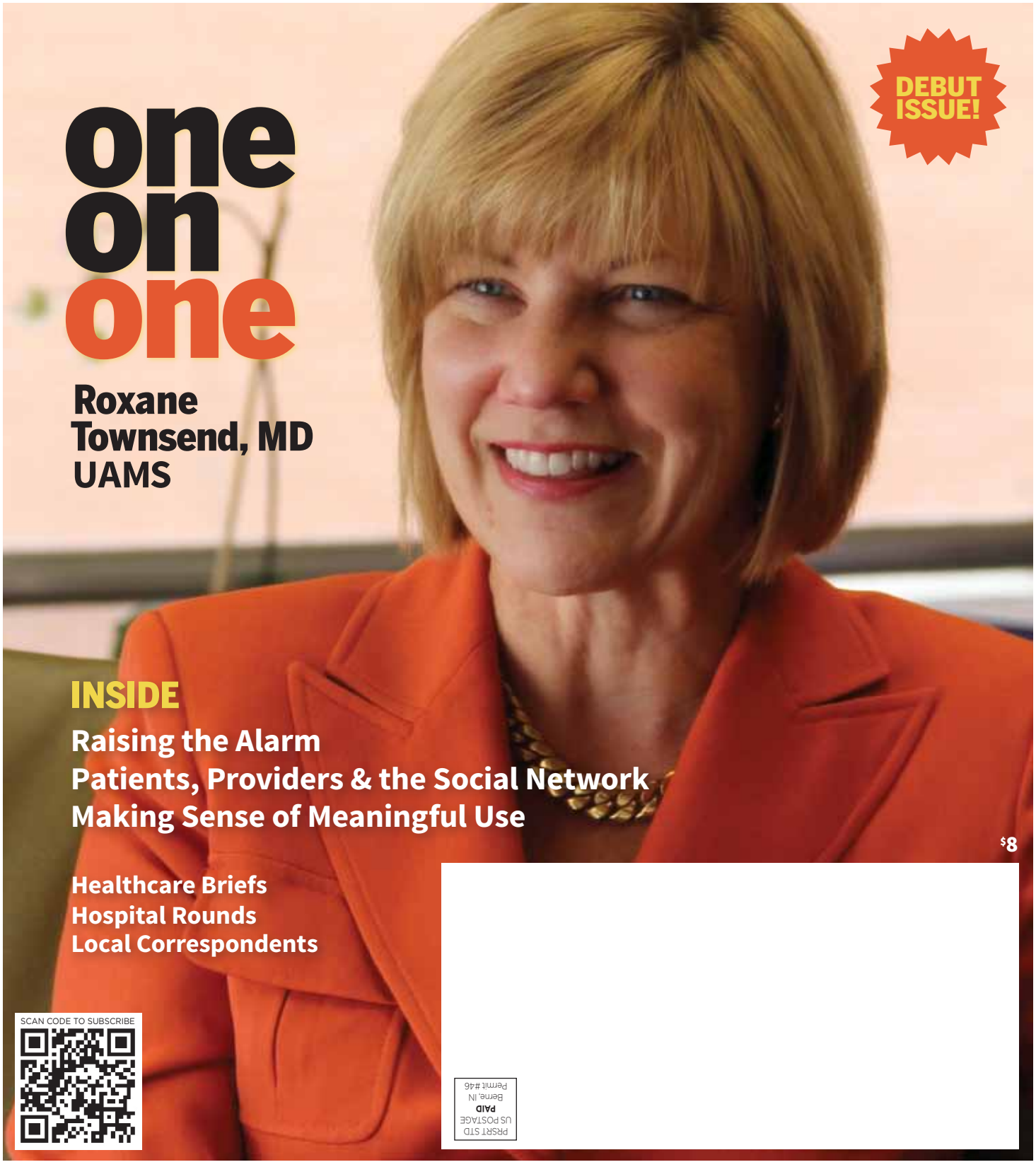
HEALTHCARE JOURNAL of Little Rock

NOVEMBER / DECEMBER 2013



DEBUT ISSUE!

one on one

Roxane Townsend, MD
UAMS

INSIDE

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Contents

November / December 2013 | Vol. 1, No. 1

DEBUT ISSUE!

PAGE 20

PHOTO COURTESY OF UAMS

One on One

Roxane Townsend, MD

Vice Chancellor for
Clinical Programs & CEO,
UAMS Medical Center

HJLR

PAGE 12

PAGE 30

PAGE 36

Features

Departments

Correspondents

Journalism largely consists of saying 'Lord Jones is Dead' to people who never knew that Lord Jones was alive.

— G. K. Chesterton, English author & mystery novelist (1874-1936)

It's an interesting time in healthcare. And, it's an interesting time for healthcare in Little Rock.

Thank you for looking at the inaugural issue of *Healthcare Journal of Little Rock*. It's our pleasure to dedicate coverage to this most important sector in the Greater Little Rock area. First, here's a little bit about what we don't do. We don't offer "advertorials" or "paid content." While advertorials are a popular publishing strategy, we are not in the business of offering quid pro quo content. Meaning, our advertisers are our advertisers and our content is our content. Some may say it's not the smartest business strategy, but I like to think readers will much prefer this approach for the long run.

Now, what is *Healthcare Journal of Little Rock*? We are the source for news, information, and analysis of the healthcare industry for Greater Little Rock. It is our intention to fairly and accurately cover the healthcare sector of the Greater Little Rock area through a collaborative effort from a local editorial advisory board, writers, and columnists. Our audience includes providers, policy makers, insurers, and very often our patients.

We mail each issue, at no charge, to most "healthcare leaders" including physicians, administrators, etc. If you are not on the mailing list yet, let us know. That's an easy fix.

And of course, we would love your input. There is so much going on and so many great story ideas. HJLR will always cover market trends, insurance issues, care issues, public health issues, hospital and physician trends and changes, and our readers' input provides some of the most unique story ideas.

Ultimately, it is our notion that the more we analyze our healthcare delivery systems, the better equipped we are to bring about optimal health to Arkansas' citizens. Thank you for your participation.

Please email me with any comments.

Here we go.

Smith Hartley
Chief Editor
editor@healthcarejournallr.com


ARKANSAS

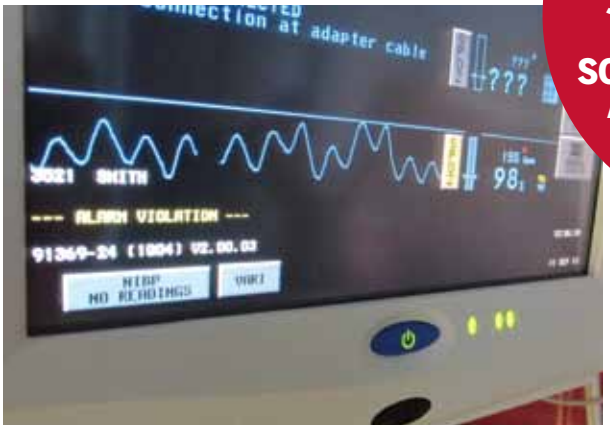
Raising the Alarm On...Well... Alarms

Today's technology never ceases to amaze. It seems on an almost daily basis another step is taken that seemed inconceivable just a few years prior. Even in the realm of healthcare, which has probably and properly been slower to adopt the latest gizmo and doodad, technology has brought a whole new level of precision, efficiency, and safety to patient care. Our ability to capture, analyze, store, and share information has never been greater and the technology that exists to test, treat, and monitor the ill and injured is nothing short of remarkable. But as with everything there is a price and the more technology enters the patient room, the more fears grow that the very tools that help us care for those patients can also prove to be a distraction or even a danger.

By Karen Tatum

Of particular concern are the myriad alarms associated with almost every device we use to monitor a patient's condition. From cardiac monitors, to ventilators, to IV pumps, to blood pressure or pulse oximetry monitors, to bed alarms, every one of them is capable of creating audible and sometimes visual alarms of varying intensity, speed, and volume. In areas that care for the critically ill, it can seem that alarms are sounding constantly. While on the surface this is a good thing–the alarms are notifying providers that something might be amiss that they might not have noticed on their own–the sheer number of alarms, sometimes hundreds per patient, per day, can not only be mentally distracting, but can also make it impossible to hear some alarms, lead to burnout responding to alarms, or cause desensitization to alarms, a condition known as "alarm fatigue." Alarms may be turned down or disabled or parameters reset in an effort to buy some peace or allow more focus on the more critical alarms. And that's when disaster can strike.

In what it calls a "gross underestimation," the Joint Commission reported that



IT CAN BE A DIFFICULT LESSON FOR CLINICIANS: JUST BECAUSE WE CAN MONITOR SOMETHING, DOESN'T ALWAYS MEAN WE SHOULD.

in a 3½ year period ending last year it had received 98 reports of alarm-related incidents, including 80 deaths. In a majority of these cases functional alarms were disabled or were inaudible, thereby failing to alert staff of a problem with the patient. Hospitals are not currently required to report alarm-related incidents, so experts speculate the problem is, in reality, significantly greater. That prompted a Joint Commission Sentinel Event Alert on Alarm Safety this April, which was quickly followed by a new National Patient Safety Goal (NPSG.06.01.01) that will go into effect in July, 2014.

It's not the first time Joint Commission has expressed concern about alarm fatigue said Julia Hyett, System Director of Risk Management for Baptist Health Center, noting that it has been on the radar since the Institute of Medicine's "To Err is Human" report in 2000. Now, "as we move forward with new technology we are looking again at alarms and alarm fatigue," said Hyett. The ECRI Institute, too, has listed alarm hazards as the number one health technology danger in its annual top ten listing for the last two years.

While most hospitals are aware of the challenges around alarm management and the danger of alarm fatigue, there is nothing quite like a Joint Commission nudge to get them to take a closer look and ensure they are ready for the new Patient Safety Goal. The Joint Commission itself admits "universal solutions have yet to be identified," but is compelling hospitals to "develop a systematic, coordinated approach to clinical alarm system management." Hyett acknowledges that although alarm management was definitely on the radar already at Baptist, the Joint Commission Sentinel Alert and Patient Safety Goal has inspired renewed focus. "To focus on it brings good things and improves outcomes for our patients," she said.

