for August 8, 2014).

Support from organizations like this can make a huge difference in helping nursing women to overcome common, but unexpected, hurdles–like jury duty. When Ms. Muller asked to defer her jury duty to avoid being separated from her baby, who was being exclusively breastfed at the time, it was a position statement from the Arkansas Breastfeeding Coalition that finally convinced the court to grant the deferral. The Coalition "supports providing exemptions for prospective jurors who are breastfeeding, to protect babies and small children who are dependent upon their mother for nutrition." The American Academy of Pediatrics defines breastfeeding as a medical necessity, and asserts that separating the mother from the child will therefore jeopardize the child's health.

In spite of the efforts of these programs and organizations, in Arkansas the percentage of babies who were ever breastfed is only 58%, compared with a national average of 77%. Breastfeeding at 6 months drops down to 25%, compared with the national average of 49%, and exclusive breastfeeding at three months is 23%, compared with a national average of 40%. The rate of exclusive breastfeeding for 6 months, as recommended by the WHO, is a mere 9.2%. Of the states bordering Arkansas (Louisiana, Mississippi, Tennessee, Missouri, Oklahoma, and Texas), only Mississippi has lower breastfeeding rates than Arkansas.

PHOTO BY LEAH WILLIAMS

While efforts to support nursing mothers will help mothers continue breastfeeding, it is postpartum hospital practices that have more influence on whether mothers start breastfeeding. Arkansas has low rates of "baby friendly" (promoting a breastfeeding relationship) practices like ensuring skin-to-skin contact between mother and baby after birth, and having the mother and baby room together rather than placing the baby in a nursery. None of the hospitals in Arkansas have yet been designated as "Baby-Friendly" by the accrediting body Baby-Friendly USA, but several hospitals are implementing services to support and encourage

Terrie Bell, Breastfeeding Counselor at Craighead County health dept. in Jonesboro, provides guidance on breastfeeding to a new mom.

KEY TO PROMOTING BREASTFEEDING IS A GOOD SUPPORT NETWORK FOR NURSING MOTHERS.

breastfeeding. Chief among these is access to lactation consultants. Muller recalls, "I was planning on giving [my son] bottles. I bought bottles, pacifiers. I had never even heard the term 'exclusively breastfeeding' until a lactation consultant visited me in recovery after he was born. When I was pregnant, my OB asked if I was breastfeeding and I think mentioned a breastfeeding class once, but it wasn't stressed as being important."

Arkansas Children's Hospital and Baptist Health in Little Rock, Conway Regional, and Washington Regional Medical Center in Fayetteville are among the hospitals that provide lactation specialists and telephone lines patients can call to get help with breastfeeding. In addition, Baptist Health offers an outpatient breastfeeding center that mothers can turn to, Expressly For You. Expressly For You provides a toll-free warmline, hosts a monthly support group, and makes outpatient appointments with International Board Certified Lactation Consultants (IBCLCs).

Jessica Donahue, RN, a lactation consultant at Baptist Health for 16 years, believes that, in Arkansas and particularly in Little Rock, "people, including the vast majority of healthcare providers, are supportive regarding breastfeeding." However, she continues, "While I believe the majority of healthcare providers in our area are very knowledgeable and supportive of the benefits of breastfeeding, and encourage moms to begin, moms should seek out providers that have an IBCLC on staff or one that they regularly refer patients to. Many new moms face typical challenges when they begin breastfeeding: pain, low supply, returning to work, and nursing in public. These challenges often cause moms to stop breastfeeding too early. Follow-up with an IBCLC-certified lactation consultant is the key to helping women face breastfeeding challenges and continue to nurse for the one year or more that the AAP recommends."

In addition, said Donahue, "Baptist Health recently received a grant from the Blue And You Foundation for a Healthier Arkansas to provide telephone triage assistance and basic breastfeeding education to our state's healthcare providers. This was a competitive grant process and [Baptist] was chosen out of a field of many worthwhile statewide health initiatives. We believe this program will help physicians' offices around the state to be more supportive of mothers who are breastfeeding, because they will have access to the expertise needed to support them. Physicians' offices are encouraged to contact us if they would like to be part of this program."

She also points out that the ADH is regularly and actively working to develop new strategies to raise breastfeeding rates. "The Arkansas Department of Health has a dedicated task force that meets monthly to come up with ways to improve our state's breastfeeding rates. This task force will establish a pilot program to be implemented in one Arkansas county and will learn which initiatives make an impact on breastfeeding

Clearly, the healthcare establishment in Arkansas is pro-breastfeeding and actively trying to raise breastfeeding rates in the state. This sense of support may be contradicted, though, by a lack of societal support outside healthcare circles.

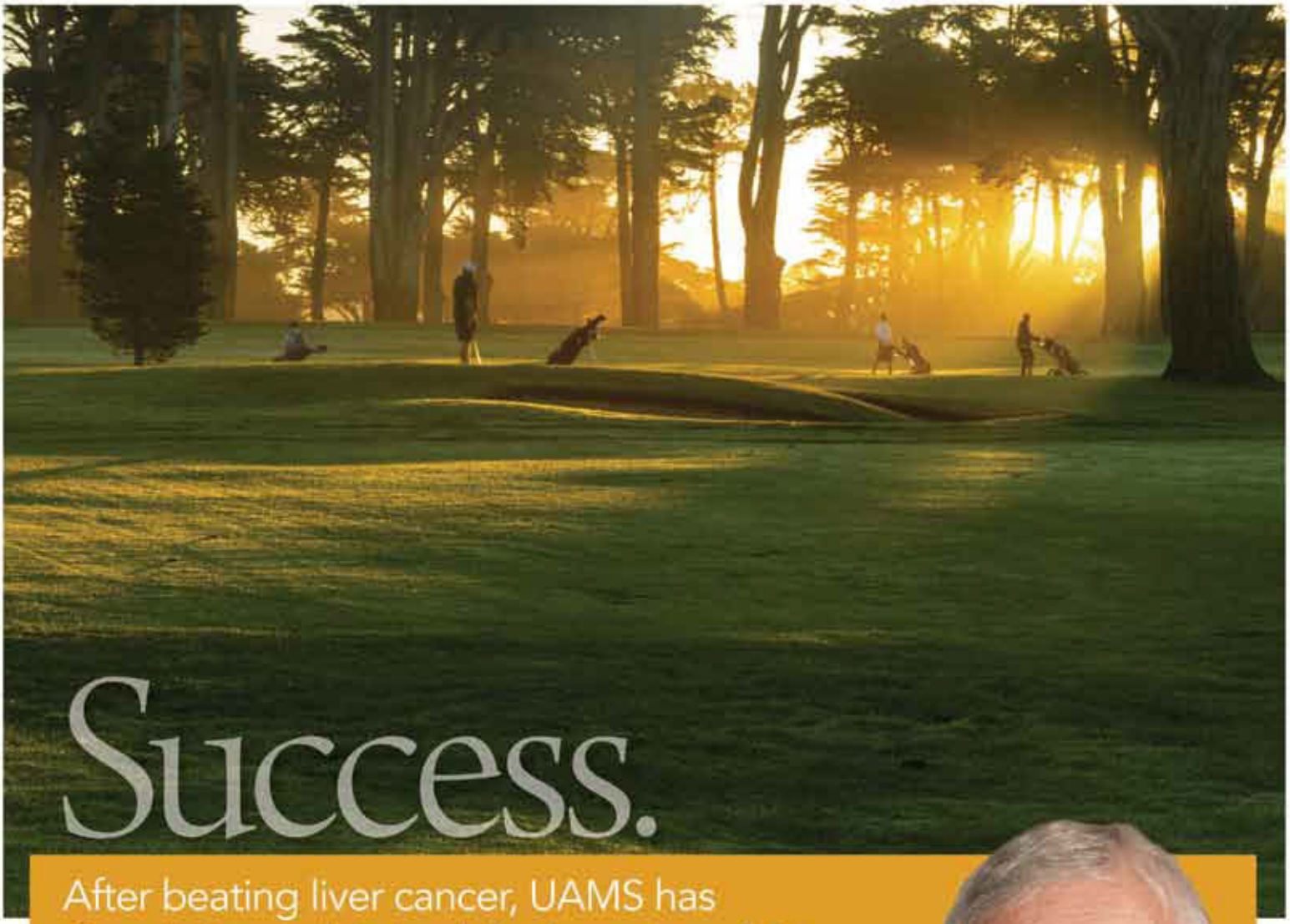
rates. The effective initiatives will then be spread statewide."

Clearly, the healthcare establishment in Arkansas is pro-breastfeeding and actively trying to raise breastfeeding rates in the state. This sense of support may be contradicted, though, by a lack of societal support outside healthcare circles. Might the low rates be related to an irrational, but stubborn, stigma against breastfeeding? While it is expressly legal to breastfeed a baby in public in Arkansas, the sight of breastfeeding mothers is not common. Muller, who lives about 15 minutes north of Little Rock, rarely sees other mothers nursing in public. "My son is almost three and since he was born I have seen two women (on separate occasions) nursing in public (other than at a La Leche League meeting). One woman was using a cover and the other was nursing in her car. That shows how unaccepted it still is even though I think most people understand that it's the healthy option."

Ignorance about breastfeeding can in fact reach shocking levels, with dire consequences, as in the case of Tasha Adams, who was arrested for breastfeeding her baby while eating a dinner that included beer at an Arkansas pizzeria. Over the course of the dinner, she had had two glasses of beer (the amount has been confirmed by her servers and the other people at her table), and was not intoxicated. However, a woman in the restaurant saw Adams drinking beer and breastfeeding at the same meal, and called the police, who then arrested the nursing mother for endangering the welfare of a minor. Her baby, who was being exclusively breastfed at the time, was taken away from her while she was handcuffed and brought to jail. (Luckily, she was able to post bond quickly; as no one else could feed her baby, the baby had to go hungry while her mother was waiting in a jail cell.)

Biomedical research overwhelmingly indicates that there is no reason to believe that this level of alcohol consumption is harmful to a breastfed baby, and in fact dark beer is traditionally recommended for breastfeeding mothers to promote milk production. Adams' attorney, Reggie Koch, believes that the reason for the arrest is pure, negative stigma rather than any real concern about the welfare of the baby. In an argument to drop the charges, he warns of the consequences of such actions: "Efforts to place restrictions on mothers about how and when they may breastfeed–including trying to use criminal statutes to regulate what they eat, what they drink, etc.–has the net effect of "chilling" or discouraging breastfeeding, which is in direct conflict with the stated [by health authorities] goal of encouraging breastfeeding. The message we are sending to breastfeeding mothers with arrests like this one is clear: The authorities are watching you; if you choose to breastfeed your baby, beware! If you engage in any behavior that other people find offensive–morally, religiously, or otherwise–you will be arrested and taken to jail. It is much 'safer' to simply use formula instead of breastfeeding."

While bottle-feeding may seem safer and more acceptable today, it is actually a very odd practice (albeit a very useful one, when it is necessary). Breastfeeding, in contrast, is a fundamentally normal activity; mothers have been doing it since the dawn of humanity, women's bodies are optimized for it, and many feel that the experience of breastfeeding is a profound and primordial part of babyhood–a link between emerging from the protection of the womb and entering into relative independence after toddlerhood. In the words of Muller, "I don't think most people understand that breastfeeding is a relationship. It's not just about the milk. I didn't understand that before I had my son." Certainly, the physical health benefits of breastfeeding are reason enough to support the practice, but if extended breastfeeding is to once again become the norm, the practice will need not only to be allowed, but respected and celebrated as well. ■



Success.