Most, if not all area hospitals have already achieved the first component of NPSG 06.01.01, which is to establish alarm system safety as a hospital priority and have established task forces engaged in meeting the second component, which is to identify the most important alarm signals to manage. At Arkansas Children's Hospital, for example, the Quality Council has created an alarm task force that includes staff from all areas of the hospital. "Our job is to go identify all the machines that have alarms, determine their default values, bring that to the council, and as a group, determine what would be considered a critical alarm," said Kevin Haralson, Director of Clinical Engineering. "Then, as a group we will decide how those critical alarms will be managed."

Obviously not all alarms are critical and not all of them indicate a patient is in distress or imminent danger. However all alarms have the potential to contribute to the "noise" that might disguise a more critical alarm. Hospitals are tasked with identifying where potential problems may exist, assessing the risk to the patient should the alarm be missed, determining which alarms are

LEFT Julia Hyett, System Director of Risk Management, Baptist Health Center.

CENTER Kevin Haralson, Director of Clinical Engineering, Arkansas Children's Hospital

RIGHT Amy Hester, PhD, BSN, RN, BC, Director of Clinical Informatics and Innovation and Director of the Diagnostic Center, UAMS.

"...customizing alarms for the individual patient is a crucial measure for reducing nuisance alarms that can contribute to fatigue."

necessary and which are just adding noise, and evaluating internal incident history related to alarms.

Under the new National Patient Safety Goal, by January 1, 2016, hospitals must have established policies and procedures for alarm management. At a minimum those must include:

- Clinically appropriate settings for alarm signals
- When alarm signals may be disabled and by whom
- When alarm parameters can be set or changed and by whom
- Monitoring and response to alarm signals
- Alarm maintenance, i.e. accurate settings, proper operation, detectability.

Hospital staff and other licensed practitioners must also be educated as to the purpose and proper operation of the alarm systems for which they are responsible.

This last element is a key one. It can be a difficult lesson for clinicians: just because we can monitor something, doesn't always mean we should. Instead the monitors and their associated alarms should be meaningful. Many hospitals are now engaged in creating or tweaking protocols for when monitors will be used and what parameter limits will be assigned for those monitors.

Every piece of medical equipment comes with default settings based on industry standards, but those defaults are seldom used in a clinical setting. Instead, depending on the type of facility, the kind of unit, and ideally, the patient himself or herself, new parameters are entered that will capture the changes requiring a nurse's attention. Standardization of these parameters for each unit and throughout the hospital make it easier to educate staff as to what alarms mean and what action is required. Obviously there will be instances when those standard parameters will have to be adjusted for an atypical patient so that, for example, a patient with an existing rapid heart rate is not triggering an alarm set for more standard heart rates. In its Sentinel Alert, the Joint Commission stated that an estimated 85 to 99 percent of alarm signals do not require clinical intervention. Customization of alarms can go a long way towards reducing meaningless alarms, false positives, and unnecessary noise and is a practice encouraged by the accrediting organization.

One of the things the alarm management workgroup at the University of Arkansas for Medical Sciences (UAMS) Medical Center is focusing on is standardization of alarm parameters, but there is not a lot of research out there to guide hospitals, said Amy Hester, PhD, BSN, RN, BC, Director of Clinical Informatics and Innovation and Director of the Diagnostic Center. "From a research perspective that's definitely something we are

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going to look at to establish the evidence that will guide clinicians in the best way to use those parameters." It can be a daunting task. Some monitors can have as many as 300 different parameter settings, explained Haralson. At Arkansas Children's Hospital, they create a multi-page worksheet lining out the new default values for each monitor in each unit. The medical director reviews and signs off on those default settings. "Every care area has approved default alarm values and the nurse can adjust those values based on the patient," said Haralson. Hyett agrees that customizing alarms for the individual patient is a crucial measure for reducing nuisance alarms that can contribute to fatigue.

Standardization of parameters will also help avoid confusion and error when attaching monitors to a new patient, but it is also important that hospitals determine who has the authority to adjust those parameters, disable an alarm, etc. Even this is not foolproof. Cases have been noted where a doctor or nurse may go into a room to perform a task and an alarm starts sounding. They may turn down the alarm in order to talk to the patient, or complete the task, with the intent of reporting the alarm when they leave the room, but may become distracted. "That is the big worry with alarm fatigue," explained Hester. "It will either result in complacency of your staff in responding to alarms or it is going to result in people becoming so absolutely frustrated that they disable the alarms because the alarms are disabling them from being able to provide adequate, thoughtful care to their patients."

Luckily few hospitals of any size rely solely on audible alarms. While these still sound, some hospitals have added visual cues that an alarm is sounding either on a light display outside a patient's room, on a main bedboard, or at the nurse's station. Newer technology allows alarms to be tied in directly to a communication device worn by the nurse responsible for that patient. For example, both UAMS and Arkansas Children's Hospital use a Vocera device worn by the nurse. "With the device connectivity projects we've got going on, we can pull those alarms automatically through the network and send them out to the nurse," explained Haralson. "It gives the nurse very specific information about the alarm so she just has to tune in to her assigned rooms instead of hearing alarms for the whole unit." This direct notification of the nurse assigned to a patient can cut down on some of the alarm "noise" in the unit and also reduces the possibility of a critical alarm being missed.

In some units, particularly telemetry units, a central location, often called the war room, is set up with dedicated personnel watching all monitors and relaying alarms to the appropriate staff. Central monitoring can be an important feature in units with multiple alarms sounding constantly and, even with new technology, can provide a fallback to ensure someone is responding. "We still have the human at the monitoring station just as a redundancy, as a safeguard," said

A system of lights triggered by equipment alarms can add a visual cue to aid in alarm response. ◀

STRATEGIES TO IMPROVE MONITOR ALARM SAFETY

1. Assemble a multidisciplinary team

- Administrative sponsor (e.g., CNO, VP Quality)
- Key medical staff
- Nurse managers
- Front-line nurses
- Monitor technicians
- Patient safety/risk manager
- Clinical engineering staff
- IT staff
- Consult with others, as appropriate

2. Review recent events and near misses

- Root causes
- Frequency of alarm types
- Aggregate of alarm types per care area/shift
- Review remediation/results
- Trends

3. Observe alarm coverage processes and ask nurses and other staff about their concerns

- Routine rounding
- Listen to staff concerns/ problems
- Map processes for alarm notification and response
- Identify obvious problems
- Excessive alarms
- Difficulty in hearing alarms
- Delayed alarm response
- Pagers not being worn

4. Review entire alarm coverage system

- Culture
- Infrastructure
- Practices
- Technology

5. Identify patient safety vulnerabilities and potential failures

FAILURES

- Delayed alarm response
- Transport Communication Breakdown
- Leads-off Apathy
- Alarm Fatigue

CAUSES

- Diffuse responsibility for alarm response
- Competing priorities
- Assumptions that someone else will respond
- Excessive nuisance alarms

6. Develop realistic, implementable strategies to address underlying causes

TODAY FIXES

- Proper skin prep
- Proper electrode placement
- Routine change of electrodes
- Battery replacement every 24 hours
- Elevate "Leads-Off Alarms" to crisis priority

THINGS TO CONSIDER

- Delineate responsibility for alarm response
- Develop a back-up plan with tiers of coverage
- Delineate responsibility for back-up response
- Implement two-way communication devices that would allow a nurse to request help
- Develop an alarm escalation scheme
  - Who receives initial alarm notification for each type of alarm
  - Who receives back-up alarm notification for each type of alarm
  - Time intervals per escalation

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Poster: "Strategies to Improve Alarm Safety" Reprinted with permission.

Hester. However, the technology that allows for individual notifications of alarms is becoming fairly sophisticated, providing the nurse with a fair amount of detail as to what is going on with the patient and more and more those devices are directly networked with the monitoring systems. The nurse can also indicate whether she is responding, notify others to respond, or see if someone else has responded. Hester said UAMS is also the first hospital in the country to integrate its fall alarms with the Vocera device. "When we did that we were very cognizant about the potential for alarm fatigue in our nursing staff. To alleviate our concerns we made sure we had some interfacing technology in place so we could send alerts to the people that needed it and not as a general broadcast," explained Hester.

Baptist Health Center's newly implemented electronic medical record, Epic, is also providing new tools and resources for monitoring the patient and providing information across the healthcare team, explained Hyett. It allows for more information and documenting ability at the bedside, meaning nurses are spending more time in the room looking at the patient and the monitors and providing more immediate response to issues. "That's probably our number one goal with technology," said Hyett. "We still want our caregivers to be trained to take care of the patients that come to see us and there is no replacement for that."

While some units, like ICUs, have a high nurse to patient ratio and alarm response assignments are pretty clear, in other larger units many hospitals have implemented an additional alarm management policy to support assigned staff. A "no pass zone" makes it everyone's responsibility to stop and investigate if an alarm is sounding in a patient room. This responsibility extends to all staff, including non-clinical workers, housekeeping etc. Even though improved personal notification technology or better unit design in newer facilities may have eliminated the need for this approach, it's another great failsafe when built into the hospital's patient care culture. Even so, "You have to use those policies very judiciously, so that you are not using it as a blanket policy. But using it where it makes the most sense for the clinician," said Hester.

Nurses are not the only ones who experience alarm fatigue. In units where hundreds of alarms are sounding every day, it is natural that patients and their families might also grow weary or frustrated, particularly if those alarms are preventing rest, or if hospital staff is perceived to be slow in responding. Not only does this affect patient comfort and satisfaction, for which hospitals are being held increasingly accountable, but patients and their families have been known to take matters into their own hands and disable the equipment themselves. Patient education is therefore a necessary component of any hospital alarm management plan. "We have specific education we give to the families to let them know, 'Here's why we are using the alarms, here's what you are going to see, what you can expect,'" said Hester. "We tell them kindly that we want them to be engaged in care, but not in the way of care."

Manufacturers, too, have done their bit to help with alarm safety although not necessarily alarm fatigue. There has been a push towards standardization so that the same alarm sound always means the same thing. While we are not there yet, manufacturers have made progress toward making critical alarms sound more distinctive and urgent. Some have also made it impossible or at least very difficult to disable or mute a critical alarm. Some facilities achieve their own standardization among alarms by carefully researching each new piece of equipment to make sure it fits in with the protocols and technology already in place. "I think some vendors are doing a very good job of that today and some are far behind," said Hester. "As healthcare providers we have to be good consumers of the products that are

A "no pass zone" makes it everyone's responsibility to stop and investigate if an alarm is sounding in a patient room. This responsibility extends to all staff, including non-clinical workers, housekeeping etc.