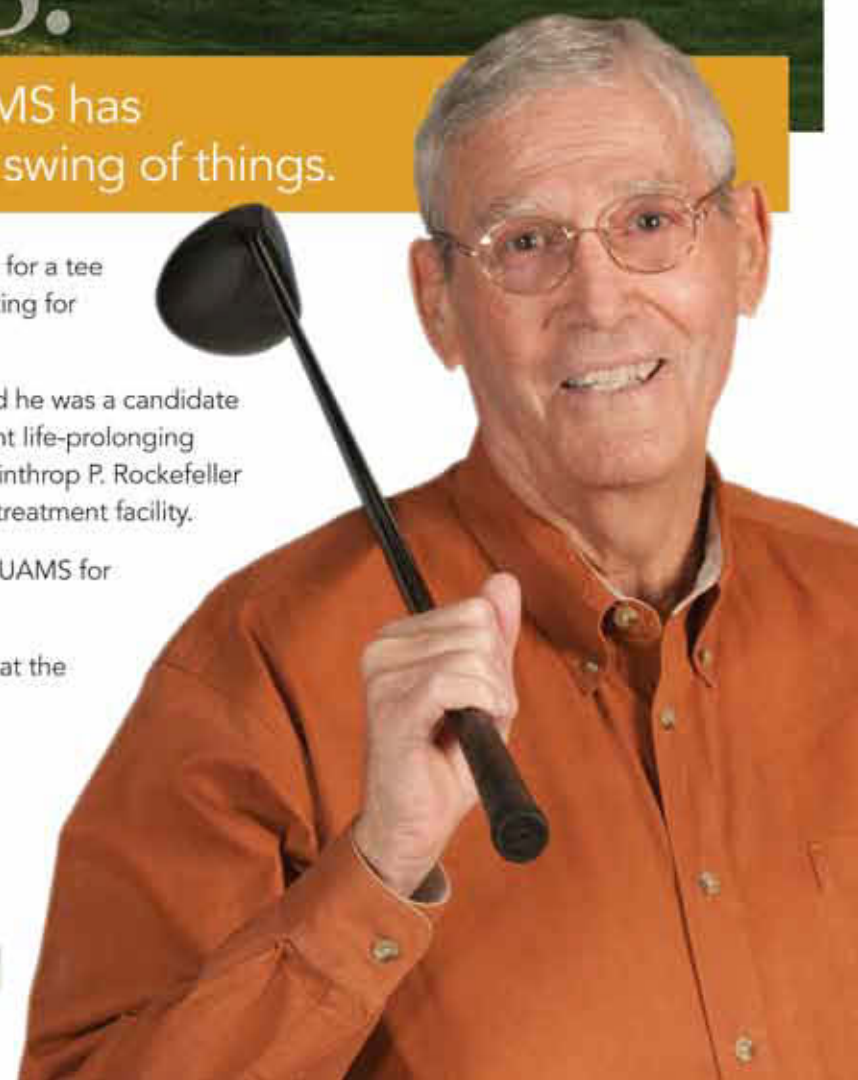
After beating liver cancer, UAMS has Carroll Martindale back in the swing of things.

In 2010, Carroll Martindale should have been waiting for a tee time at his favorite golf course. Instead, he was waiting for something entirely more important: a new liver.

After being diagnosed with liver cancer, Carroll was told he was a candidate for a transplant. While waiting for a donor, he underwent life-prolonging chemotherapy and radiation treatment at the UAMS Winthrop P. Rockefeller Cancer Institute, Arkansas' official cancer research and treatment facility.

Three years later, the call came and Carroll returned to UAMS for a successful liver transplant.

Today, he is healthy, back on the course and thankful that the best things in life are worth waiting for.



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HEALTHCARE briefs

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HEALTHCAREBRIEFS

STATE

Private Option Enrollments Continue to Increase

Even as legislators gathered to decide the fate of the Private Option, the latest county-level review of data showed enrollment continued to increase in every Arkansas county, with hundreds, and in many cases thousands, of people in each county now getting healthcare coverage under the new program, according to information released by the Arkansas Department of Human Services (DHS).

"We are pleased to see that enrollment has remained steady across the state," said DHS Director John Selig. "We can tell word is really getting out about the program and people are really seeing its value."

In all, 96,950 people had gained healthcare coverage through the Private Option as of February 6th. Coverage under the Private Option (formally known as the Health Care Independence Program) began Jan. 1. Of those enrolled so far, 87,061 were covered by a private health insurance plan and 9,889 had been determined to be better served by the traditional Medicaid program because of exceptional healthcare needs.

The 10 counties with the highest enrollment are: Pulaski County with 12,094; Washington County with 4,338; Garland County with 4,202; Benton County with 4,078; Craighead County with 3,318; Faulkner County with 3,303; Jefferson County with 3,263; Sebastian County with 3,122; Crittenden County with 2,560; and Saline County with 2,310.

The Department also released the ages of enrollees. As of February 6th, 53% of Private Option enrollees were under the age of 40. The ages break down as follows:

18-29= 25,437
30-39= 26,427
40-49= 20,435
50-59= 18,839
60+= 5,808

The Private Option allows the state of Arkansas to use federal Medicaid funding to pay the private health insurance premiums for eligible individuals who make no more than 138 percent of the federal poverty level. Those annual income limits, by household size, are: Household of 1 - $15,856, Household of 2 - $21,404, Household of 3 - $26,951, Household of 4 - $32,499 Household of 5 - $38,047.

Arkansans who, based on their income, believe they are eligible for the program can apply at www.access.arkansas.gov. People also may apply at their local DHS county office.

Payment Improvement Initiative Part II Begins

Hundreds of primary care physicians in Arkansas are now receiving supplemental monthly payments to help them provide better and more comprehensive patient care as part of Medicaid's effort to transform the state's healthcare system.

The "care coordination" payments are for physicians who enrolled to be Patient Centered Medical Homes (PCMH), a concept that uses financial incentives to encourage physicians to focus more on management of chronic medical conditions, prevention, and empowerment of patients through health education.

"Arkansas Medicaid and private insurers have been working aggressively over the last two years toward a more efficient and effective healthcare system," said Medicaid Medical Director Dr. William Golden. "We recognized that investing in our state's primary care physicians through medical homes was a fundamental part of moving the system forward."

Golden said the medical home program not only offers needed financial support to physicians, but also enhances patient experience and should lead to better patient health. Participating physicians, for example, will offer more same-day appointments and provide 24/7 live voice access for patients. Both of these requirements are intended to increase patient access to care and to reduce the inappropriate use of the emergency room.

The launch of medical homes is an expansion of the Arkansas Health Care Payment Improvement Initiative, which began in 2012 when the state changed the way it pays for certain acute medical episodes, like upper respiratory infections and pregnancy. The overall initiative aims to reward hospitals, physicians, and others who adapt their practices so that they are providing high-quality, cost-effective care.

Although the medical home concept has been around for years, Arkansas's approach includes several innovative components. In addition to the care coordination payments, participating physicians also will have available practice transformation support and will be able to share in savings generated by the program.

Open enrollment for the first year of the medical home program closed on Dec. 16. A total of 637 primary care physicians from across the state are participating. Their practices cover nearly 243,000 Medicaid beneficiaries with 40,000 of those beneficiaries covered by practices participating in a state/federal program called the Comprehensive Primary Care Initiative (CPCI), which is considered to be the first wave of medical homes in Arkansas. Together, medical homes and CPCI cover about 72 percent of all PCMH eligible Medicaid beneficiaries.

"Enrollment has far exceeded our expectations," Golden said. "We had hoped to have at least 40 percent of eligible Medicaid beneficiaries covered. Clearly, physicians are excited about the additional support and the opportunity to do more to keep their patients healthy."

A second wave of enrollment for participation beginning July 1, 2014 has begun and will close May 15, 2014. Enrollment for participation in 2015 will open on October 1, 2014.

Alongside medical homes, Medicaid also is initiating a pilot project in 39 Delta counties called the Delta Primary Care Case Management (PCCM) program. That program, as described in Act 1453 of 2013, serves as a second option for primary care physicians looking for additional support so they can better serve their patients. Rather than paying physicians directly as is done in the medical home model, Medicaid will contract with a vendor to provide care coordination for practices enrolled in the pilot project. Medicaid issued a request for proposal for those services today.

"The pilot project really gives the state an opportunity to see what aspects of both models best support physicians so that they can empower their patients to be healthier and more proactive when it comes to their health care needs," said John Selig, Director of the Department of Human Services, which oversees Arkansas Medicaid.

Andy Allison

CBO Taps Allison for 2014 Advisory Panel

Arkansas Medicaid Director Andy Allison has been selected to serve on the Congressional Budget Office's (CBO) panel of health advisors for 2014. Allison, who oversees Arkansas Medicaid and the Department of Human Services (DHS) Division of Medical Services, has nearly twenty years of experience in researching, overseeing and running Medicaid programs. Since coming to Arkansas in 2011, he has taken a lead role in Arkansas's efforts to transform the state's healthcare system and in the creation of the state's innovative alternative to Medicaid expansion, commonly called the "Private Option."

Allison joins 19 other panel members who are widely-recognized healthcare experts. In an announcement posted on its website, the CBO said of the panel, "We benefit from the advisers' understanding of cutting-edge research and the latest developments in health care delivery and financing. As a result, the quality of CBO's analysis of health policy is greatly enhanced."

The CBO is a nonpartisan office that produces independent analyses of budgetary and economic issues to support the U.S. Congressional budget process.

Allison, who is a founding board member and former president of the National Association of Medicaid Directors, said he's honored to be selected. "I'm eager to join the CBO panel of health advisors to share our successes and experiences here in Arkansas and to learn from other professionals from across the country who work in health care policy and the healthcare industry," he said.

MARK YOUR CALENDAR

ASBN Hosts Workshop

The Arkansas State Board of Nursing will host "2014: LIGHTING THE WAY FOR THE FUTURE OF NURSING," a continuing education workshop, on three dates at three locations this year. The first workshop was held in Little Rock in February, but two more remain:
September 18 - Southern Arkansas University, Reynolds Center, Grand Ballroom, Magnolia
November 13 - Northwest Arkansas Community College, White Auditorium, Bentonville

The workshop agenda is as follows:
8:30 a.m. - ASBN 101
9:00 a.m. - Navigating Safely Through Social Media
10:00 a.m. - Break
10:15 a.m. - Swimming with the Sharks: Creating a Healthy Work Environment
11:00 a.m. - View From the Lighthouse: ASBN Perspective
12:00 p.m. - Lunch
12:45 p.m. - Avoiding the Rocky Shores: Issues of Liability
1:30 p.m. - "I'm Allergic to Tylenol, but Percocet Works Great!" Drug Diversion & Tools to Combat Drug Abuse
2:30 p.m. - Break
2:45 p.m. - Zapping Your Fear of NCLEX®

This continuing education sponsored by the Arkansas State Board of Nursing is awarded 6.0 contact hours. Participants who leave immediately prior to the NCLEX presentation will receive 5.0 contact hours. This continuing nursing education is approved by Arkansas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

The registration fee is $45.00 (includes lunch) and pre-registration is required. Registration must be received one week prior to date of workshop. All fees are non-refundable. To register go to:
https://www.ark.org/nursing_reg/index.php/workshop/register.
E-mail info@arsbn.org if you have questions.

HEALTHCAREBRIEFS

Allison came to Arkansas from Kansas, where he oversaw that state's Medicaid program, Children's Health Insurance Program, and state employee health plans. He began his career as a Medicaid analyst at the federal Office of Management and Budget and later served as a health policy researcher at the Kansas Health Institute. He received his Bachelor's Degree in History from Ouachita Baptist University in Arkadelphia before earning a Master's Degree in Public Policy from Duke University and a PhD in Economics from Vanderbilt University.

Surgeon General Projects Millions of Arkansas Children Will Die Too Soon

Approximately 5.6 million American children will die prematurely from smoking-related diseases unless the current smoking rates drop, according to a new Surgeon General's Report. In Arkansas, this represents about 69,000 children alive today who ultimately will die prematurely because of smoking (State data available in Chapter 12, Appendix 12.2 of the Surgeon General's Report).

Agreeing that, "Enough is enough," Dr. Gary Wheeler, Medical Director for the Tobacco Prevention and Cessation Program at the Arkansas Department of Health said, "We must take immediate and bold action to protect the lives of everyone in Arkansas, and especially our children."

The report, The Health Consequences of Smoking: 50 Years of Progress, calls the epidemic of cigarette smoking over the last century an enormous and avoidable public health tragedy. In just the last 50 years, 20 million Americans have died because of smoking. The new report updates estimates on the human and financial tolls of the cigarette smoking epidemic, finding that it kills close to half a million Americans a year and costs more than $289 billion a year in direct medical care and economic loss.

In Arkansas, smoking kills about 4,900 adults each year. Lost productivity for smoking in Arkansas accounts for more than $1.4 billion per year. Smoking is attributable to more than $812 million in medical costs per year in Arkansas. In 2004, this addiction cost the nation more than $96 billion per year in direct medical expenses as well as more than $97 billion annually in lost productivity. (State data available at www.cdc.gov/state_system and at http://www.tobaccofreekids.org/facts_issues/toll_us/arkansas June 2013).

This most recent report comes 50 years after the historic Surgeon General's Report, which concluded that cigarette smoking causes lung cancer in men. Since the 1964 report, evidence has linked smoking to diseases of nearly all the body's organs; the new report establishes new links, finding that cigarette smoking causes diabetes, colorectal cancer, and liver cancer.

The report also explains that smokers today have a greater risk of developing lung cancer than they did in 1964, even though they smoke fewer cigarettes. Changes in the design and composition of cigarettes may have contributed to this increase in risk. At least 70 of the chemicals in cigarette smoke are known carcinogens.

New findings in this report conclude that smoking causes rheumatoid arthritis and immune system weakness, increased risk for tuberculosis disease and death from TB, ectopic pregnancy and impaired fertility, cleft lip and cleft palates in babies of women who smoke during early pregnancy, erectile dysfunction in men, age-related macular degeneration, and increases the failure rate of cancer treatment. The report concludes secondhand smoke exposure is known to cause strokes in nonsmokers.