Additional Resources

The good news is that there is plenty of help out there with webinars, conferences, workplace reviews, training posters, and more. Check out the following resources:

The Joint Commission
http://www.jointcommission.org/topics/patient_safety.aspx

ECRI Institute
https://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx

Association for the Advancement of Medical Instrumentation
http://www.aami.org/htsi/alarms/index.html

available and be educated as to what is available out there."

Obviously, not every alarm carries the same weight. There are generally three levels: crisis, which requires immediate response; warning, which may alert nurses to things like a change in rate, rhythm, level; and advisory, which alert staff to things like an IV medication being completed, etc. Unlike crisis alarms, warning and advisory alarms can often self-reset after the bump or spike returns within parameters or after a certain time frame. The problem is that sometimes those warning alarms may be more clinically meaningful than staff realize. One benefit to newer technology is that many devices allow facilities to capture data on alarm incidence, false positives, and response times to help hospitals address their alarm management in a more scientific manner. At Arkansas Children's the Bedmasters system allows all of the patient monitors to be networked and pulls and records data on every patient case, alarm, and parameter. "We can capture how many alarms are happening," said Haralson. "It's a useful step in looking at alarm fatigue."

Sometimes, however, the tweaks are not intuitive. For example, during a quality improvement alarm management initiative at Boston Medical Center to improve patient safety on general medical/surgical units by reducing the number of clinically insignificant audible cardiac monitor alarms, the team found that there were a large number of warning alarms for heart rate and arrhythmia. These were not always immediately addressed and would also self-reset. A review of alarm history data indicated that some alarms and opportunities for intervention had been missed. Since these were important, but not critical, alarms it might have made sense to adjust parameters to make them less sensitive. Instead, Boston Medical Center staff raised the acuity of these alarms from "warning" to "crisis." By doing so, those alarms sounded more infrequently, but required more immediate response. Addressing them more aggressively considerably reduced the level of background noise in the unit, made other warning alarms and system alerts that had been in danger of being drowned out more audible, and, as an unexpected bonus, increased patient satisfaction.

Many monitors and other medical equipment may also emit system alert alarms that indicate a problem with the equipment such as a low battery, a malfunction, leads-off etc. So addressing equipment maintenance and simple things like changing out batteries, leads, and electrodes more regularly can also reduce the number of alarms sounding in a unit and help reduce the possibility of alarm fatigue.

As hospitals across the state and the country go through the steps of reevaluating their alarm policies and parameters it is likely some more defined best practices will emerge. Manufacturers, too, are being called on to help with standardization of monitoring equipment and alarms. Of course, technology continues to evolve so hospitals are also tasked with finding and utilizing the best equipment they can, tailor it to their patient population, integrate it with existing technology, and keep staff educated as to how to use it safely and effectively. "As we move forward I think there are opportunities in communication technologies and their enhancement with our existing medical device technologies," said Hester. ■

one on one

with **Roxane Townsend**, MD
Vice Chancellor for Clinical Programs,
CEO, UAMS Medical Center

Roxane A. Townsend, MD joined University of Arkansas for Medical Sciences (UAMS) as vice chancellor for clinical programs and chief executive officer of UAMS Medical Center in February 2013. She is responsible for the strategic oversight of the UAMS hospital and clinics, which together have more than 3,000 full-time employees.

Townsend previously served as assistant vice president for health systems at Louisiana State University (LSU) in Baton Rouge. In that role, she worked with the system's 10 hospitals and their clinics in the development of operational strategies and system-wide policies. Townsend also served as CEO of the Interim LSU Public Hospital in New Orleans, Earl K. Long Medical Center in Baton Rouge, and as CEO of the LSU Health Care Services Division. Prior to joining LSU in 2007, she was appointed by Louisiana Gov. Kathleen Blanco as secretary for the Louisiana Department of Health and Hospitals (DHH) for the transition to a new administration. She also served DHH as the Medicaid medical director and deputy secretary of the Department.

A native of Pennsylvania, Townsend received a bachelor's degree in nursing from Duquesne University in Pittsburgh. After nine years working as a nurse, she entered medical school at LSU in New Orleans. She graduated from medical school in 1992 and completed a residency in Internal Medicine.

Even the Legislature, regardless of what side of the aisle they are on, they're supportive of the mission; they want to see us train doctors, they want to see us have healthcare professionals into the future, and we have a safety net mission as well. So, it's kind of the perfect set up.

PHOTO COURTESY OF UAMS

Chief Editor Smith W. Hartley: *Let's start with the relationship between UAMS and the University of Arkansas and what does it mean to be the only academic medical center in Arkansas?*

Roxane Townsend, MD: You know that was one of the things that really attracted me about the job. When I came to interview, one of the things you sense is that because the University of Arkansas and the Razorbacks are such a big thing in Arkansas, to be part of that UA system and then on top of that, we're the only academic medical center that's here, we're the only College of Medicine in the state, you really have built in state support. Even the Legislature, regardless of what side of the aisle they are on, they're supportive of the mission; they want to see us train doctors, they want to see us have healthcare professionals into the future, and we have a safety net mission as well. So, it's kind of the perfect set up.

Editor: *UAMS is moving more toward ACOs. Can you talk about how that's going and where you are in the process?*

Dr. Townsend: Right. Arkansas is doing some pretty innovative things. One of the things they started, I think back in 2011, was the Arkansas Payment Improvement Initiative. Governor Beebe has really been a healthcare governor, even though I don't think that's what he intended when he first took office. He and the Surgeon General Joe Thompson, have started outlining this plan where they are essentially bundling payments and they've done it in a way where it's not just Medicaid that's looking at it, but they have gotten the biggest commercial payers in the state to get involved as well. As UAMS, we are actively involved with designing these payment initiatives. I think the initial four included things like ADHD, I know we've got things like total joints in there. It's got a three part mission. They want to make sure they improve the quality, improve the patient experience, and be cost effective at the same time. So they are trying to do all that with this. It's really not an ACO model as much as a bundled payment plan. Rather than fee-for-service they want to move to paying for quality outcomes. That's kind of exciting to be part of that and get to plan how that's going to work for Arkansas.

So that started first and then, as the Affordable Care Act came into play they started talking about Medicaid expansion. A lot of people weren't interested in expanding into Medicaid. They didn't feel like that was a plan that necessarily assured the best outcomes. They wanted to do something a little bit different so the Governor went and talked to Secretary Sebelius and that's why we are actually doing our Medicaid expansion through the private option. It's a 1115 waiver and we are going to be able to take the money that the Feds would have paid to expand Medicaid and we are going to pay for private insurance for that population between essentially 0% and 138% of federal poverty level. It's causing people to align and we are certainly thinking, because of the payment initiative, bundling payments, we are thinking about more alignment among the different providers. But not really an ACO model; a little bit different. So Arkansas has taken a little bit of a different tack than other people.

Editor: *What does that mean for your payer mix then? Will you have relatively the same payer mix? Are you looking for different commercial options?*

"It's causing people to align and we are certainly thinking, because of the payment initiative, bundling payments, we are thinking about more alignment among the different providers. But not really an ACO model; a little bit different. So Arkansas has taken a little bit of a different tack than other people."

Dr. Townsend: From a payer mix standpoint, we actually have a pretty good payer mix here at UAMS. Very different from what I came from at LSU where the state hospitals have a 50% uninsured rate. Here our uninsured rate is about 13%, so a much more favorable payer mix, but still twice the average of uninsured that you would see across the country. It makes it somewhat of a challenge. We do get DSH (Disproportional Share Hospital) through the Medicaid program to help us cover some of those patients. But what we think is going to happen between the bundled payments and the private option is that we are projecting at least half of those patients that are currently uninsured will sign up for private insurance, which will be a significant improvement in the payer mix here at UAMS.

We are hearing from the insurance companies who are going to participate in the health insurance exchange and it looks like those rates, from a commercial standpoint, are going to be pretty close to our commercial rates right now. So we really think this is going to be favorable to us. We think we could see as much as $8 million over a six month period if about 75% of the people actually get signed up for insurance. That's pretty aggressive. It will probably be closer to about 50% might get there in those first six months. Enrollment opened in October so we are going to wait and see what happens.

Editor: *As far as the change to measuring by outcomes. Are you doing some things differently internally to prepare?*

Dr. Townsend: We've been modeling what being the accountable provider would look like. For many of the payment improvement initiatives, the accountable provider is actually the physician, so it is our physicians and our faculty group practice who are being the accountable provider that the payment is tied to. We have actually been tracking those different measures that they are going to want to see, to see if you are within the acceptable range to receive the bundled payment. Actually what we are seeing is that, for the most part, our physicians do a great job and we meet all of the measures that would be needed for the upper respiratory infection and for the total joints. For those kinds of things, we are able to meet the quality measures so we feel comfortable we will realize those payments.

The other piece of that though, is not just meeting the quality measures, but also looking at how your costs compare to other providers. Because that's what they are doing, they are looking at average costs. And we always have to deal with the extra, added teaching costs and educational costs that you have to have in an academic medical center, that you may not have with other providers. But even with that, for the most part, we are showing pretty favorable outcomes.

Editor: *What role does your information technology play in all of this? UAMS is moving to the Epic system I believe?*

Dr. Townsend: It's interesting you should say that. We are doing an Epic implementation. We call our product You Connect and Wave 1 went live on August 1st. That was mainly our primary care clinics, so Family Practice, Internal Medicine, and Medicine Subspecialties all went live August 1st. It's had its own bumps and warts, but overall it's been a really good clinical implementation. The last wave of the implementation is March 1st and at that point the hospital and all of the clinics will be on the same platform. So that's very exciting for us and it's going to make that information gathering to meet bundled payment measures and things like that, that much easier.

Right now we've kind of got "best of breed" so we have a different inpatient system versus a different outpatient system, and some of the outpatient systems are a little bit different, depending on what best of breed was at the time they were implemented. Epic is going to give us a common platform, all of our patient information is going to be in one record. So we are excited about the advance

and the advantage it is going to give us for quality and safety for our patients.

Editor: *Is UAMS involved in the rural communities at all? Telemedicine?*

Dr. Townsend: Yes! Actually UAMS has sites throughout essentially every county in Arkansas. We have eight AHEC (Area Health Education Centers) sites that are now called regional programs and I think six of them have family medicine residency programs attached. All of that is not part of the clinical programs that I'm responsible for, but it is part of UAMS. So we have lots of outreach activities.

One of the things we are doing right now—the new Dean of the College of Medicine and I are partnering to try to reach out and see how we can be more of a state asset to some of the community hospitals. I don't know how many different sites, but basically we've got a lot of internet access, a lot of wire laid, so we actually have more than 400 telemedicine sites throughout the state. What that allows us to do is we can take our specialists here and provide telemedicine services to some of the outlying areas because what we really want to see is best care closest to home.

It is not unusual for UAMS' medical center to have 100% occupancy first thing in the morning essentially Tuesday through Friday. So it is in our best interest to allow patients that can be adequately cared for in a hospital close to home to stay there if we can help support it in some way, so that the tertiary care kinds of thing, the specialists that are only available here, we can receive those patients and not have our beds tied up every morning. It's really hard—it delays the operating room schedule, people are coming in expecting to have their surgery start at 7:30, but maybe it can't start then because we are not going to have an ICU bed until later. So we can't get the operating room started on time. We have transfers wanting to come in—appropriate transfers from outlying hospitals—that we can't necessarily get into the system. So, we are trying to decompress and like I said, best care, closest to home is what we would like for Arkansans. And we would like to be able to support that the best way we can.

Editor: *Are there takeover talks with St. Vincent's?*

Dr. Townsend: We've had discussions with St. Vincent and CHI out of Denver. They predated my arrival. I think almost two years of talks had gone on to try to figure out if there was going to be some way we could partner to be able to get some economies of scale, efficiencies, get some cost savings between the organizations. We recently decided that there really wasn't going to be a path forward because of the different structures. We saw definite possibilities for savings, but in order to achieve that, it looked like one entity was going to have to essentially take over the other and neither entity was interested in doing that. UAMS was certainly not interested in letting anyone else manage their hospital and obviously St. Vincent is managed by CHI and so it just looked like there would not be a path forward.

But there was some really good thinking about potential. Whenever your hospitals are just a mile apart you really do think about ways that, even with some back office functions, you could share a cross finance. The medical center and St. Vincent actually had the same contract for housekeeping, with the same company, so it would have been great if we had been able to figure out a way that we could have done a single contract across both entities and perhaps saved some money, some management costs and things like that. But it was too difficult to try to manage with our Board of Trustees and the CHI corporate structure.

Editor: *In regard to primary care physicians, is there a shortage in Arkansas? Perhaps more so outside of Little Rock? Or do you have any specialty issues here?*

Dr. Townsend: Certainly primary care is an issue for the state and it's something that everyone is very cautious about as we go into this Medicaid expansion, because we know as people get insurance they are likely going to utilize more services and they are going to want to access primary care. In most of our rural communities there are not enough physicians to take on that primary care.

Within Little Rock, and probably within Pulaski County, if you look at the large number of physicians we have here, we don't show up as a shortage area. So from a primary care perspective Pulaski County is okay. The rest of the state, especially in the rural areas, do deal with much more in the way of shortages.

We do have some specialty shortages across the state. You can't get neurosurgery most places. Little Rock is probably one of the few places that you can. There are some bigger hospitals in Northwest Arkansas, but in many areas, you've got to travel a bit to get to things like neurosurgery or other kinds of specialized surgery. For some of the specialized cancer therapies you have to come here to UAMS. So yes, in pockets, there are specialty shortages.

As the only academic medical center and the only College of Medicine we really do try to keep in mind what the needs of the state are. Our chancellor, prior to my coming, was involved in a task force that looked at the healthcare needs across Arkansas and made some recommendations to Governor Beebe about ways we might be able to fill those. And some of those AHEC programs, those regional programs, that's one of the ways. I think we are training about 160 residents right now in those family practice areas and they are in the rural areas so the hope is they'll train in those areas and stay in those areas and provide the primary care that people really need.

Editor: *Your Palliative Care Program just got special accreditation. Are you the only program in the state that does that? And what does that mean for UAMS and for your patients?*

Dr. Townsend: This has just been a terrific program for us. Sarah Beth Harrington is the physician who specializes in palliative care. She started the program and kind of started small, but has seen a real exponential increase in the number of consults she's getting and really the acceptance and understanding. When you start off with palliative

care a lot of people think it's just hospice care, it's only end of life; that's the only thing they can do. When in truth it's really very good for many patients because it helps with pain control. It does help with end of life issues, and I laugh saying there is only one way any of us are getting out of here, so those are important discussions to have with patients and families, but many of their consults really are for comfort control, pain control, so they have really done a great job. They are a bunch of caring, committed folks, and she has actually taken on her first Fellow this year and so we are hoping to see the program expand and have more physicians trained because it's such an important part of medicine. We have to help patients through whatever the outcome is going to be for their illness so they can enjoy life and have more quality.

Editor: *Is UAMS doing anything to increase transparency, getting more information to patients and the public, better access to medical records, or anything like that?*

Dr. Townsend: Absolutely. Actually, through our legacy system that we are replacing with Epic, we've had a patient portal, but we are implementing the Epic patient portal and it really does give better access. As we get better at using it, we'll allow more two-way communication with our patients. They'll be able to talk to their doctor, ask questions, not just from their doctor, but in the future we will also have nurses that can answer health questions they might have. They'll be able to view, make, and cancel appointments, pay bills, look at their medicine lists, and overall have much better access to their electronic medical record. I think that's a real benefit for patients to have that information readily available. Because it's a web portal that means they can be anywhere and have access to their medical record. So if they are on vacation and have to go into urgent care and the urgent care has internet access, they could allow their physician to see their medical record. So it's a real benefit.

"One of the things we've done here that is a little bit different—I don't think a lot of places are doing it—we have a real emphasis on patient family centered care."

Editor: *Are public funds decreasing a little bit here?*

Dr. Townsend: We actually had a really good session this year. UAMS gets around $106 million in a state appropriation. We were cut just a little bit this year—about $1.6 million, but there's been some work going on to really try to make the campus whole. There's a lot of pressure. We've got state budget issues just like every other state does. Rising costs, etc. Fortunately Governor Beebe has done a great job and actually showed a surplus for the state at the end of last year. It's been an interesting turn of events, but we've been able to stay pretty flat this year so we were happy about that.

Editor: *What are some of the things you are working on? What's coming up next?*

Dr. Townsend: One of the things we've done here that is a little bit different—I don't think a lot of places are doing it—we have a real emphasis on patient family centered care. We recently hired a new associate vice chancellor, Julie Moretz, and she works across clinical programs and the academic programs.

She comes from the Institute for Patient Family Centered Care out of Bethesda and has a wonderful personal story. She is the mother of a young man who died after a heart transplant and she has been a real champion for patient family centered care and helping families find their voice. We've got this wonderful effort going. Instead of a patient visitor policy we have a family presence policy. We just changed our announcement at night so that it is welcoming...we want families to stay with patients throughout their hospitalization if the patient wants that. We want to make more information available. We want to involve patients and their families in their care.

I am so proud of our nursing staff. They have done this wonderful job of starting bedside rounds. That's a big deal for nurses. I was a nurse and in the old days you basically tape-recorded your report. So you were taking care of the patients while the nurse that was coming on was hunkered back in some little room with a closed door listening to your taped report. Now the nurses are actually going to the bedside, they are giving the report in front of the patients. We have put white boards up in the patient rooms. It lists who your caregiver is, who your doctor is, what the phone numbers are, what the plan for the day is, what your pain control needs are, and there is a part of that board that is the patient and family's so they can write notes. During the change of shift the nurse can check on that and make sure everything is right.

We've had some really good positive feedback from our patients' families and the nurses. I spoke with one of the nurses the other day and she said, "I was one of the skeptics; I didn't think this was a good idea, but I am really finding out the patients appreciate it." What that told her was the patient was thinking, "I was kind of worried. I wasn't really sure you knew what was wrong with me, or knew about my heart condition, but you talked about it when you and that nurse changed shifts, so now I feel more comfortable because I know you know what's going on with me." So rather than talking about patients we are talking with patients in the room. That's really a very exciting thing that's going on right now and it's a real change for those of us dinosaurs who came up 30 years ago. We didn't think that way. It was a much more paternalistic attitude. You told patients what to do and you expected them to follow your advice and now it's really engaging them in the care.

That's one of the most exciting things we have going on, but there are always lots of new things. People keep asking me, "So how's this going to work with the new Medicaid expansion and the Payment Improvement Initiative?" I honestly have to tell people I really don't know how it's going to work out, but we really do believe that it's going to be better for patients. ■

Meaningful Use

Dr. David Nilasena, chief medical officer for the Centers for Medicare & Medicaid Services' Southwest Region, is writing a series of articles to help healthcare providers better understand the government's electronic health record incentive programs.

PART 1

Stage 2 of the electronic health record incentive programs: Building from Stage 1

The Centers for Medicare & Medicaid Services has published the final rule for Stage 2 of the Medicare and Medicaid electronic health record incentive programs. The rule provides new criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet to participate successfully in the incentive programs.

Stage 2 core and menu objectives

Stage 1 established a core and menu structure for objectives that providers had to achieve in order to demonstrate meaningful use. Stage 2 retains that core and menu structure for meaningful use objectives.

In Stage 2:

Eligible professionals will be required to meet 17 core objectives, as well as three menu objectives (which they select from a list of six), for a total of 20 objectives.

Eligible hospitals and critical access hospitals must meet 16 core objectives, as well as three menu objectives (which they select from a list of six), for a total of 19 objectives.

Changes to Stage 2 meaningful use objectives

Most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of those Stage 2 objectives, the threshold that providers must meet to achieve them has been raised. CMS expects that providers who reach Stage 2 in the incentive programs will be able to demonstrate meaningful use of their certified electronic health record technology for an even larger portion of their patient populations.

Some new objectives were also introduced for Stage 2, and most of those were introduced as menu objectives. As with Stage 1, many of the Stage 2 objectives have exclusions that allow providers to achieve meaningful use without having to meet objectives outside their normal scope of clinical practice.

Providers can visit the CMS website and download comparison tables for the Stage 1 and Stage 2 core and menu objectives and measures: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html ■

PART 2

What you need to know about pre- and post-payment EHR audits

An eligible professional, eligible hospital or critical access hospital that attests to receive an incentive payment for either the Medicare or Medicaid electronic health record incentive program may be subject to an audit.

The Centers for Medicare & Medicaid Services and its contractor, Figliozzi and Co., will conduct audits on Medicare and dually-eligible (Medicare and Medicaid) providers who are participating in the EHR incentive programs. Medicaid providers participating in the Medicaid EHR incentive program will be subject to audits by the states and their contractors.