The report finds that tobacco control efforts have averted at least 8 million early deaths since 1965, but that these evidence-based tobacco control interventions continue to be underutilized.

Studies show about 70 percent of all smokers want to quit. They can get free help by calling 1-800-QUIT-NOW (1-800-784-8669) or visiting www.smokefree.gov. To read the full report, The Health Consequences of Smoking: 50 Years of Progress, go to www.SurgeonGeneral.gov.

Governor Appoints Two to ASBN

Governor Mike Beebe recently appointed two new members to the Arkansas State Board of Nursing, Ramonda Housh of Pocahontas and Patricia Staggs of Searcy.

Ramonda Housh is a certified pediatric nurse practitioner, and fills the Board position for advanced practice registered nurse. Housh received her bachelor's degree from Arkansas State University in Jonesboro. She earned her Master of Nursing Science degree from University of Arkansas for Medical Sciences in Little Rock. Housh is the interim director of nursing at Black River Technical College in Pocahontas. Previously she served patients as a registered nurse in medical-surgery and as a community health nurse, as well as pediatric patients as an Advanced Practice Registered Nurse. Housh is a member of Sigma Theta Tau and is a Certified Pediatric Nurse Practitioner.

Patricia Staggs is a licensed practical nurse and fills the position for one of the licensed practical nurses or licensed psychiatric technician nurses on the Board. Staggs earned a nursing certificate from Crowley's Ridge Technical Institute in Forrest City. She enjoys working with the geriatric population in her position as a clinic nurse at Nephrology Associates and previously at Searcy Healthcare.

AG Arrests Worker for Medicaid Fraud

Attorney General Dustin McDaniel announced that a Craighead County healthcare worker was arrested for Medicaid fraud as part of an investigation by the Attorney General's Medicaid Fraud Control Unit.

Amanda Fielder, 28, of Bono was arrested on one count of Medicaid Fraud, a Class C felony. She is accused of billing the state's Medicaid program for services she did not provide. She was released from the Craighead County Detention Center on her own recognizance.

Fielder is accused of making fraudulent claims to Medicaid in the amount of $2,216.16. She is alleged to have lied about providing attendant care services to a Medicaid beneficiary in Jonesboro during the time period from Aug. 29, 2013, to Oct. 5, 2013. According to investigators, Fielder lived in a town 52 miles away from Jonesboro and had no transportation during the time she was alleged to have been assisting the Medicaid beneficiary.

Charges are merely accusations and a defendant is presumed innocent unless and until proven guilty.

To report instances of Medicaid fraud or abuse and neglect in nursing homes, call the Medicaid Fraud Control Unit hotline at (866) 810-0016.

Arkansas Lung Cancer Rates Declining

A new analysis of lung-cancer data suggests tobacco control efforts are having a major impact on Americans' health. Nationally, the rate of new lung cancer cases decreased in the U.S. from 2005 to 2009, according to a report in the *Morbidity and Mortality Weekly Report*. Those results are also being seen here in Arkansas.

"The drop in the nations' rates of lung cancer has been trending down for years. Finally we are seeing that in Arkansas. Further, we are seeing a statistically significant drop in rates from 2005 - 2009 that may be even faster than the nation's," said Dr. Wheeler, Medical Director for the Tobacco Prevention and Cessation Program. "While our incidence and rates of lung cancer and mortality is nearly 1/3 higher than the nation, fewer people in Arkansas are starting to smoke and more are quitting."

"There is a dramatic decline in the number of young adults with lung cancer which shows tobacco prevention and control programs work - when they are applied," said Centers for Disease Control and Prevention (CDC) Director Tom Frieden, MD, MPH. He went on to say, "While lung cancer incidence rates are dropping in the U.S. one preventable cancer is one too many. Implementation of tobacco control strategies is needed to reduce smoking prevalence and the lung cancer it causes."

"Unfortunately, here in Arkansas the incidence and mortality of lung cancer in women continues to rise. We need to make an even stronger effort to encourage women not to smoke," Dr. Wheeler explains. "The impact of women's smoking goes beyond the direct impact on their own health. Smoking during pregnancy leads to complications for the unborn child. And it can lead to infections, asthma, and other complications from secondhand smoke."

Tobacco costs Arkansas nearly $2 billion in direct health and indirect economic costs every year. A recent study in the *American Journal of Public Health* found that for every dollar spent by tobacco prevention and control programs in 2000 and 2009, more than five dollars were saved by reducing hospitalizations for heart disease, stroke, respiratory disease and cancer caused by tobacco.

To learn more visit StampOutSmoking.com. If you are a tobacco user and want to quit, the Arkansas Tobacco Quitline can help. Call 1-800-QUIT-NOW to learn more about free nicotine replacement therapy and other services.

Sponsors Needed for Summer Food Program

The Arkansas Department of Human Services (DHS) is seeking schools, nonprofit organizations, and government agencies that are willing to provide children with nutritious meals and snacks during the summer as part of the agency's Summer Food Service Program. The program is operated by the DHS Division of Child Care and Early Childhood Education. It began accepting applications on February 24th.

This 100 percent federally-funded program was created to ensure low-income children who receive free or reduced lunches during the school year don't go hungry when school is not in session.

Organizations that qualify as program sponsors will receive reimbursement for meals and snacks that are served to children.

"We need sponsors in every county in the state so that all children in Arkansas who are at risk of hunger have a place to go for a meal," said Buster Lackey, program administrator. "Organizations that are interested but nervous about joining this effort should know that DHS will be there to support sponsors every step of the way. We provide training and are always available to answer any questions they may have."

Last year, the Summer Food Service Program provided 3.7 million meals to children across the state, Lackey said.

Organizations eligible to serve as program sponsors include public or nonprofit private school food authorities; public or nonprofit private residential summer camp; local, municipal, county, or State governments; public or private nonprofit colleges or universities which are currently participating in the National Youth Sports Program; and private nonprofit organizations.

The Summer Food Service Program operates in areas in Arkansas where at least 50% of children are eligible for free or reduced price meals under the National School Lunch Program, or at specific service sites where at least 50% of the enrolled children are eligible for free or reduced price meals. Children 18 years of age and under, and persons over 18 years of age who are determined by a State educational agency or a local public educational agency of a State to be mentally or physically handicapped and who participate in a public or nonprofit private school program established for the mentally or physically handicapped may participate.

Sponsors are needed to oversee the production and distribution of the food at sites like schools, playgrounds, and churches. All sponsors receive training on how to plan, operate, and monitor a successful food service program. Sponsors submit claims and may be reimbursed weekly. Sites may serve up to two meals per day and may choose from breakfast, lunch, a snack or supper. Each meal served must meet the Summer Food Service Program meal pattern.

DHS will accept applications for sponsors through April 15, 2014. Please contact the Health and Nutrition office for more information or assistance at 501-682-8869 or 1-800-482-5850 ext. 28869. Information about the Summer Food Service program and a sponsor application form may be found at this link: https://dhs.arkansas.gov/DCCECE/SNP/SummerInfoM.aspx.

HEALTHCAREBRIEFS

Meals are available to all children regardless of age, color, sex, race, national origin, or disability. The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender, identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities).

Wig Boutique Named for Northwest Arkansas Mom

It was a bittersweet celebration when family and friends of Kristen J. Madsen gathered at the University of Arkansas for Medical Sciences (UAMS) to honor her memory. A 39-year-old mother of two sons, Madsen died in 2009 of ovarian cancer. Since her death, Madsen's family members have devoted their time to promoting ovarian cancer awareness and raising funds for research through the Wig Out to Defeat Ovarian Cancer event and the Ovarian Cancer Northwest Arkansas Teen Council.

Proceeds from the 2013 Wig Out event totaling almost $54,000 were donated to the UAMS Winthrop P. Rockefeller Cancer Institute to support gynecologic oncology research. In recognition of their donation, the institute unveiled the new name for its wig shop — the Kristen J. Madsen Wig Boutique — at the celebration. Located in the institute's Patient Support Pavilion, the boutique offers a free wig and hats to each patient who has lost her hair due to cancer treatment.

"Kristen loved her hair, and after she lost it, she loved her wig," said Jo Ann Johnson, Madsen's mother. "She is smiling down on us today, knowing that this place is helping people get through their experience with cancer."

Family members joining Johnson at the ceremony were Madsen's father, Butch Johnson; son Aaron Whitt; sister Lynli Williams; and nieces Anna and Emily Williams.

"The wig boutique was deliberately placed in the center of our Patient Support Pavilion because it plays such a pivotal role in the emotional healing process for our patients. We are honored today to name this space after Kristen," said Cancer Institute Director Peter Emanuel, MD.

Members of the teen council also attended the ceremony following a day-long experience at the Cancer Institute touring research labs, hearing from physicians and scientists, and learning about advances in ovarian cancer detection and treatment.

Dyanne Gaillard Sykes developed the idea for the council after being asked to serve on the Wig Out planning board and committee. The group of 11 high school sophomores, plus a college advisor, will assist with the upcoming Wig Out fundraiser, scheduled for April 12 at Highlands Oncology Group in Rogers.

The girls also host other fundraising events and educate members of their community about ovarian cancer. Deemed "the disease that whispers," ovarian cancer's symptoms can be subtle, resulting in many women being diagnosed with late-stage disease. Symptoms of ovarian cancer include bloating; pelvic or abdominal pain; difficulty eating or feeling full quickly; and changes related to the urgency and frequency of urination.

Worker Bills Medicaid for Services Not Provided

Attorney General Dustin McDaniel announced that a Sebastian County healthcare worker was arrested for Medicaid fraud following an investigation by the Attorney General's Medicaid Fraud Control Unit. Sondra Torres, 34, of Fort Smith was arrested on one count of Medicaid Fraud, a Class C felony. She was released from the Sebastian County Detention Center pending an initial court appearance in Pulaski County.

Torres is accused of fraudulently billing the Arkansas Medicaid Program for payment as an attendant-care provider to a Medicaid beneficiary. The beneficiary told investigators that Torres did not provide assistance during the time from July 14, 2013, to July 27, 2013. According to investigators, Torres billed Medicaid for services during that time period.

The Attorney General's Office began its investigation of Torres after a referral from the Office of Medicaid Inspector General.

Charges are merely accusations and a defendant is presumed innocent unless and until proven guilty. To report Medicaid fraud or abuse and neglect in nursing homes, call the Medicaid Fraud Control Unit hotline at (866) 810-0016.

Birth Defects Affect Nearly 1,300 AR Babies

Each year in Arkansas, approximately 1,300 babies are diagnosed with a birth defect and more than 100 babies will die because of them. Nationally, birth defects affect one in every 33 babies born each year, according to the Centers for Disease Control and Prevention (CDC). Birth defects occur before a baby is born. Most birth defects occur in the first three months of pregnancy, but some birth defects can happen later in pregnancy. Most birth defects are caused by a complex mix of factors, including genes, health habits, and things in the environment. While not all birth defects can be prevented, there are many things a woman can do before and during pregnancy to increase her chance of having a healthy baby.

"Birth defects are the leading cause of infant death," David Grimes, MD, Branch Chief of Family Health at the Arkansas Department of Health, said. "Yet, nearly 20 percent of all birth defects are preventable."

A woman of childbearing age, pregnant or planning to get pregnant, should do the following to help ensure a healthy baby:

- Take 400 mcg of folic acid, sometimes called vitamin B-9, every day, starting at least one month before getting pregnant. Most prenatal vitamins include the recommended amount of folic acid.
- Don't drink alcohol, smoke or use drugs. If you need help quitting tobacco, call the Arkansas Tobacco Quitline at 1-800-QUIT-NOW.
- Talk to a healthcare provider about taking any medications, including prescription and over-the-counter medications, and dietary and herbal supplements. Talk to a doctor before stopping any medications that are needed to treat health conditions.
- Get a flu shot and Tdap shot during pregnancy.

These shots will protect mother and baby from flu and pertussis (sometimes called whooping cough).

- If possible, be sure any health conditions are under control, before becoming pregnant. Some conditions that increase the risk for birth defects include diabetes and obesity.
- See a healthcare provider regularly.

By taking these steps, a woman can reduce the chances her baby will have defects of the brain or spine, defects caused by alcohol and drug use, low birth weight, and other serious health conditions. In addition, following these guidelines will improve the health of the mother and reduce the risk for serious complications during birth.

For more information about healthy babies and preventing birth defects, visit http://www.cdc.gov/ncbddd/birthdefects/index.html.

LAMMICO Declares Dividend

The LAMMICO Board of Directors has declared another dividend for all policyholders in Louisiana and Arkansas, marking the seventh time since 2008 the company has authorized the payment of a dividend to its insureds. The dividend affects over 6,000 insureds who will receive a 10.5 % dividend of a policyholder's written premium during the first quarter of 2014.

The 10.5 percent dividend declared totals approximately $5-million. A 10 percent dividend was also declared each year from 2009 through 2012, preceded by two separate 20 percent dividend declared in 2008.

All LAMMICO policyholders in Louisiana and Arkansas (including individual physicians and other healthcare professionals, groups & healthcare facilities) holding a LAMMICO policy in force as of December 11, 2013 (with the exclusion of medical student and tail policies) will receive a dividend check early this year.

Large and Small Grants Available for Health Programs

The Blue & You Foundation for a Healthier Arkansas is accepting applications for large and small grants to organizations to implement health improvement programs in Arkansas.

Any public charity, public school, government agency, or non-profit hospital in Arkansas is eligible to apply. Grants are not made to individuals. Funds must be used in an effort that produces some positive health outcome for Arkansans. The grant may be used for general operational or specific program support, for an existing or new program.

Applications for $1,000 mini-grants will be accepted in the months of February, March, and April, with 75 mini-grants allotted for the three months. Applicants will be notified of mini-grant awards within approximately 30 days.

Regular grants of $5,000 to $150,000 have an application deadline of July 15 and will be awarded in November to fund health improvement programs during 2015.

Arkansas Blue Cross and Blue Shield established the Blue & You Foundation in 2001 as a charitable foundation to promote better health in Arkansas. In its 12 years of operation, the Blue & You Foundation has awarded nearly $19 million to 423 health improvement programs in Arkansas.

The foundation is an independent licensee of the Blue Cross and Blue Shield Association and serves the state of Arkansas. The foundation is a 501(c)(3) organization.

Information about the grants and the online application submission process can be found at www.BlueAndYouFoundationArkansas.org.

Arkansas Health Network Named Medicare ACO

Arkansas Health Network has been selected as one of 123 new Accountable Care Organizations (ACOs) in Medicare, providing approximately 1.5 million more Medicare beneficiaries with access to high-quality, coordinated care across the United States.

Doctors, hospitals, and healthcare providers establish ACOs in order to work together to provide higher-quality coordinated care to their patients, while helping to slow healthcare cost growth. Since passage of the Affordable Care Act, more than 360 (ACOs) have been established, serving over 5.3 million Americans with Medicare. Beneficiaries seeing healthcare providers in ACOs always have the freedom to choose doctors inside or outside of the ACO. ACOs share with Medicare any savings generated from lowering the growth in healthcare costs when they meet standards for high quality care.

The ACOs must meet quality standards to ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely. The Centers for Medicare & Medicaid Services (CMS) evaluates ACO quality performance using 33 quality measures on patient and caregiver experience of care, care coordination and patient safety, appropriate use of preventive health services, and improved care for at-risk populations.

The new ACOs include a diverse cross-section of healthcare providers across the country including providers delivering care in underserved areas. More than half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately one in five ACOs include community health centers, rural health clinics, and critical access hospitals that serve low-income and rural communities.

The next application period for organizations interested in participating in the Shared Savings Program beginning January 2015 will be in summer 2014.

More information about the Shared Savings Program is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/.

HEALTHCAREBRIEFS

LOCAL

More Than $3.5 Million Awarded by UAMS Translational Research Institute Since 2009

Over the past five years, the University of Arkansas for Medical Sciences (UAMS) Translational Research Institute has provided pilot and strategic investment funds totaling $3.68 million to researchers.

The 62 pilot awards and four strategic investments have helped UAMS researchers advance science in their laboratories and in Arkansas communities. Their work has resulted in 58 publications, five patent applications and generated $3.9 million in additional funding from outside sources.

"We've had a healthy return on our investment, and we expect it to grow considerably as work continues on our most recently funded pilot studies," said Lisa Jackson, JD, RN, executive director of the Translational Research Institute.

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. It was established with a five-year $19.9 million award from the National Institutes of Health (NIH) in 2009 and with significant support from UAMS. It is one of 62 NIH Clinical and Translational Science Award (CTSA) recipients. The CTSA program is managed by the National Center for Advancing Translational Sciences (NCATS).

Significant funding support for the pilot program also came from UAMS and the Arkansas Children's Hospital Research Institute, which is staffed by UAMS faculty researchers.

Early-stage research received the bulk of the pilot awards, with 77 percent going to basic (laboratory-based) sciences and clinical trial studies. The balance has gone to community-based research and policy and outcomes research.

The pilots, which total $3.52 million, include targeted awards for research utilizing UAMS' Enterprise Data Warehouse, community engagement, and the Western States Collaborative, a multi-institutional project.

In addition, strategic investments were made to four projects totaling $152,998, bringing all pilot and strategic investment awards to $3.68 million. The strategic investment program is used to increase the likelihood of funding success from outside sources; provide targeted supplemental resources that are lacking in research already funded from outside sources; and provide financial assistance that supports federal Food and Drug Administration approval for new drugs, devices or biologics.

More information about TRI's Novel Methodologies and Pilot Studies Program is at tri.uams.edu.

Ali I. Raja, MD, FAANS, FACS

Local Neurosurgeon Initiated Into ACS

Arkansas Neuroscience Institute neurosurgeon, Ali I. Raja, MD, FAANS, FACS, was among 1,622 initiates from around the world who became Fellows of the American College of Surgeons (FACS) during the Convocation ceremony at the College's 2014 annual Clinical Congress in Washington, DC. This past year's class of Initiates was among the largest ever admitted into the College.

Raja received a medical doctorate degree in 1998 from King Edward Medical College of Punjab University and is currently practicing at the Arkansas Neuroscience Institute located at St. Vincent Infirmary in Little Rock.

By meeting the College's stringent membership requirements, Fellows of the College have earned the distinguished right to use the designation of "FACS" (Fellow, American College of Surgeons) after their name. An applicant for Fellowship must fulfill the following requirements: possess the ability to speak and/or write in English; be a graduate of an approved medical school; possess documentation of the completion of the basic surgical requirements determined by his or her country; possess a full and unrestricted license to practice medicine in the country and state or province in which he or she practices; have completed three years of surgical practice; have a current hospital appointment; have a current surgical practice and display ethical fitness and professional proficiency as established by references and documentation. Moreover, the surgeon's acceptance as a Fellow of the College must be approved by three-fourths of its Board of Regents.

The Convocation ceremony was a highlight of the five day meeting, which also featured reports on research-in-progress, postgraduate courses, panel discussions, symposia, and scientific and industrial exhibits. Total estimated attendance at the Congress was 12,407, including approximately 8,310 physicians. Allied health professionals and members of the scientific and consumer media also attended the meeting.

The American College of Surgeons is a scientific and educational organization of surgeons that was founded in 1913 to raise the standards of surgical practice and to improve the quality of care for the surgical patient. The College is dedicated to the ethical and competent practice of surgery. Its achievements have established it as an important advocate for all surgical patients. The College has more than 79,000 members and is the largest organization of surgeons in the world. For more information, visit: www.facs.org.

Development Director Named for College of Health Professions

Donna Norvell Smith has been named director of development for the College of Health Professions at the University of Arkansas for Medical Sciences (UAMS) and will lead fundraising efforts in support of the allied health school.

Smith brings skills to the college including donor and guest relations, event coordination and strategic planning. She will work closely with the college's dean, the advisory board, donors, faculty, staff and alumni in support of the college,


Donna Norvell Smith


Dr. Paul Nail


Dr. Elson Bihm


Dr. Joan Simon

which has 21 academic programs across professions ranging from audiology to laboratory sciences to respiratory care.

She previously served as associate director of development for the UAMS College of Medicine. Before that she worked in the development office of the UAMS Psychiatric Research Institute.

Arkansas Urology Acquires Epoch Health Brand

Arkansas Urology has acquired the Epoch Health brand, which created and launched the state's first physician-run testosterone therapy clinic. Arkansas Urology has also opened its first Epoch Health clinic.

The clinic, located at 4617 E. McCain Blvd. in North Little Rock, provides comprehensive men's healthcare. The site was formerly an Encore Health clinic. "The services offered by Arkansas Urology complement Epoch Health's brand," said Dr. Tim Langford, president of Arkansas Urology. "We are merging decades of men's health expertise into one medical organization by fusing our physicians' expertise with Epoch's ability to reach and screen large numbers of patients, especially those who may not usually visit a doctor."

Epoch Health created a physician-run clinic model designed to help men as young as 29 enjoy an enhanced quality of life through proper health screenings, treatments, and lifestyle modifications, specifically focusing on symptoms of low testosterone. Men with low testosterone levels can experience a lack of energy, weight gain, reduced exercise results, hair loss, depression, and a lack of concentration and performance.

The medical term for low testosterone, or "Low T," is hypogonadism, a disease in which the body is unable to produce normal amounts of testosterone. Only within the past several years has the medical community acknowledged the prevalence and negative impact of Low T in men. With the addition of Epoch Health's Low T treatment, Arkansas Urology will ensure a total men's health experience for every patient.

Another of Epoch Health's innovative approaches to Low T therapy is that every patient is provided a fairly comprehensive assessment that includes a free prostate screening during the initial appointment. Prostate cancer is the No. 1 cancer among men, behind skin cancer. For the past nine years, during National Prostate Cancer Awareness Month in September, Arkansas Urology has spearheaded efforts to educate men about prostate cancer by offering a free screening at the Kickoff to Men's Health event. At this year's event, nearly 300 men who had never been screened before were screened at Arkansas Urology's clinics in Little Rock and North Little Rock.

Professors Awarded NIH Grant to Study Bullying

Three University of Central Arkansas professors have been awarded a $286,500 grant from the National Institutes of Health to study middle school bullying. The Department of Psychology and Counseling Department announced that Drs. Paul Nail, Elson Bihm, and Joan Simon have been awarded the grant entitled, "Decreasing Bullying with Self-Affirmation: A Test of the Compensation Model."

Nail says that he first became interested in bullying from his study of organizational psychology. According to Nail, "Leaders in dysfunctional organizations often bully employees, even when the consequences are in direct opposition to the organization's stated goals. Our current research is directed toward finding and testing new ways to decrease bullying in middle school, hopefully before it becomes a deep-seated way of dealing with others."

The duration of the grant is two years. The professors will specifically study the social relations in middle school children. The research will be conducted in conjunction with the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

UAMS Programs Receive Blue & You Foundation Grants

The University of Arkansas for Medical Sciences' (UAMS) Center for Dental Education, the planned internal medicine residency program in northwest Arkansas, and the physician assistant program were among UAMS programs that received grants totaling more than $450,000 from the Blue & You Foundation and its parent company, Arkansas Blue Cross and Blue Shield in February.

The Blue & You Foundation awarded more than $350,000 in grants to UAMS programs including $150,000 to the Center for Dental Education and $95,000 to the physician assistant program, both in the UAMS College of Health Professions. A $77,500 grant was presented to the UAMS Northwest regional campus and area hospitals creating an internal medicine residency program to expand the number of resident physicians being

HEALTHCAREBRIEFS

trained in that part of the state. A $29,722 grant was awarded to the Safety Baby Showers program at UAMS South in Magnolia that has provided infant safety training and safety equipment to new or expectant parents in south Arkansas.

The Center for Dental Education also received $100,000 in support from Arkansas Blue Cross and Blue Shield. Together the $450,000 in grants and support from the two organizations will allow for continued development or expansion of education, patient care and outreach programs at UAMS.

"The Blue & You Foundation grants and support from Arkansas Blue Cross and Blue Shield provide much-needed funding for programs that aid the UAMS mission of health care improvement in Arkansas through education of new health care professionals, increasing the number of physicians providing patient care and helping parents learn potentially lifesaving infant safety techniques," said UAMS Chancellor Dan Rahn, MD.

Patrick O'Sullivan, executive director of the Blue & You Foundation, joined UAMS officials to announce the grants. The Center for Dental Education, physician assistant program, internal medicine residency program and Safety Baby Showers program all received previous grants from the Blue & You Foundation.

"These UAMS programs reinforce the mission of the Blue & You Foundation to support programs that bring communities together in positive and healthy ways. We are excited to support their work in making Arkansas safer and healthier," O'Sullivan said.

The grant to the Center for Dental Education will support an externship program at UAMS for fourth-year dental students from the University of Tennessee College of Dentistry to start in February. The students will spend time working in the center's Oral Health Clinic and at Arkansas Children's Hospital providing general dental care for patients under supervision of adjunct faculty.

The $100,000 in support from Arkansas Blue Cross and Blue Shield continues the development of a dental residency program and provides equipment for the clinic, which will soon open five more exam rooms — for a total of 10 — along with a lab and sterilization area it will share with the adjacent UAMS dental hygiene program.

The Blue & You Foundation awarded more than $350,000 in grants to UAMS programs including $150,000 to the Center for Dental Education and $95,000 to the physician assistant program, both in the UAMS College of Health Professions.