Pre- and post-payment audits

CMS began pre-payment audits in 2013, starting with attestations submitted during and after January 2013. The pre-payment audits don't replace pre-payment edit checks that have already been built into the EHR incentive programs' systems to detect inaccuracies in eligibility, reporting and payment.

Pre-payment audits will be random and may target suspicious or anomalous data. Providers selected for pre-payment audits will have to present supporting documentation to validate their attestation data before CMS releases their incentive payment.

CMS, through its contractor, will also conduct post-payment audits during the course of the EHR incentive programs. Providers selected for post-payment audits will be required to show supporting documentation to validate their submitted attestation data.

Preparing for an audit

To be prepared for a potential audit, providers should have on hand electronic or paper documentation that supports their attestation. If they are selected for an audit, providers will also need to produce documentation that supports the values they entered in the attestation module for clinical quality measures. Hospitals should also maintain documentation that supports their payment calculations. For more guidance on what documentation to retain for audits, see the "Supporting Document for Audits" fact sheet: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Supporting-Documentation_Audits.pdf

Audit results

Providers found ineligible for an EHR incentive payment based on their pre-payment audit will not receive payment. In the case of post-payment audits, the payment will be recouped when a provider isn't found to be eligible. CMS may also pursue additional measures against providers who attest fraudulently to receive an EHR incentive payment.

Starting in 2013, providers found ineligible for their incentive payment will also face a payment adjustment beginning in 2015. Providers should always accurately report and properly document to avoid payment penalties.

Audit materials

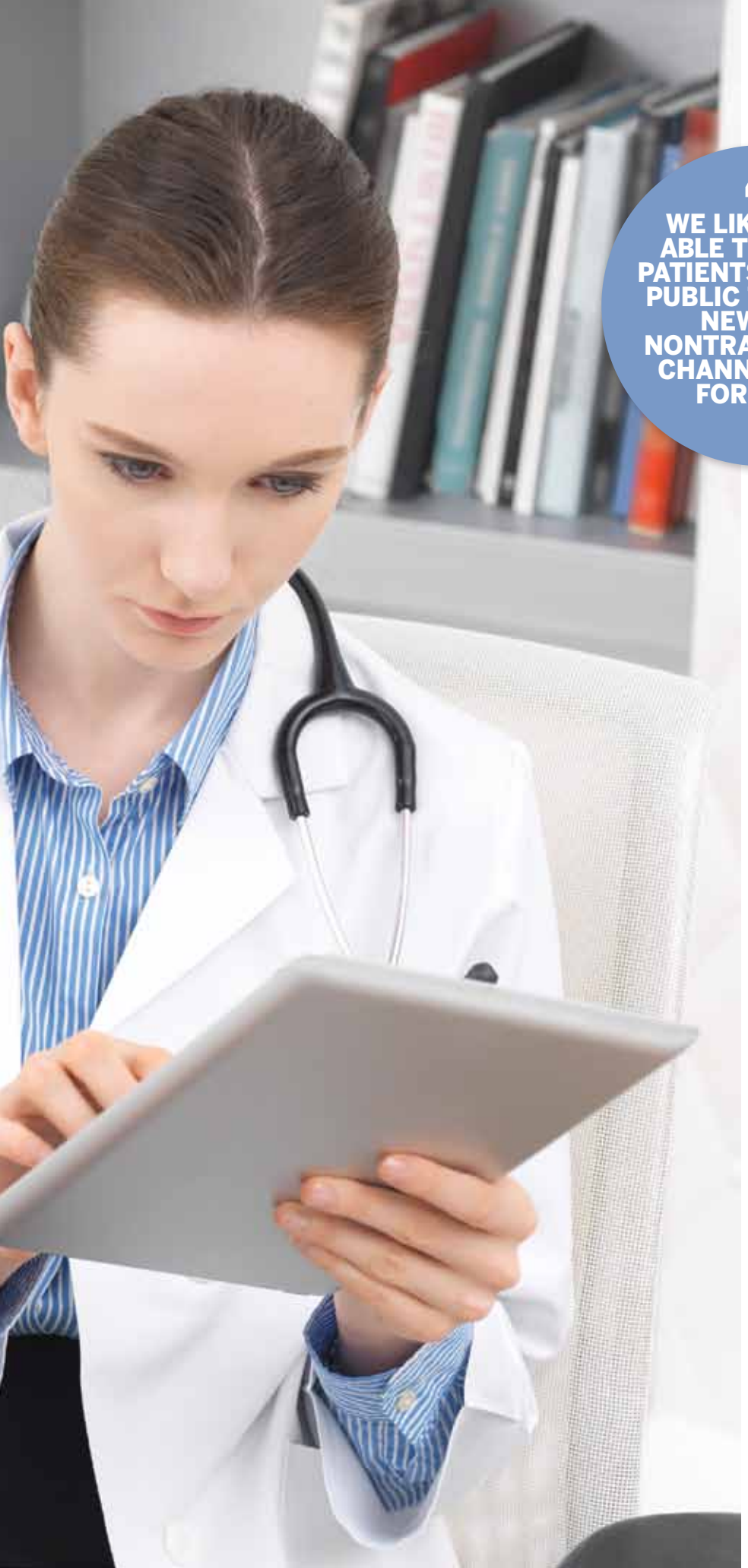
Additional audit materials can be found on the educational resources page of the CMS EHR incentive programs website under the title "Audit Information and Guidance": http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/EducationalMaterials.html ■

The Patient Provider CONNECTION

More Turning to Social Media

By Ronna Pennington

If adults are not checking email or scrolling through Facebook, they are probably searching for health-related information online. A 2010 survey by the Pew Internet and American Life Project found that 59 percent of all American adults look for health information online. Consider only the adults who do get online and the number increases to 80 percent.[1]



> **“WE LIKE BEING ABLE TO REACH PATIENTS AND THE PUBLIC THROUGH NEW AND NONTRADITIONAL CHANNELS AND FORMATS.”**

The social media trend has not caught healthcare professionals off guard. An article from March 2011 called “Twitter for Neurosurgeons” prepared healthcare providers who were not familiar with the social media platform to set up an account and make posts.[2] Some healthcare providers have embraced social media; others have not. Perhaps time or staffing are issues. In addition to those concerns, medical professionals must protect privacy policy guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). They also are faced with determining what is or isn’t quality information before sharing it.

Regardless of these concerns, authors of “Social Media: The Competitive Edge in Healthcare,” say that participation in social media is a necessity. Since the Internet allows patients to shop around, keeping them informed and engaged is the key to getting and keeping them.[3] Many in the Little Rock healthcare community participate in social media in one form or another. To what extent usually depends on the size of the clinic or practice and the amount of interaction they want to create with the public.

For instance, Dr. Johnny Ledbetter of Little Rock Children’s Clinic takes care of the clinic’s Facebook posts himself. He spends just a few minutes per day on these posts, usually when he checks his own social media accounts. “It’s just easier for me to do it. I’m bombarded with interesting

> "WE MADE A FLU VACCINE ANNOUNCEMENT AND WITHIN 30 MINUTES, WE WERE GETTING CALLS FOR APPOINTMENTS."

articles," he said, adding that he wouldn't want the clinic's office manager or a nurse to have the added duty of sorting through and determining which articles would be most appropriate to share.

Ledbetter carefully selects the posts to share, but does not inundate the Facebook page with them. Instead, he uses the page more for clinic announcements and health reminders. "Like during snow and ice, when we can't open, we post our closing on Facebook," he said. He knows Facebook works for the clinic because of patient feedback. "We made a flu vaccine announcement and within 30 minutes, we were getting calls for appointments," he said.

Ledbetter says he stays away from making diagnoses through social media. He reminds current patients that they can call in to talk to a nurse if they don't want to come into the office. The clinic's website homepage also reminds patients that Facebook is not a forum for diagnosis. It clearly states that the social media page will offer interesting articles and clinic announcements.

Hospitals reaching out through social media usually have a dedicated person or small team of public relations professionals to monitor and post on their behalf. The University of Arkansas for Medical Sciences is one of the most active. Leslie Taylor, vice chancellor for communications and marketing, says UAMS utilizes Facebook, Twitter, YouTube, Pinterest, and Flickr. Its Facebook

Leslie Taylor
Vice Chancellor for Communications and Marketing, UAMS

Dayna Holden
Marketing Manager, St. Vincent Health System

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"Utilizing social media opens us up to immediate public feedback which can be either positive or negative. We have to be prepared to address both of these in the best interest of our patients and their families."

page engages readers with brief quizzes or video interviews featuring UAMS physicians and nurses. On Twitter, UAMS offers various health tips, news snippets, links to physician interviews, and more. Most of those interviews are parked on YouTube and photos shared are at Flickr.

On Pinterest, UAMS offers 25 boards of topics ranging from Family Health, Medical Myths, Men's Health, and Inspiring Patients. There are Pins to make followers laugh, learn, and motivate.

Why does UAMS use so many social media outlets? Simply to reach more people, Taylor said. Like Little Rock Children's Clinic, UAMS uses social media as a tool to educate the public and to serve current patients. UAMS also uses social media, however, to target potential patients. "As the only academic medical center in the state, we use social media as an educational tool to improve the health of Arkansans," Taylor added.

Taylor said that UAMS enjoys the two-way conversation that social media offers between them and their patients and the public. "We like being able to reach patients and the public through new and nontraditional channels and formats," she added. The amount of time UAMS spends on social media varies. Taylor explained that several staff members take turns posting and managing accounts, and determining social media strategies.

Like UAMS, St. Vincent Health System uses several social media outlets for patient outreach—Facebook, Twitter, and YouTube. Dayna Holden, marketing manager, said those three forms of social media allow the hospital to communicate directly with patients to share important information about the hospital, healthcare services, physicians, and health tips. "We no longer have to wait for an ad to run or a commercial to be created. We can provide real-time news and information to our patients and their families," she explained.

St. Vincent tries to post items daily, sometimes spending as little as 10 minutes or as much as an hour or two per day. Holden said St. Vincent's use of social media is to create top-of-mind awareness for the hospital. The hospital's marketing team is responsible for all social media content. Like UAMS, having a designated group responsible for the posts guarantees that all privacy policies are maintained.