"The grants to our Center for Dental Education and physician assistant programs continue the momentum for two of our newest programs, improving access to medical or oral health care as well as growing the number of health care professionals in Arkansas," said College of Health Professions Dean Douglas Murphy, PhD.

The $95,000 grant to the physician assistant program will continue development for the program established in 2011, including raising awareness of the physician assistant profession among Arkansas physicians and preparing them to host students while they gain further clinical experience.

The first class of 26 physician assistant students started the 28-month master's degree program in 2013. Physician Assistants are licensed medical providers who work with the supervision of a physician. They take patient medical histories, conduct physical exams, order diagnostic tests, diagnose medical conditions, write prescriptions, and manage acute illness and chronic disease with the supervision of a physician.

The internal medicine residency program in northwest Arkansas, which hopes to admit its first group of eight physicians in July 2015, is

Bill Greene

continuing to move through the accreditation process. The three-year program will have a total of 24 residents, admitting eight each year, who will see patients at five hospital systems in the region — Mercy Rogers, Mercy Fort Smith, the Springdale-based Northwest Health System, the Sparks Health System in Fort Smith, and the Veterans Health Care System of the Ozarks — as the physicians serve a post-medical school residency.

"We are moving steadily forward in the multi-step process for establishing and gaining accreditation for our internal medicine residency and we could not have come this far without the support of the Blue & You Foundation," said Peter Kohler, MD, vice chancellor for UAMS Northwest. "We had a positive site visit in August 2013 from the accrediting body and feel good that we are creating the kind of quality program that will help patients in Arkansas for many years to come."

Funding to the residency program is for equipment and resources to coordinate the conferences and continuing education fees associated with providing CME credit to physicians who will be preceptors supervising the resident physicians at the hospitals.

The grant to the three-year-old Safety Baby Showers program, based at UAMS South in Magnolia, will cover program costs for a year of safety classes that have reached about 200 new or expectant parents a year in Ouachita and Columbia counties. Participants learn about motor vehicle injury prevention, safe sleep practices for infants, infant CPR and choke-safety, and home safety.

"We've had a great response from those who have participated in Safety Baby Showers to date and are excited at the support that will continue this program," said Rebecka Wendling, outreach coordinator for the Safety Baby Showers program.

Along with the safety training, the participants receive a portable crib and other home safety items, such as cabinet locks, that are intended to reduce the risk of injury to infants.

Arkansas Blue Cross and Blue Shield established the Blue & You Foundation in 2001 as a charitable foundation to promote better health in Arkansas. The Blue & You Foundation awards grants annually to nonprofit or governmental organizations and programs that positively affect the health of Arkansans.

Greene Named Director of Operations for Epoch Health

Epoch Health has tapped Bill Greene to be the director of operations for Epoch locations in central Arkansas. Arkansas Urology recently acquired the Epoch Health brand, which created and launched the state's first physician-run testosterone therapy clinic.

Greene has more than 20 years of experience in healthcare marketing, working with such industry leaders as Stryker Endoscopy, Space Labs Medical and Covidian/U.S. Surgical Corporation. He has held executive roles in business development, sales management & training, medical practice marketing, and business development for medical clinics.

Greene has a BBA/Marketing and earned a Master's Certificate in Marketing from Tulane University. Additionally, he has completed executive-level education programs in leadership and executive management from Texas A&M University, and participated in the Harvard Business Review ManageMentor® Leadership Development program.

Greene has served in various capacities in civic organizations, including being appointed to the Arkansas Governor›s Council for Developmental Disabilities by Governor Mike Huckabee, former board president of Down Syndrome Society/Down Syndrome Family & Friends, former board member of the Francis A. Allen School for Children with Special Needs, and former board member and Boy Scout Leader, of the Pioneer District, Quapaw Council for 10 years.

Carter to Lead Development of Dental Residency

Niki Carter, DMD, who has more than 24 years of dental experience, has joined the faculty of the Center for Dental Education at the University of Arkansas for Medical Sciences (UAMS), where she will see patients while leading the effort to develop a dental residency program.

Since 1989, Carter has owned and operated Niki Carter Family Dentistry in Little Rock. She has been appointed an associate professor, serving as part-time faculty for the Center for Dental Education in the UAMS College of Health Professions and also for the Department of Surgery in the UAMS College of Medicine.

Carter, an Arkansas native, earned her Doctor of Dental Medicine degree in 1988 from the University of Louisville School of Dentistry. Following graduation, she served a one-year general practice dental residency at University of Louisville School of Dentistry Humana Hospital before returning to Arkansas to begin her dental practice.

Carter will lead the effort to secure accreditation from the Commission on Dental Accreditation for a general practice residency at UAMS and will serve as director of the residency program. The goal is for the center to achieve accreditation in 2014 and then begin accepting dental residents in 2015.

Hosting dental residents would increase the number of dentists beginning their careers in Arkansas. That was a goal of the Center for Dental Education when it was established in 2012, along with improving access to dental care for patients and to continuing education opportunities for practicing dentists.

Carter is a member of the American Dental Association and the Arkansas State Dental Association. ■

Prescription drug abuse and misuse has become a major health problem in the United States. Prescription opioid deaths quadrupled from 1999 to 2010. While medical research has provided significant advances in treatment for pain, anxiety, sleep disorders, and Attention Deficit Hyperactivity Disorder (ADHD), medications used to treat these disorders may be misused or abused.

Incorporating Arkansas Prescription Monitoring Program Can Reduce Prescription Drug Abuse in Arkansas

Taking more than prescribed, using prescriptions for a purpose other than that for which they were prescribed, or taking medication prescribed for someone else all have serious health consequences and may even lead to death. In fact, more Americans now die from prescription drug abuse than from cocaine, hallucinogens, heroin, and inhalants combined.

Arkansas has not escaped this national epidemic. The statistics for Arkansas are sobering:

- Arkansas ranks among the highest in the country for non-medical use of prescription pain relievers.
- Nearly 20 percent of Arkansas teenagers have abused prescription drugs by the time they are seniors in high school.
- Arkansas ranked among the second highest group of states in overall drug overdose deaths in 2008, with a rate of 5.1 per 100,000 for deaths resulting from nonmedical use of opioid pain relievers.
- Arkansas ranked among the highest group nationally in the rate of kilograms of opioid pain relievers sold per 10,000 people in 2010.

In 2011, the Arkansas Department of Health (ADH) partnered with the Arkansas Drug

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WE ENCOURAGE ALL PROVIDERS TO SIGN UP FOR ACCESS TO THE DATA THE PMP PROVIDES.

Director, Arkansas Medical Society, Arkansas State Board of Pharmacy, State Medical Examiner, and others to support Act 304, establishing the Arkansas Prescription Monitoring Program (PMP). PMPs are operational in 48 states and are proving to be effective tools in the fight against the misuse of prescription controlled substances.

The Arkansas PMP became operational in March, 2013. The Arkansas PMP monitors the use of Schedules II-V controlled substances through data collected from pharmacies and other dispensers. For each controlled substance prescription dispensed to an individual in Arkansas, dispensers must report detailed information (including the patient's name, date of birth, and address), details about the prescription (prescriber's name and DEA number, date written, amount prescribed, refills authorized, etc.) and dispensing records (date filled, quantity dispensed, refill number, days' supply, etc.). Arkansas pharmacies are required to report this information weekly through a secure web-based program called RxSentry.

Information in the database is confidential. Access is limited to practitioners, dispensers, law enforcement officials pursuant to a warrant, as well as health professional licensing boards and medical examiners pursuant to an investigation.

The Arkansas PMP allows authorized users to access this information to aide prescribers and dispensers in making sound clinical decisions when prescribing or dispensing controlled substances. PMP data are unique in being able to assist practitioners in identifying questionable activity with respect to prescription drugs, such as doctor and pharmacy shopping, prescription fraud, and problematic prescribing.

Practitioners may sign up to access data for their patients through the AR PMP website. Enrollment is quick and easy. Go to www.arkansaspmp.com, click on the practitioner/pharmacist tab, and follow the practitioner/pharmacist registration instructions.

By accessing data in the PMP before prescribing or dispensing, a practitioner can provide better patient care. Benefits of PMP access for practitioners include:

- Information is based on data received from pharmacies licensed by the Arkansas State Board of Pharmacy, including out-of-state pharmacies that dispense to Arkansas residents and other dispensers.
- Reports can be used to determine a patient's previous use of controlled substances.
- Access can help minimize the risk of duplicate prescriptions from other prescribers and pharmacies.
- Reports may also provide insight into possible addiction and/or potential illegal activity.

Another new tool in the effort to reduce prescription drug abuse is prescribing guidelines for emergency room physicians, who frequently see patients about whom they have little previous information. The guidelines are available online in the Injury Prevention Section of the ADH website, www.healthy.arkansas.gov.

We are excited to be able to report that there has been a steady drop in the number of individuals who visit multiple prescribers and pharmacies since the program became operational on March 1, 2013.

Prescription drugs can provide relief and improved quality of life for many patients when used under the direction and supervision of practitioners in their medical practice. However, these same drugs can have dire consequences when they are misused or abused. We encourage all providers to sign up for access to the data the PMP provides. Incorporation of information from the PMP into current health care practice and the use of prescribing guidelines can be instrumental in reducing the devastating effects of prescription drug abuse in Arkansas. ■

"Do It Right" Campaign Saves Lives

Arkansas has the sixth highest rate of death due to colorectal cancer (CRC) in the country, and CRC is the second biggest cancer killer in the Natural State. To improve the quality of colonoscopies, the Arkansas Foundation for Medical Care (AFMC) has implemented the "Do It Right" campaign (afmc.org/doitright).

COLON CANCER CAN BE PREVENTED WITH A COLONOSCOPY AND POLYP REMOVAL

"Do it Right" works with patients and doctors to ensure everybody who needs a colonoscopy is getting one, and to make sure those colonoscopies are high-quality tests. Our mission is to make sure colonoscopies are done at the right time, with the right physician, and in the right way. Our goals are to promote the adoption of evidence-based best practices for screening procedures and increase the reporting of quality indicators.

The Right Time. More than 90 percent of people who develop CRC are over 50. The majority of patients and those at normal risk of CRC should get a colonoscopy at age 50 and repeat it every 10 years. Screenings should begin before age 50 and occur more frequently if CRC risk factors are present.

The Right Physician. At least 20 percent of patients have polyps. A physician performing screening colonoscopies should know his or her rate of polyp detection. When it is higher than 20 percent (15% for women; 25% for men), the physician is doing an adequate job finding polyps. Clinical guidelines now recommend a withdrawal time of at least six minutes. Going slowly and carefully checking all areas of the colon is what the right physician does.

The Right Way. Both patients and physicians contribute to a quality colonoscopy.

- Stress to patients that they must carefully follow directions in preparing for a colonoscopy. Adequate bowel prep is the first evidence-based quality indicator of this project.
- Physicians need to take enough time to find all polyps in the colon. A colonoscope withdrawal time equal to or greater than six minutes is the second evidence-based quality indicator.
- Physicians should document adenoma detection rates, including number, location, and size. This is the third quality indicator.
- Achieve a cecal intubation rate of at least 95 percent.

Ways to Improve Colonoscopies

Endoscopists should:

- Monitor performance using recommended quality indicators.
- Adopt evidence-based screening guidelines, specifically record and report adequate bowel prep, colonoscopy withdrawal times,

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Arkansas Foundation
for Medical Care

High-Risk Individuals

Patients at higher risk for colorectal cancer include those who:

- **Smoke tobacco**
- **Eat a high-fat, low-fiber diet**
- **Drink alcohol**
- **Are obese (BMI >30 = 1.5 times higher risk of CRC)**
- **Are older than 60**
- **Are sedentary**
- **Are African-American, Native American, Alaskan native, Ashkenazi Jew or Eastern European**
- **Have a history of CRC; cancer of the ovary, endometrium or breast; inflammatory bowel disease; family history of polyps; or CRC**
- **Have hereditary cancer syndromes (familial adenomatous polyposis or hereditary non-polyposis colon cancer).**

and adenoma detection rates, including number, location, and size.

• Document prep quality as "good," "fair" or "poor" in procedure notes. This enhances appropriate scheduling of screening intervals. The recommendation is one year if prep quality was less than "good."

• Document cecal intubation rate (by photo); should be greater than 95 percent.

Referring providers should:

• Increase patient awareness of the importance of quality endoscopies, especially with Medicare or high-risk patients.

• Increase patient knowledge of the significance of early identification of polyps and adenomas. Explain the value of a high-sensitivity fecal occult blood test (FOBT) for appropriate patient populations, and that it must be done annually. Use either a high-sensitivity guaiac-based FOBT (Hemacult Sensa has better sensitivity) or an immunochemical FIT test. The latter has higher sensitivity and specificity and is not influenced by food or medication. Positive screening results should be followed up with a colonoscopy.