Facebook seems to be the best format of social media for St. Vincent, Holden said. "With most forms of social media, we can communicate our messages to thousands of people within hours, but the Facebook advantage is that we can also be given immediate feedback by those same thousands of people," she explained.

The only downside to social media use seems to be the time required to monitor comments. Ledbetter addresses it head-on, making posts that don't encourage comments. Even the clinic's webpage clearly states that the Facebook page is used for sharing informative articles and clinic-specific information. Both UAMS and St. Vincent have individuals or teams tasked with monitoring. "Utilizing social media opens us up to immediate public feedback which can be either positive or negative," explained Holden. "We have to be prepared to address both of these in the best interest of our patients and their families," she added. ■

End Notes

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"So before you suggest a healthier lifestyle for your patients, it might be worth spending a few minutes finding out just what that means to them."

What is Healthy?

By Philip Gatto

It is widely agreed that as we try to address escalating healthcare costs healthcare consumers need to become more engaged in their own health. Along with prescribed medicine and treatments, it is crucial that patients also make the lifestyle changes suggested by their physicians. And, more and more, consumers are being urged to and sometimes rewarded (by insurance carriers and employers) for staying healthier in the first place, thereby avoiding or delaying the need for healthcare. But when we ask our patients to be more healthy, what exactly are we asking? Based on a recent Aetna "What's Your Healthy" study conducted by Harris Interactive, "healthy" may be more of a moving target than you anticipated.

The study looked at 1800 American adults ages 25-64. The study grouped respondents into three generations, Millenials, Generation Xers, and Baby Boomers. Interestingly nearly 50% of the people surveyed named their own generation as the healthiest. For the most part those surveyed believed themselves to be relatively healthy even if the majority stated that they needed to lose weight. More than half indicated that it is possible to be overweight and healthy, yet almost 70% wanted to lose a significant amount of weight.

When asked to define "healthy" in their own words, the results were extremely interesting:

- 41% said "being healthy/not getting sick"
- 15% or fewer gave more specific answers such as getting regular exercise, eating well, or staying happy.

When asked to choose the top three definitions of "healthy" from a list, the most frequent responses were:

- Being physically active (49%)
- Eating right (43%)
- Being the right weight (37%)
- Getting the right amount of sleep (23%)
- Managing stress (20%).

Millennials gave greater weight to emotional stability, happiness, and looking good. Baby Boomers selected health screenings and being able to pursue hobbies far more often than either of the other groups. Women were more likely to choose definitions like eating well, getting exercise, being the right weight, and getting regular checkups, while men were more likely to emphasize being able to eat all they want and participate in

major fitness events such as marathons.

While almost half did not rate themselves any more or less healthy than five years ago, about one-third (34%) said they are living "healthier" than they were then. A few honest souls (18%) admitted they were living "less healthy." Among the healthy changes noted were:

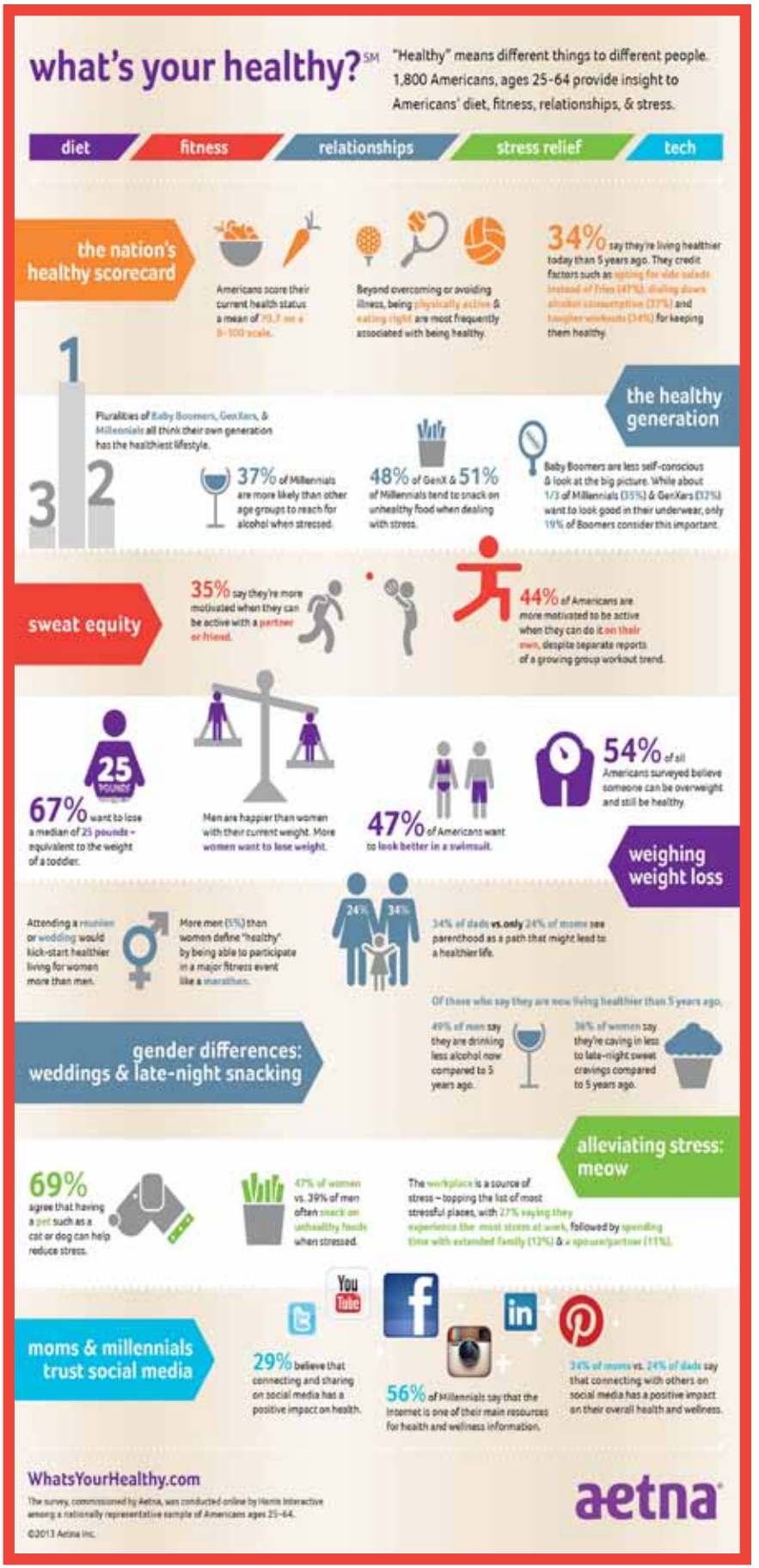
- Opting for side salads instead of French fries
- Cutting down on alcohol
- Pushing harder in workouts.

So before you suggest a healthier lifestyle for your patients, it might be worth spending a few minutes finding out just what that means to them. The good news is that many already know what they need to do to be healthier. A particularly interesting question asked what they would tell a younger version of themselves:

- 60% of all adults age 25-64 would tell themselves to "eat their fruits and veggies"
- 46% said "don't sweat the small stuff"
- 39% correctly stated "smoking isn't sexy"
- 37% advised "don't eat like a pig"
- 31% advocated "push yourself to sweat more," "don't drink like a sailor," and "take more 'me' time."

You should also know that almost half of those surveyed consider the Internet the "go-to" resource for health and wellness information, so be sure to direct them to credible sites. And nearly 69% agreed that having a cat or dog can help reduce stress, so perhaps you should prescribe a pet while you are at it. ■

Source: Aetna & Meredith Corp.



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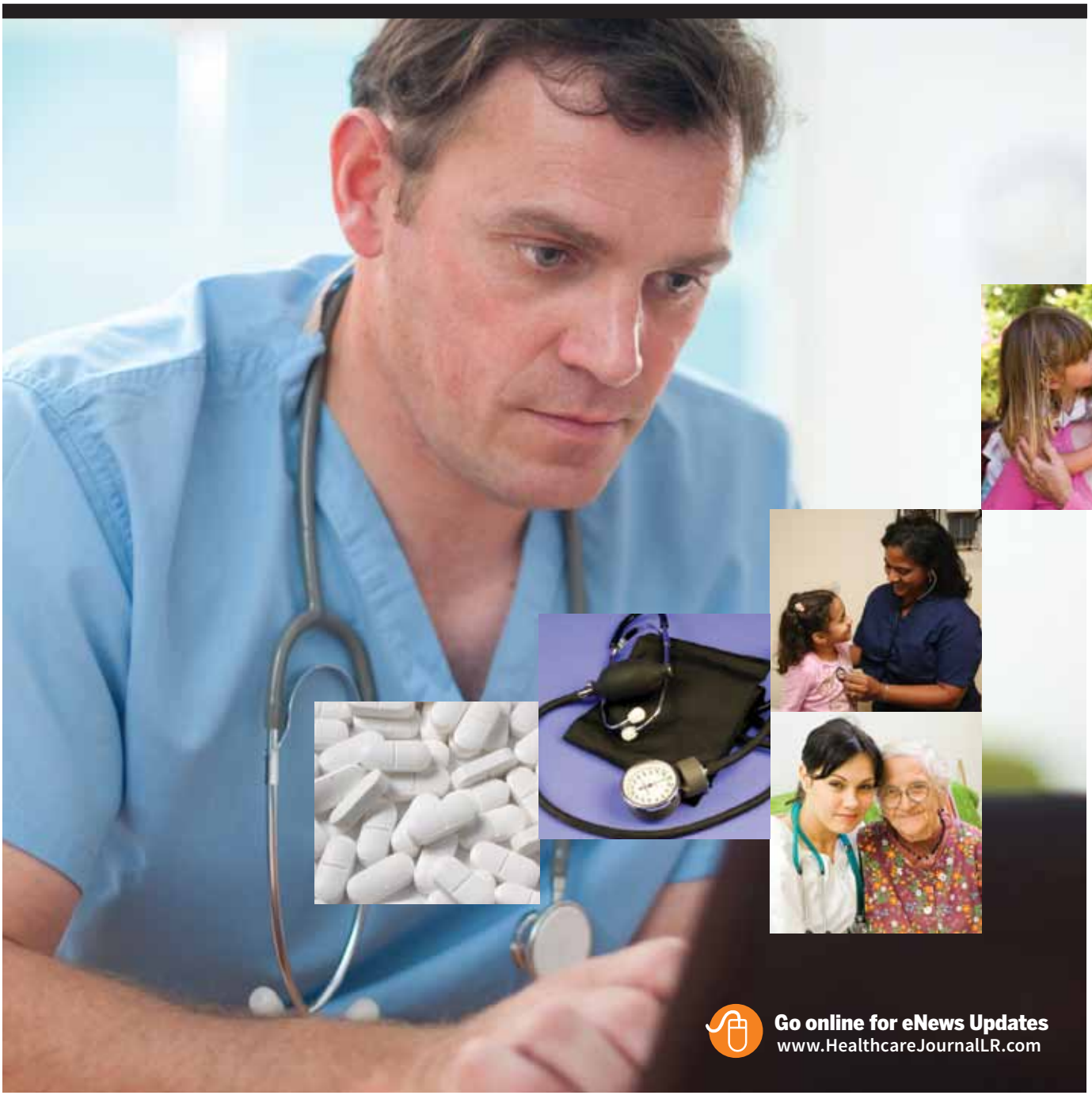

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HEALTHCARE BRIEFS

State

Arkansas Approved for Private Option

The Department of Health and Human Services (HHS) informed Governor Mike Beebe that the Medicaid waiver request, which is needed to implement the Arkansas Private Option, has received official federal approval.

"Arkansas came up with its own plan to expand Medicaid using the private-insurance market, and Secretary Sebelius and her team worked to ensure that we had the flexibility to make that plan a reality," Governor Beebe said. "Our actions have drawn positive attention from across the country, and now we will focus on getting this insurance to the Arkansans who need it to lead healthier, more productive lives. Hopefully, this bipartisan, intergovernmental achievement can be an example for Congress as the government shutdown looms."

The Arkansas Private Option will use federal Medicaid funds to provide insurance-premium assistance to more than 200,000 Arkansans living near or below the Federal Poverty Line. It is part of the State's Health Insurance Marketplace, which becomes active on October 1st. Arkansans can get information and personalized help through the Arkansas Health Connector, available online at arhealthconnector.org, or by calling 1-855-283-3483.

Health Department Negotiates Deal with USDA on WIC

As the government shutdown loomed, officials at the Arkansas Department of Health (ADH) reached an arrangement with the United States Department of Agriculture (USDA) that would preserve benefits and jobs in the Women Infants and Children's (WIC) program on a week-by-week basis. The commitment from USDA covered ADH administrative costs for WIC for the first week, action that prevented furloughing WIC staff and allowed ADH to continue issuing certifications and re-certifications without interruption. ADH planned to have ongoing discussions with USDA to raise issues of funding shortfalls over the following weeks.

In August, the WIC program in Arkansas served 23,595 infants, 42,105 children, and 22,039 women. Of those women, 10,725 were pregnant and 2,760 were breastfeeding. Currently there are 273 ADH employees whose jobs are funded by the WIC program.

WIC provides:

- Supplemental foods high in nutrients during time of critical growth and development.
- Nutrition education designed to improve dietary habits and health status and to emphasize the relationship between nutrition and health.
- Information, support and encouragement for breastfeeding.
- Referrals for other health services.

Pregnant, breastfeeding, and postpartum women, infants, and children under age 5 may qualify if they live in Arkansas, have a nutritional need and have an income at or below WIC guidelines or receive Medicaid, ARKids, TEA or SNAP (Food Stamps).

Prescription Drug Drop-Boxes Go Out Statewide

The Trauma, Injury Prevention and Control Branch of the Arkansas Department of Health (ADH) has identified reduction of illicit and illegal use of prescription drugs as a priority injury and violence prevention initiative. Through the "MONITOR SECURE and DISPOSE" Drop Box Project, 60 MedReturn Drug Collection Units have been awarded to law enforcement agencies across the state with priority given to agencies from counties where there are presently no drug collection units.

State partners in prescription drug abuse prevention are expanding a successful program to help reduce the rates of overdose and death from prescription drugs in Arkansas. An effective method of fulfilling a community's need for prescription medicine disposal options is to install a permanent drop-box.

The drop boxes will offer safe and convenient disposal sites for unused prescription drugs for people all over our state. Arkansas Drug Director, Fran Flener, says that the boxes are a very important part of the over-all effort the state has undertaken to remove more than 32 tons of medicines from Arkansas homes.

"Prescription drop boxes and take back events offer great opportunities for people to safely and legally dispose of medicine they no longer need. We are very grateful to our partners, the Arkansas Department of Health, the Arkansas National Guard Counterdrug Program, and our state's law enforcement community, for the addition of these sixty new boxes across our state, and are excited about the positive impact this will have on abuse, accidental ingestion, and protection of the environment" said Flener.

According to Nate Smith, MD, Director, Arkansas Department of Health and State Health Officer, prescription drugs in 2010 killed nearly 400 people in Arkansas, 13.1 deaths for every 100,000 residents.

As an added benefit, safe destruction of the drugs will help to prevent contamination of rivers, lakes, and streams in the state. Arkansans are encouraged to visit www.artakeback.org for more information.

Governor Announces Appointments to Boards and Commissions

Governor Mike Beebe recently announced 34 appointments to boards and commissions. Among the appointments to healthcare related boards were:

- Erna Boone, Cabot, reappointed to the Arkansas Respiratory Care Examining Committee. Appointment expires August 7, 2016.
- Niki Cung, Fayetteville, reappointed to the Emergency Medical Services Advisory Council. Appointment expires July 1, 2015.
- Beverly Lyn-Cook, Little Rock, to the Arkansas Biosciences Institute Board. Appointment expires October 1, 2017. Replaces Kurt Knickrehm.
- Lisa McDermott, Texarkana, to the Arkansas State Board of Acupuncture and Related Techniques. Appointment expires July 31, 2016. Replaces Cynthia Wolfe.
- Dr. Michael Pollock, Little Rock, reappointed to the Governor's Trauma Advisory Council. Appointment expires July 1, 2015.
- Eddie Schmeckenbecher, Little Rock, reappointed to the Arkansas Child Abuse, Rape and Domestic Violence Commission. Appointment expires July 1, 2015.
- Annette Watson, Lonoke, reappointed to the Arkansas Child Abuse, Rape and Domestic Violence Commission. Appointment expires July 1, 2015.

Marion County Woman Arrested For Medicaid Fraud

Attorney General Dustin McDaniel announced that a Marion County healthcare worker accused of billing the Arkansas Medicaid Program for services she did not provide has been arrested for felony Medicaid fraud. Amanda Coker, 35, of Yellville, was being held in the Pulaski County Detention Center on $2,500 bond.

Coker is accused of fraudulently seeking Medicaid reimbursement for personal-care services that she claimed to have provided to a Medicaid beneficiary in mid-2011. A former housemate of Coker's told an investigator with the Attorney General's Office that Coker could not have rendered the services since she did not have a means of transportation at that time.

Coker was alleged to have worked as an attendant to a Medicaid beneficiary for just a few days in May 2011. However, Medicaid records indicated that Coker billed the program for services spanning a period between May 10, 2011, and July 28, 2011. She is alleged to have received $3,831.73 as a result of the fraudulent claims.

Medicaid Fraud is a Class B felony. Charges are merely accusations and a defendant is presumed innocent unless and until proven guilty.

To report suspected Medicaid fraud or abuse or neglect in nursing homes, call the Attorney General's Medicaid Fraud Control Unit hotline at (866) 810-0016 or visit www.ArkansasAG.gov.

McDaniel Seeks FDA Regulation of E-Cigarettes

Attorney General Dustin McDaniel and other attorneys general from across the country are urging the U.S. Food and Drug Administration to implement restrictions on the advertising of electronic cigarettes and to prohibit the sale of the products to minors.

In a letter to the FDA, McDaniel and 39 of his counterparts asked the regulatory agency to immediately take all available measures to regulate electronic cigarettes, or e-cigarettes, as "tobacco products" under the Federal Tobacco Control Act.

E-cigarettes are increasing in popularity among both adults and youth, with sales doubling every year since 2008. E-cigarettes are battery-operated products that heat liquid nicotine derived from tobacco plants into a vapor that is inhaled by the user. Unlike with traditional tobacco products, there are no federal age restrictions to prevent children from obtaining e-cigarettes. Earlier this year, the Arkansas Legislature enacted Act 1451, which prohibits the sale of e-cigarettes to minors in the state. However, there is no such federal prohibition.

According to the Centers for Disease Control and Prevention, nearly 1.8 million middle and high school students tried e-cigarettes in 2012. The U.S. Surgeon General has stated that nicotine is highly addictive, has immediate biochemical effects on the brain and body at any dosage, and is toxic in high doses.

McDaniel and other attorneys general said the lack of federal regulation of e-cigarettes places youth at a greater risk of developing a lifelong addiction to a potentially dangerous product, and that e-cigarette use could lead to use of other tobacco products.

E-cigarette manufacturers engage in tactics that appeal to youth. Celebrity endorsements, cartoon characters, attractive packaging, fruit flavoring, and cheap prices all serve to encourage youth consumption of the products. Additionally, manufacturers claim that e-cigarettes do not contain the same level of toxins and carcinogens found in traditional cigarettes, cigars and other tobacco products. These claims imply that e-cigarettes are a safe alternative to smoking, even though the health effects of e-cigarettes have not been adequately studied. The lack of regulation puts the public at risk because users of e-cigarettes are inhaling unknown chemicals with unknown effects.

ADH Highlights Drug-Resistant Health Threats

Every year, more than two million people in the United States get infections that are resistant to antibiotics, and at least 23,000 people die as a result. The Centers for Disease Control and Prevention (CDC) released a landmark report presenting a snapshot of the burden and threats posed by the antibiotic-resistant germs having the most impact on human health. The use of antibiotics is the single most important factor leading to antibiotic resistance around the world. Antibiotics are among the most commonly prescribed drugs used in human medicine. However, up to half of antibiotic use in humans and much of antibiotic use in animals is unnecessary or inappropriate.

"Antibiotics are a precious, limited resource and if we overuse and misuse them today we will be less likely to have effective antibiotics tomorrow" emphasized Dr. Gary Wheeler, Branch Chief, Infectious Disease, at the Arkansas Department of

HEALTHCARE BRIEFS

Health (ADH). According to the CDC, loss of effective antibiotic treatments will not only cripple the ability to fight routine infectious diseases but will also undermine treatment of infectious complications in patients with other diseases. Many advances in medical treatment, such as joint replacements, organ transplants, and cancer therapies, and improvements in the treatment of chronic diseases such as diabetes, asthma, rheumatoid arthritis, and other immunological disorders, are dependent on the ability to fight infections with antibiotics.