• Refer patients to endoscopists who provide a high-quality procedure and meet ASGE quality guidelines.

• Increase Patient Compliance

The number one reason patients gave for not getting a colonoscopy is that their doctor never talked to them about it.

Patients cited fear, embarrassment, discomfort, time, and cost as specific reasons for not getting a CRC screening.

Patients were not aware of the benefits of screening or of their individual risk for CRC (smoking, obesity, being sedentary, family history of cancer, age 60+, and high-fat-low-fiber diet). There are no signs or symptoms of polyps or early colon cancer. The only way to know if you have polyps is to have a quality colonoscopy. Colon cancer can be prevented with a colonoscopy and polyp removal. The five-year survival rate is greater than 90 percent if cancer is in situ when identified; less than 10 percent if distant metastases. Polyp removal confers a 53 percent lower risk of CRC death than the general population.

PCPs should explain that colonoscopy prep is now easier, gentler, and causes less discomfort. It no longer requires suppositories, enemas or harsh laxatives. The recommended prep is Polyethylene glycol (PEG) with electrolyte replacement (MOVIprep or Miralax with Gatorade). The patient is responsible for completing the entire prep the day before.

The cost of over-the-counter prep medications is less than $10. Medicare requires a $50 co-pay for prescription prep medications. Private insurance does not cover prep medications.

The quality of the patient's prep determines success in cecal intubation and the adenoma detection rate. It also strongly influences the complication rate. PCPs must emphasize the importance of carefully following prep directions.

A physician's recommendation is the most consistently influential factor in CRC screening. And while screening has increased from 39 percent in 2000 to 59 percent in 2010, there is still enormous progress to be made. ■

HEALTH INFORMATION Technology

THE BACKBONE OF HEALTH SYSTEM TRANSFORMATION

| **By Joe Thompson, MD, and Ray Scott**

If you are older than 45 years old, you remember when you could not get money out of your bank account without going inside your bank during regular banking hours, talking with a teller, and filling out a paper request for a withdrawal.

Fast forward to today.

Today you can get money at any automatic teller machine anywhere in the world, know your account balance, manage your money, and pay bills from your computer. We are completely electronic and confident in our banking system regardless of which bank we use or where we access it.

Now, contrast the banking system with our health care system, where lab results, x-rays or cat scans, hospital outcomes, and other critical pieces of information are often difficult for your doctor to access in a timely manner. This lack of access to vital information can result in tests being repeated, gaps in knowledge resulting in incorrect treatments, and other inefficiencies leading to frustration among both patients and providers. Combine this with the burden of risk factors and poor health too many Arkansans suffer from and it is a disaster waiting to happen. But things are changing!

Years of work on the part of consumers, providers, associations, policymakers, academics, and other stakeholders from both the public and private sectors have culminated in a shared vision for a transformed health care system that improves lives through greater access, controlled cost, and improved quality of care. We are now well on our way to realizing that vision through the Arkansas Health System Improvement Initiative. With a new strategic plan for our healthcare workforce, expansion of coverage through the health Insurance Marketplace and Arkansas's own Health Care Independence Program, commonly known as the Private Option, and new payment strategies that reward positive outcomes and efficient practices, Arkansans are improving our healthcare system.

The backbone of these efforts is accelerated use of health information technology in the form of electronic health records (EHR) at every point in the system and importantly, the secure transmission between providers of this information through the Arkansas State Health Alliance for Records Exchange, commonly known as SHARE.

Across the state, many primary care practices, hospitals, and other providers are converting from paper to electronic health records. This is more than just putting a computer in the exam room. It requires redesign of both the patient experience and the clinic work-flow. Transfer of old paper-based information into the new system, incorporation of electronic prescriptions and laboratory results, improving the availability of x-ray results and specialist recommendations are all necessary steps in transition to an electronic health records system. Each of these takes effort, but results in opportunities to provide better and more efficient care.

The average patient is cared for by more than 18 different doctors. Too often, lack of communication between providers leads to problems for patients and unnecessary costs. In fact, one out of three hospitalized patients is subject to mistakes that could actually harm rather than help them. And mistakes are costing money. Recent studies have shown that one-third of health care spending—an estimated $750 billion—pays for things that don't even improve health. Our health care providers need to know what other providers have to say about their patients. And they need that information at their fingertips the moment they are treating a patient.

To truly move forward, we must have not only electronic health records in the office, but a mechanism to connect offices with hospitals and with pharmacies. The connections must be secure and safeguarded—you don't want your personal health data out there on the internet!

Over the past three years, Arkansas has developed a secure, encrypted, and monitored

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mechanism for providers to appropriately share such information. SHARE gathers clinical patient data from all participating health care providers to instantly provide a more complete view of a patient's health history, treatment, and progress. Security mechanisms are in place to ensure that only authorized users are accessing information. That's powerful information that can transform the way that health care is planned, delivered, and coordinated.

A small team of dedicated individuals within the Arkansas Office of Health Information Technology has been recruiting and are supporting clinical providers joining SHARE across the state. Some communities have both their hospital and most primary care providers "sharing" information and helping their patients. This includes developing a way that information lets a clinician know if their patient was in the emergency room last night and what tests were done and will relay test results indicating needed treatment changes to avoid hospitalization.

Current participation in SHARE includes 14 hospitals, 135 physician practice sites, and 503,414 patients with this number steadily growing.

With SHARE Health Care Providers Can:

• Exchange clinical patient information in an efficient, timely, and cost-effective manner without changing existing patient consent practices.

• Connect to hospitals, physicians, nurse practitioners, behavioral health providers, labs, long-term care facilities, and others involved in a patient's care throughout Arkansas.

• Order tests and receive lab results in one place.

• Protect patient information by exchanging only with providers who have agreed to privacy practices within the SHARE network, and who have an established relationship with the patient.

• Avoid duplicate testing and procedures through records sharing.

• Identify drug interactions and reduce medication errors.

• Make better-informed care decisions through immediate access to patient health information from all points of care.

• Promote a patient-centered environment and better coordinate patient care with their other providers – a key element of the Patient-Centered Medical Home (PCMH) model underway as part of the Arkansas Payment Improvement Initiative.

• Meet Meaningful Use criteria and qualify for EHR incentives as an eligible provider.

• Lower administrative costs associated with data management.

What Information Can We SHARE?

Patient health information is pushed from the provider's EHR system to SHARE, where other health care providers are contributing their pieces of patient health records. Providers can access the following clinical patient health information in SHARE:

- Admission, Discharge and Transfer reports
- Laboratory results
- Radiology reports
- Medication lists
- Problem lists
- Transcribed reports

Three Ways to SHARE

SHARE is growing and offers three different ways to help providers get better care for their patients through exchanging patient health information with other health care providers and entities:

• Secure Messaging: Even without an electronic health record, encrypted emails containing information about a patient's recent treatment can be sent securely to other trusted health care providers. Secure Messaging is encrypted and replaces faxing between providers that is anything but secure.

• One-Way SHARE: Patients' health records can be viewed in the HIE. A provider can view x-rays, laboratory results, or discharge information for their patient seen in the emergency room or hospital in the Virtual Health Record (VHR) available through SHARE.

• Complete Health Information Exchange (HIE): Patients' real-time electronic health records, including lab results, doctor's notes, diagnosis and treatment plans, prescribed medication and more can be viewed. Data can be pushed from a provider EHR system to a patient's health record in SHARE and new patient data can be downloaded from one provider's EHR system into another.

As we move forward with measures to address our health workforce limitations, restructure the payment and delivery system, and expand health care coverage for all Arkansans, effective use of important health information technology tools like SHARE is essential to the successful transformation of our health care system.

For more information on the value and benefits of SHARE, or for help in getting funding and connecting to SHARE, visit www.sharearkansas.com, call 501.410.1999, or email info@sharearkansas.com. In many ways, Arkansas is leading the nation with a much needed restructuring of our health care system. Now we need all hands on deck to finish the important work that has been started to better meet the needs of patients, providers, and payers. For more information on the Arkansas Health System Improvement Initiative and its parts, visit www.achi.net. ■

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.

HOSPITAL Rounds

HOSPITAL NEWS & INFORMATION

HOSPITAL ROUNDS

Baptist Welcomes Hot Spring Medical Center

Baptist Health officially welcomed Hot Spring County Medical Center in Malvern into the Baptist Health family as the healthcare system's eighth hospital. The new name for the hospital – Baptist Health Medical Center-Hot Spring County – was unveiled during a ceremony in January.

"This is an exciting day for Baptist Health as we expand our services to provide convenient access for residents of Hot Spring County and surrounding areas," said Russell Harrington, president and CEO of Baptist Health.

Baptist Health Medical Center-Hot Spring County is a community-based hospital licensed for 72 acute-care beds. The hospital has been in operation since 1923.

"Our hospital staff is looking forward to the new partnership with Baptist Health and all the additional resources it will provide that will enable us to continue providing the quality care that our patients and their families have come to expect," said Sheila Williams, the current vice president and administrator of the hospital who will retain the same position with Baptist Health.

Telemedicine Program for Hand Trauma First in Nation

Patients with hand injuries now have access to the nation's first hand trauma telemedicine program established with partnerships by the University of Arkansas for Medical Sciences (UAMS), the Arkansas Trauma Communications Center, and the Arkansas Department of Health.

Through the Hand Telemedicine Program, patients and their physicians in hospitals throughout Arkansas can consult in real time with hand trauma surgeons and specialists via a high-definition broadband video connection provided through e-Link Arkansas.

The real-time telemedicine consultations will provide the best possible treatment for hand injuries. The surgeons, using an iPad or other mobile device, will connect to local doctors and hospitals that use telemedicine equipment called e-Link carts. The equipment was distributed to healthcare providers around the state by e-Link Arkansas using a $102 million federal grant from the Broadband Technology Opportunities Program (BTOP) received by UAMS' Center for Distance Health and partners to boost broadband connections across the state.

The UAMS Center for Distance Health provides technical support and quality management to the program, said Terri Imus, RN, trauma telemedicine coordinator with the Center for Distance Health, who played a key part in organizing the new program.

Todd Maxson, MD, UAMS professor of pediatric surgery, Arkansas Children's Hospital trauma director, and Health Department trauma medical consultant, said hand injuries affect people's livelihood, and treatment is often long and difficult. "Providing timely, expert care is paramount to a successful recovery," Maxson said. "The Center for Distance Health's Hand Telemedicine Program gives patients and physicians immediate access to hand experts."

Dr.Maxson said that previously, hand patients were transferred at significant cost and inconvenience from a clinic or hospital in their hometown even when they may not have required further treatment. This program will allow providers to decide which patients need to be transferred.

The Arkansas Trauma Communications Center has organized a group of hand surgeons to be on call to evaluate injuries through real-time video. UAMS Medical Center is the only provider in the state that performs hand reattachment surgery.

UAMS surgeons Theresa Wyrick, MD, and John Stephenson, MD, are part of the on-call team, which includes two more physicians in Central Arkansas and three in northwest Arkansas. Wyrick said the need for hand specialists is not unique to Arkansas.

"Most states struggle with taking care of hand trauma injuries for many of the same reasons," she said. "Through this partnership, hand specialists at UAMS and in private practice have come together to help provide better care for these injuries in the people of our state. The major benefit is to our citizens who are farmers, carpenters, craftsmen, and industrial workers who do physical work with their hands. Other states are going to want to know how we accomplished this so they can model their own systems after it."

Under the program, when a patient goes to a local hospital with a hand injury, the emergency department staff connects to a virtual hand trauma room along with staff at the Arkansas Trauma Communications Center and the hand surgeon. The hand surgeon evaluates the patient's injury and makes recommendations for treatment. If the hand surgeon recommends the patient be transported to a different hospital for further treatment, ATCC coordinates the transfer, confirming that the right specialist is available without delay.

"The trauma system is only three years old," said Jeff Tabor, Arkansas Trauma Communications Center program director. "We have made progress in leaps and bounds in securing acceptance for trauma patients, but we always struggle with hand trauma. We find appropriate care for the average trauma patient in six-and-a-half minutes. With hand patients, it can take hours due to the limited number of hospitals providing an on-call hand specialist in the state. The physicians in the call group are working with us to identify the significant hand emergencies and to provide timely care to all hand trauma patients."

Conway Regional Senior Center Relocates

The Conway Regional Senior Evaluation & Counseling Center (SECC) has relocated to Suite 301 of Conway Regional Medical Center.

The center had been located on Dave Ward Drive since it opened in 2010. The SECC staff includes Annette Anderson, MD, a Geriatric Psychiatrist; Therapist Londa Revis; and Linda Morey, RN. SECC provides outpatient mental health services for senior adults and those services will remain the same after the move, including:

- Dementia and mental health evaluation and counseling
- A personalized plan of care
- Medication evaluation and management
- Individual and family therapy
- Referral source for senior services for individuals in Faulkner & surrounding counties.
- Access to information regarding nonprofit agencies that provide social services for seniors

The center is part of Conway Regional Behavioral Health Services.

Angie Longing, BSN, MHSM, RN, NE-BC

Longing New Executive Director of Nursing at St. Vincent

Angie Longing, BSN, MHSM, RN, NE-BC, has accepted the role of executive director of nursing at St. Vincent Infirmary. Longing was most recently executive director of nursing at St. Vincent North and St. Vincent Morrilton. She joins Susan Pastor, ND, RN, President of Patient Care Services and Brenda K. Baird, RN MSN CENP, Vice President and Chief Nursing Executive for St. Vincent Health System.

Longing earned a Master of Arts degree in health services management at Webster University and a Bachelor of Science degree in nursing from the University of Central Arkansas at Conway. She is a member of the American Organization of Nurse Executives, the Arkansas Hospital Association, and the Arkansas Nurses Association.

UAMS Begins Statewide Sickle Cell Clinical Program

The University of Arkansas for Medical Sciences (UAMS) has opened a multidisciplinary clinic to serve Arkansas' adult sickle cell patients as part of a statewide comprehensive program to address the disease.

The multidisciplinary clinic at UAMS' Outpatient Center is led by Robin Devan, MD, a palliative care physician in the Department of Internal Medicine in the UAMS College of Medicine. Clinic staff will include an advanced practice nurse, a registered nurse and a social worker. Patients will be seen annually and will receive any primary or specialty care they may need.

The program also includes:

• A Call Center with nurses available 24/7 to assist and advise providers and patients at 1-855-Sic-Cell (742-2355)

• A Transition Clinic, which will facilitate the smooth transition of pediatric sickle cell patients to adult care

• A Patient Registry of consenting adults with sickle cell, tracking their care, morbidity, and mortality over time.

Sickle cell affects an estimated 1,300 children and adults in Arkansas. The goal of the program is to improve sickle cell care and the overall well-being of patients across Arkansas through provider training, the use of evidence-based medicine, and patient education.

The program is funded in part by the Arkansas Legislature and Medicaid and is made possible through a partnership with the UAMS Center for Distance Health. More information about the program is at: http://sicklecell.uams.edu.

Breast Center Named Center of Excellence

Baptist Health Breast Center on the campus of Baptist Health Medical Center-Little Rock has been designated a Breast Imaging Center of Excellence by the American College of Radiology (ACR).

By awarding facilities the status of a Breast Imaging Center of Excellence, the ACR recognizes breast imaging centers that have earned accreditation in mammography, stereotactic breast biopsy, and breast ultrasound (including ultrasound-guided breast biopsy).

"This is exciting news from this prestigious group that validates the excellent care that our Baptist Health Breast Center provides the patients of Arkansas," said Greg Crain, vice-president and administrator of Baptist Health Medical Center Little Rock. "We are especially honored to be the only breast center in central Arkansas and one of two in the state with this distinction."

Peer-review evaluations, conducted in each breast imaging modality by board-certified physicians and medical physicists who are experts in the field, have determined that this facility has achieved high practice standards in image quality, personnel qualifications, facility equipment, quality control procedures, and quality assurance programs.

The ACR is a national professional organization serving more than 36,000 diagnostic/interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists with programs focusing on the practice of medical imaging and radiation oncology and the delivery of comprehensive healthcare services.

Saline Memorial and UAMS Open Neurosurgery Clinic

Saline Memorial Hospital and the University of Arkansas for Medical Sciences (UAMS) have joined to open a neurosurgery clinic in Benton to make services more convenient for local patients and to support the healthcare system in the Benton area.

Surgeons from the Department of Neurosurgery in the UAMS College of Medicine will be seeing patients in the clinic located next to Saline Memorial and performing several types of surgery at Saline Memorial.

"This collaboration will expand services within a community that is underserved in terms of practicing neurosurgeons. UAMS has a local and national reputation for excellence, and together we will be able to offer more patients access to the latest technology and services," said Bob Trautman, Saline Memorial CEO.

UAMS' J. D. Day, MD, chairman of the Department of Neurosurgery, will be medical director of the program at Saline Memorial. He, along with Hazem Ahmed, MD, and Demetri Serletis, MD, will evaluate all spine and other surgical neurological problems at the clinic.

The neurosurgeons will perform a variety of spine surgeries, including anterior cervical decompression, cervical fusions, lumbar decompressions, fusions, and disc surgeries at Saline Memorial. More complex surgeries such as craniotomies and complex spine procedures, will be performed at UAMS, as appropriate.

This new clinic is the latest effort by UAMS to collaborate with healthcare providers around the state to assist with care so that patients can receive the best care closest to home.

HOSPITAL ROUNDS

ACH Launches MyACH iPhone App

Arkansas Children's Hospital (ACH) has launched the free MyACH iPhone app to help busy parents manage their children's health information in an easily accessible and secure way.

"MyACH is an app that's a must for every parent. As parents, we're increasingly on the go with more and more of our lives transitioning to the mobile environment. That's exactly why we've created the MyACH app: to meet parents where they are and to make their child's health information accessible and secure," said Dan McFadden, ACH director of Communications.

MyACH offers the following free tools and resources:

- Health Library – This area of the app offers a wealth of pediatric healthcare information that can be searched by keyword (i.e. "headache") or by article category. There are over 30 categories to select from including "Common Childhood Injuries and Poisonings," "Growth and Development", and "Pregnancy and Childbirth."
- My Info – A pin code-protected area to store information ranging from medical history to prescription information to emergency contacts. You can also input insurance information, including a photo of the front and back of your insurance card, in this area of the app.
- Find a Doc – Browse a list of children's healthcare specialists and sub-specialists, and even see photos of the physicians you find.
- Maps – Access maps to facilities and clinics on the Arkansas Children's Hospital campus or Centers for Children in Lowell and Jonesboro. Scan one of the QR codes located on monitors throughout the hospital to get turn-by-turn directions to select areas of the hospital.
- Contact ACH – Offers key phone numbers to the primary areas of the hospital.
- About ACH – Learn more about Arkansas Children's Hospital and have quick access to the website, archildrens.org.
- CareHub – A convenient way to log into CareHub to get appointment info, pay your bill or access other available features.
- Connect – Connect with ACH via social platforms, such as Facebook, Twitter, YouTube, and Pinterest. You can also access the newsfeed and provide thoughts on the app in a quick survey.
- Give – Link to the Arkansas Children's Hospital Foundation webpage offering information on how you can make a difference in the lives of ACH patients.

Currently the app is available only on the iPhone, with the possibility of expanding access to Android users being explored.

To download the free MyACH app, visit your iPhone App StoreSM, search for "MyACH" or "Arkansas Children's Hospital" and install the app.

Looking for a Few Good Women

The Conway Regional Women's Council membership kick-off for 2014 was held in February. Some of the benefits of Women's Council membership include:

- Free entry into all the member programs and events
- Early entry in to the Women's Health Fair in April
- Two general admission entry tickets to Dazzle Daze 2014
- Early entry into Dazzle Daze Girls Nite Out with the purchase of a ticket
- Special members only offers throughout the year
- Supporting women's health education opportunities
- Networking and fellowship opportunities
- A quarterly newsletter with key health resources.

UAMS Weight Loss Clinic Relocates

The UAMS Weight Loss Clinic celebrated its move to new clinic space with an open house featuring free blood pressure and BMI screenings, weight loss program food samples, and door prizes.

Patients will now attend health classes, visit their physician, and receive lab work all in one

convenient location. Along with a better location, the clinic has an updated look with new furniture, wider chairs and exam tables, and facilities that will better accommodate patients.

Those interested in joining the 16-week weight loss program will attend a free orientation where they will receive details on the program. Patients do not need a physician referral to begin the program. Participants must receive a screening evaluation that includes a review of their medical history, a physical check of their vital signs, a review of the program, and a discussion of their individual health and fitness needs.

The program offers patients classes on behavior modification and nutrition taught by registered dietitians and is medically supervised by Monica Agarwal, MD, a fellowship-trained endocrinologist who is also board certified to treat obesity.

After completing the program, the clinic offers a weight maintenance program where patients can receive one-on-one counseling for meal planning.

Two St. Vincent Clinics Relocate

St. Vincent Diabetes and Endocrinology and St. Vincent General and Colorectal Surgery (formerly Little Rock Surgical Clinic) Clinics are in a new location. Patients are now being treated at 701 N. University Ave in Little Rock.

St. Vincent Diabetes and Endocrinology Clinic is located in Suite 201. Hours of operation are Monday through Friday, 8 a.m. until 4:30 p.m.

St. Vincent General and Colorectal Surgery Clinic is located in Suite 203. Hours of operation are Monday through Friday, 8 a.m. until 5 p.m.

Former Dean Funds Memorial Fountain

Former dean of two University of Arkansas for Medical Sciences (UAMS) colleges and longtime UAMS supporter Thomas A. Bruce, MD, has donated $275,000 to construct a fountain on campus in memory of his late wife.

Bruce was the inaugural dean of the UAMS Fay W. Boozman College of Public Health from 2001 to 2002, and dean of the College of Medicine from 1974 to 1985, and is a longtime supporter of UAMS in several other areas.

The memorial fountain will be named for Dolores Bruce, who died Jan. 11, 2013. It is under construction in a circular green space in front of the UAMS Medical Center and Ward Tower and will feature a basin that is 18 inches deep and 50 feet in diameter with a 25-foot center spray and eight 15-foot-high sprays arching toward the center, all highlighted with LED lighting.

"During the 11 years I was dean of the College of Medicine, Dolores worked as hard as I did to advance the well-being of faculty, staff and students and their families," Bruce said. "Her role was always voluntary, but it was no less enthusiastic and effective. Honoring her memory with a fountain in front of the hospital is just another way of furthering her lifetime goals, including creating a place of solace and rest, not just for patients and visitors, but a place of beauty and pride for all members of the campus family."

When the Bruce family lived in Little Rock in the 1970s and 80s, Dolores Bruce became involved in the Faculty Wives Club, the Winfield Methodist Chancel Choir, and the Arkansas Opera Theatre. She also served as president of the Hall High School PTA. After returning to Little Rock in 2005, she served on the Little Rock Arts and Culture Commission and the board of directors of Wildwood Park for the Arts where the Dodi Tea House is named in her honor. She received a number of honors including the Special Appreciation Award and the Janet Pearcy Ambassador Award from Wildwood Park, the Double Helix Award from UAMS, the Spirit of Central High Award from Little Rock Central High School Museum, the Giving Tree Society Award of the Arkansas Community Foundation, Care Link's David Pryor Award for Community Service, and the President's Award as Philanthropist of the Year by the Arkansas Chapter of the American Society of Professional Fundraisers.

Bruce's gift was matched by the UAMS College of Medicine's Faculty Group Practice matching gifts fund, bringing the total to $550,000. A portion of the gift will support an endowment for operation and maintenance of the fountain.

Bruce Commons, a popular gathering spot for students, faculty and guests on the first floor of the UAMS College of Public Health, is named in honor of Bruce.

Amy Funderburk, MSN, RN, NE-BC

Funderburk to Direct Jack Stephens Heart Institute

Amy Funderburk, MSN, RN, NE-BC, has accepted the new leadership position of executive director for the Jack Stephens Heart Institute (JSHI) at St. Vincent. Funderburk has been working in an interim capacity for the past several months. Funderburk will report to Marcia Atkinson Vice President of the JHSI and to Susan Pastor, ND, RN, President of Patient Care Services.

Funderburk most recently held the position of administrative director of Quality and Infection Prevention and executive director for women's, medical, and behavioral health.

Funderburk earned a BSN at the University of South Carolina at Columbia and an MSN at Drexel University Philadelphia, Penn.

Gift Completes First Phase of Lobby Gallery

Longtime University of Arkansas for Medical Sciences (UAMS) supporters Dale and Lee Ronnel recently donated $150,000 to complete the first phase of the build-out of the lobby gallery in the UAMS Medical Center. The lobby gallery is a 900-square-foot performance and meeting space with state-of-the-art projection and video conferencing equipment.

The unfinished lobby gallery space was built as part of the UAMS Medical Center's nine-floor patient tower that opened in 2009. With the

UAMS Chancellor Dan Rahn, MD (far left), and Roxane Townsend, MD, CEO of the UAMS Medical Center (far right), helped celebrate a gift from Dale and Lee Ronnel that helped finish the first phase of the Lobby Gallery.

Ronnels' donation, carpeting, drywall, heat and air conditioning, lighting, audio-visual equipment, large screens, and video monitors were added to the room. When additional funding is available, the second phase will include a prep area for catering, additional furniture, window treatments, a portable stage, and a large doorway that will allow the meeting space to expand into an adjacent gallery for larger events.

The Ronnels are recognized for their generous gift with a plaque on a wall inside the lobby gallery.

The Ronnel family's relationship with UAMS began more than 25 years ago when UAMS physicians saved Lee Ronnel's leg following a skiing accident. Ronnel since has served as a member and former chairman of the UAMS Foundation Board. He now serves as the UAMS board's representative and chairman of the University of Arkansas Foundation Board. Dale Ronnel is a member and former chairman of the Donald W. Reynolds Institute on Aging Community Advisory Board. The Ronnels also have a named fellowship and a cardiovascular research fund at UAMS. ■

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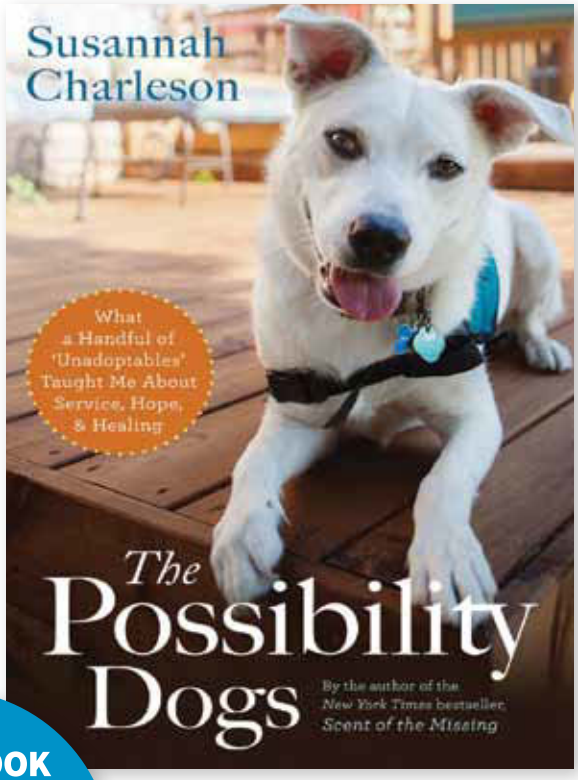


by **Susannah Charleson**
c.2013, Houghton Mifflin Harcourt

Timmy's in the well.

And it's a good thing your good-natured dog isn't in charge of rescue. He doesn't know anybody named Timmy, has no clue what a well is, and besides, he's got his rawhide. Timmy's in the well, he seems to say. Well, so what?

Yep, your dog has a one-track mind, one thing at a time. So wouldn't you be surprised at what else he can do? In the new book "The Possibility Dogs" by Susannah Charleson, you'll see his hidden potential.

As the human half of a Search-and-Rescue team, Susannah Charleson knows what it takes to teach a dog an important task. Using the innate talents and personality of her golden retriever, Puzzle, Charleson taught her girl to find lost or injured people.

So when Charleson met a man with a "psych dog" (a service dog for someone suffering psychiatric disorders), she was intrigued. Most everybody knows about guide dogs and hearing-assistance dogs, but what kind of canine Einstein would it take to help a person whose disabilities weren't quite as visible?

TAKE A LOOK AT THE COVER OF THIS BOOK. WHO COULD RESIST A FACE LIKE THAT, HUH?

With the encouragement of her extended pool of contacts, Charleson decided to find out. She already had a houseful (two cats, Puzzle, and a small herd of Pomeranians), but she began to search for the perfect-personality puppy – which arrived unexpectedly when a neighbor who knew about Charleson's love of dogs hastily dropped off an emaciated, terribly sick, half-starved puppy at her Dallas-area doorstep.

Could this little guy be like Haska, who helps her person withstand PTSD? Would he be like Merlin, who assisted both father and son to overcome disabilities? Could the puppy be like Annie, who gives a teacher control over OCD; or like Juice Box, who helped his partner deal with depression and social problems? Could the puppy she named Jake Piper someday assist with loneliness, fear, illness, or isolation?

Or would he be just a dog – cherished, pampered, and special only in the eyes of his human?

Charleson wasn't sure if the little guy would be trainable, or even if he'd live. One thing was sure, though: she was going to give him every possible chance...

Take a look at the cover of this book. Who could resist a face like that, huh? Not author Susannah Charleson, and in this wonderful book, you'll meet that boy, and others – but don't think that the potential in "The Possibility Dogs" is only canine.

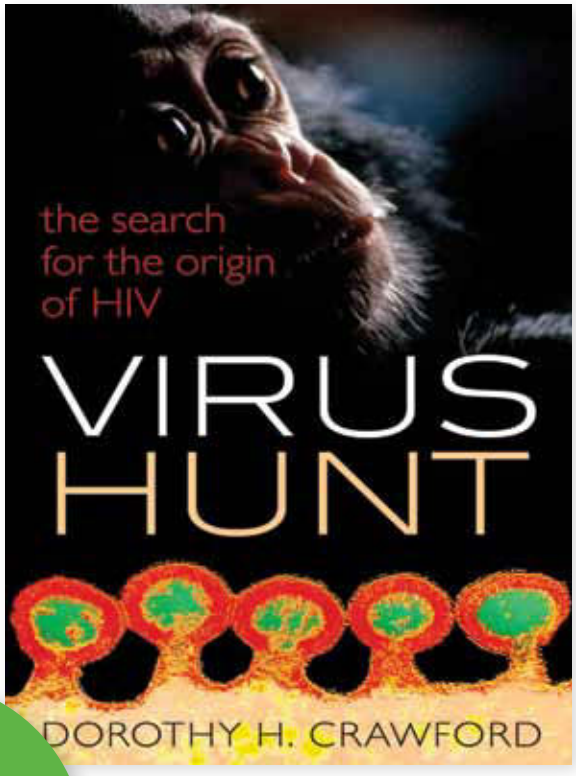
Through interviews and personal experiences, Charleson shows how these highly trained (though very intuitive) dogs can make an amazing difference in the lives of people who might have otherwise had to suffer at home, in silence. Those stories will touch your heart, and they might spur you to think about finding your own dog to raise or help. To that end, Charleson offers subtle advice with her addicting tales.

This slice-of-life is about dogs that nobody initially wanted – but if you're a pet-lover or are interested in service dogs, you'll definitely want this book, so fetch "The Possibility Dogs." It's a story you'll like very well. ■

TERRI SCHLICHENMEYER IS **THE BOOKWORM**

Your best friend shares practically everything with you.

Half her clothes are in your closet. His home is open when you need it. You share meals, rides, ideas, music, and gossip. What's hers is yours - which explains where your last cold came from...



by **Dorothy H. Crawford**
c.2013, Oxford University Press

Some things are easy to track down. Others take years, even decades. And in the new book "Virus Hunt" by Dorothy H. Crawford, you'll see how scientists discovered the roots of HIV.

In 1981, doctors in California began noticing "rare infections... and an unusually aggressive tumor" in certain patients. Soon, the same was reported in New York, Florida, and elsewhere around the country. By 1982, the disease was called AIDS.

The risk of catching AIDS seemed at first to be limited to sexually-active gay men, particularly those with multiple partners. Within weeks, heroin users and hemophiliacs were added to the at-risk group, then doctors discovered that infected mothers could pass it to their children. "Fear of AIDS" became "a disease in its own right."

By 1984, the "causative virus was identified [as human immunodeficiency virus]... and shortly thereafter the genome was sequenced..."

But where did HIV come from?

Soon after the first description of AIDS was released in 1981, Boston researchers noticed that their captive macaque population was affected with something that sounded similar. Four years later, scientists at that research facility isolated a simian immunodeficiency virus (SIV) which had spread and mutated as animals were "unwittingly" shipped around to other facilities.

That led to the discovery that some SIVs are "closely related" to certain strains of HIV and share "between 62 and 87 percent" of their genetic sequences. It didn't take much to see how the virus mutated, or how it leaped from animal to human, possibly via Africa's sooty mangabey monkeys (a "natural host of the virus"), which were sometimes hunted for food.

But the question of where HIV came from needs to go back even further than 1981. A man from Memphis was reported with what doctors would consider to be typical AIDS symptoms in 1952. SIVs were discovered in Icelandic sheep in 1949.

WHAT READERS WILL WANT TO KNOW, HOWEVER, IS THAT IT'S VERY ACADEMIC...

Scientists, in fact, believe that SIVs are "ancient parasites" and that HIV has been "circulating in the African population since near the start of the 20th century."

At the beginning of this book, author Dorothy H. Crawford indicates that the search for the beginnings of HIV is somewhat like a mystery. She's absolutely correct. It is, but you need a Sherlockian PhD to understand it all.

That's not to say that "Virus Hunt" is a bad book – that's not the case at all. What readers will want to know, however, is that it's very academic and heavily steeped in genetics, epidemiology, and laboratory-level research. That's great for anyone employed in those fields. For the layperson, this mystery's not unreadable but it's as far from relaxing entertainment as you'll ever get.

Tackle this book, therefore, but give yourself some time to absorb it. Without that kind of consideration and careful contemplation, "Virus Hunt" may leave you cold. ■

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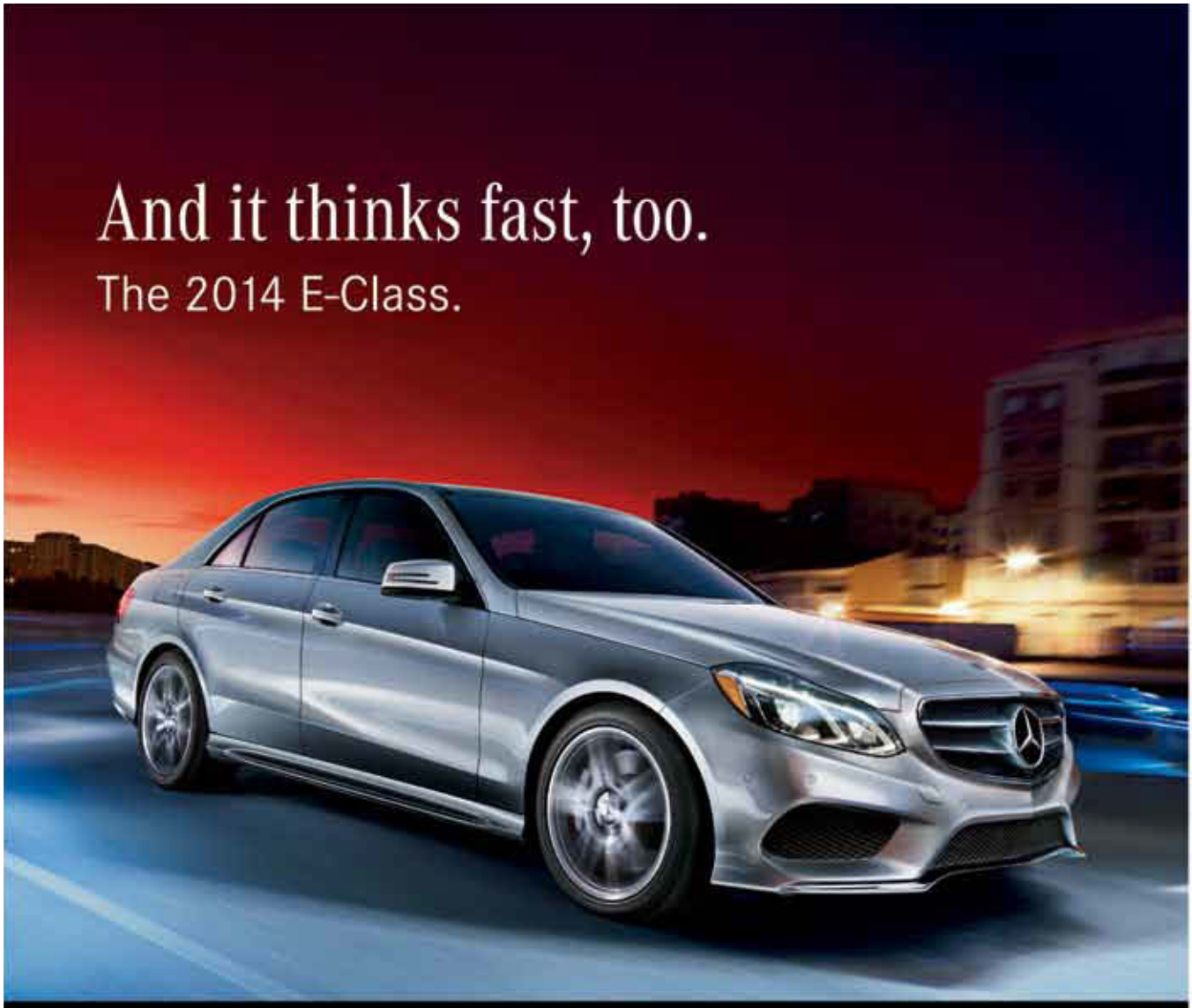

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