Arkansas has a small CDC grant to compile aggregate data on the antibiotic resistant problem in Arkansas and to provide education to the medical community. The Arkansas Hospital Association and Arkansas Foundation for Medical Care are important partners in this effort. Hospitals in Arkansas are acutely aware of the importance of addressing this issue. There is a multi-disciplinary Healthcare-associate Infections (HAI) workgroup made up of physicians, nurses, consumers, and others who meet regularly to address the problem and solutions for Arkansas. For more information visit this website http://www.healthy.arkansas.gov/programsServices/epidemiology/Pages/HAI.aspx#1.

The CDC report ranked the threat in categories of urgent, serious, and concerning. Threats were assessed according to seven factors associated with resistant infections: health impact, economic impact, how common the infections is, 10-year projection of how common it could become, how easily it spreads, availability of effective antibiotics, and barriers to prevention.

Drug Resistance is not a problem that will be solved by a single entity. It will take diligence on the part of physicians, hospitals, other healthcare providers and patients to combat this serious health threat. The CDC has identified four core actions that must be taken:

- *Preventing Infections, Preventing the Spread of Resistance:* Avoiding infections in the first place reduces the amount of antibiotics that have to be used and reduces the likelihood that resistance will develop during therapy;
- *Tracking:* CDC gathers data on antibiotic-resistant infections, causes of infections, and whether there are particular reasons (risk factors) that caused some people to get a resistant infection;
- *Improving Antibiotic Use/Stewardship:* Perhaps the single most important action needed to greatly slow the development and spread of antibiotic-resistant infections is to change the way antibiotics are used;
- *Development of Drugs and Diagnostic Tests:* Because antibiotic resistance occurs as part of a natural process in which bacteria evolve, we will always need new antibiotics to keep up with resistant bacteria as well as new diagnostic tests to track the development of resistance.

Drug development for new antibiotics and new antifungals is necessary but is not enough to combat the growing problem. Antibiotic stewardship is critical to win the battle. CDC encourages patients to be actively involved in their care. Patients are encouraged to ask questions such as "Do I really need an antibiotic for my problem?" "Does your facility have an antibiotic stewardship program?"

For more information call the HAI program at ADH at 501-661-2296 or visit the CDC website at http://www.cdc.gov/features/AntibioticResistanceThreats/index.html

Three Arrested For Medicaid Fraud

Attorney General Dustin McDaniel announced that a Medicaid beneficiary and two of his associates have been arrested for allegedly conspiring to defraud the Arkansas Medicaid Program of nearly $17,000.

Robert Lee Miller, 47, and Robin Shuntell Morris, 25, both of Morrilton, and Tracey Denise Miller, 28, of West Memphis were each arrested for one count of felony Medicaid fraud following an investigation by the Attorney General's Medicaid Fraud Control Unit.

The three are accused of a scheme in which Robert Miller, a Medicaid beneficiary, identified Morris and Tracey Miller as his personal healthcare attendants, and the state Medicaid program was billed for their services. Though they did not perform the services, Morris and Tracey Miller received payment from Medicaid. They are accused of then turning over most of that money to Robert Miller, and, in several instances, Robert Miller is accused of fraudulently filing timesheets and directly taking the payments for himself. Robert Miller was part of Medicaid's Independent Choices program, in which beneficiaries can directly employ attendants to assist them.

Tracey Miller is alleged to have received checks from Medicaid from May 2009 to January 2010 and signed them over to Robert Miller. In return, Robert Miller paid her $50 per check, even though she performed no work. Robert Miller is accused of continuing to submit bills to the Medicaid program using Tracey Miller's identification and name from February 2012 to March 2013.

According to investigators, Robin Morris was paid for services from March 2010 to January 2012, and although 21 checks were paid in her name, only two were signed and cashed by her. Timesheets for Morris were submitted by Robert Miller, with Miller signing both his and Morris' name.

Robert Miller was arrested for Class B felony Medicaid Fraud. He is accused of defrauding Medicaid of $16,869.01. Morris and Tracey Miller are both accused of Class C felonies. Morris is alleged to have made $527 in fraudulent claims and Tracy Miller $1,632.08.

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

Swine Flu Variant in Arkansas

At least two people in Arkansas have been infected with a strain of influenza known as H1N1(v) after contact with swine (pigs). These cases have been confirmed by the Centers for Disease Control and Prevention (CDC).

"A few times a year an animal variant of the influenza virus is identified in humans," said Dr. Dirk Haselow, State Epidemiologist. "Viruses of this type typically cause only mild illness in those affected and, in contrast to seasonal flu, are not easily transmitted from person to person," added Haselow. ADH has carefully monitored the patient contacts for several days without evidence of any

human to human spread. Both patients identified to date have recovered fully.

When an influenza virus that normally circulates in swine is detected in a person, it is called a variant influenza virus and is labeled with a 'v'. Influenza viruses such as H1N1(v) and other related variants are not unusual in swine and can be directly transmitted from swine to people and from people to swine. When humans are in close proximity to live swine, such as in barns and livestock exhibits at fairs, movement of these viruses can occur back and forth between humans and animals.

"We are not currently aware of any additional human influenza cases caused by H1N1(v) and do not anticipate making any new public health recommendations regarding human exposure to swine. However, we will continue to assess the situation and conduct aggressive surveillance for additional influenza cases," Haselow emphasized.

Influenza has not been shown to be transmitted by eating properly handled and prepared pork or other products derived from pigs.

"ADH has been carefully following all suspected cases of influenza. We have also worked closely with our veterinary colleagues and the Arkansas Livestock and Poultry Commission to remain informed about potential infections in swine. It is because of this careful surveillance that these cases have come to our attention," said Haselow.

Case investigations have indicated that the illnesses resulting from H1N1(v) infection have been similar to seasonal influenza. Symptoms include fever, muscle aches, decreased energy, coughing, runny nose, and sore throat.

Local

UAMS Awarded $8.7 Million for Radiation Research

The Biomedical Advanced Research and Development Authority (BARDA) has exercised two contract options worth approximately $8.7 million with the University of Arkansas for Medical Sciences (UAMS) to proceed with advanced development of a promising treatment for use in radiological or nuclear emergency situations.

The first option by BARDA, which is part of the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR), is for $7.5 million over two years. A second one-year option for $1.24 million is for research to be done as part of an interagency agreement between BARDA and the U.S. Department of Defense (DOD).

Including the base BARDA contract for $4.5 million entered into in 2011, the total value awarded is more than $13 million.

Under the contract, UAMS' Martin Hauer-Jensen, MD, PhD, an internationally renowned radiation researcher, will lead the evaluation of the drug, pasireotide, formerly known as SOM230, to treat gastrointestinal injuries after radiological or nuclear accidents or terrorist attacks. Hauer-Jensen will be assisted by an 18-person team of UAMS researchers.

The intestine and bone marrow are most susceptible to radiation because of their rapidly proliferating cells. Treatments exist for irradiated bone marrow but not for the intestine.

Radiation damage to the intestine often determines whether a person lives or dies after exposure, Hauer-Jensen said.

The potentially life-saving pasireotide inhibits the secretions from the pancreas, giving the intestine a chance to heal after radiation exposure. Assuming the drug also receives FDA approval to treat gastrointestinal injuries from radiation exposure, it would be a breakthrough for emergency preparedness as one of a very small number of drugs that protects people after they've already been exposed to radiation.

Hauer-Jensen said that it is his hope that the drug will someday be available to address public health emergencies and to benefit cancer patients receiving certain radiation therapies.

The research contract is the largest in the UAMS College of Pharmacy's 60-year history, said Stephanie Gardner, EdD, PharMD, dean of the College of Pharmacy.

Novartis developed the pasireotide to treat hormone disorders known as Cushing's disease and acromegaly. The U.S. Food and Drug Administration (FDA) and the European Union recently approved the drug for the treatment of Cushing's disease.

In the first phase of the research begun in 2011, Hauer-Jensen and his team generated data Novartis needed to initiate discussions with the Food and Drug Administration about using pasireotide for radiological emergencies. During the next two years of the contract, the team will perform a range of studies to continue the development process.

Smith Joins Arkansas Hospice

Dr. Clark Smith of Little Rock has joined Arkansas Hospice as a physician for the central Arkansas area. He graduated from the University of Arkansas for Medical Sciences in 2009, and he completed his residency in family practice in 2012.

Dr. Smith also completed a fellowship in hospice and palliative care in 2013, before joining Arkansas Hospice.

Former Nursing Home Employee Enters Guilty Plea

Attorney General Dustin McDaniel announced that a Saline County man accused of stealing a nursing home resident's prescription painkillers has been convicted of obtaining drugs by fraud.

Jeremiah Rabon, 36, of Bryant pleaded guilty in Saline County Circuit Court in Benton. Circuit

HEALTHCARE BRIEFS

Judge Bobby McCallister sentenced Rabon to three years of probation and assessed $1,450 in fines and costs. Obtaining a controlled substance by fraud is a Class C felony. Rabon is a licensed practical nurse.

Rabon was employed as an LPN by Southern Trace Rehab and Care Center in Bryant. The center began an internal investigation into Rabon on Nov. 2, 2012, after colleagues said he was behaving abnormally. He later admitted having stolen the prescription medication intended for a resident. Rabon said he did not ingest the pills himself, but offered no plausible explanation of what became of the pills. Rabon is no longer employed by the nursing home.

Twenty-second Judicial District Prosecuting Attorney Ken Casady appointed an attorney with McDaniel's Medicaid Fraud Control Unit as a special deputy prosecutor in the case.

To report Medicaid fraud or abuse and neglect in nursing homes, call the Medicaid Fraud Control Unit's tip line, (866) 810-0016.

UAMS Receives $135,000 for Teacher Health Education

Through a unique statewide outreach program of the University of Arkansas for Medical Sciences (UAMS), two grants totaling $135,000 will fund professional development for Arkansas' pre-K-12 teachers.

The UAMS Partners in Health Sciences (PIHS) program, which targets lung, heart, and skin health, has reached more than 22,400 teachers and provided nearly 80,000 hours of training throughout the state in its 22-year history. The program has been awarded more than $3.05 million in extramural funding since its inception in 1991.

The most recent funding grants include $100,000 from the Arkansas Department of Human Services' Division of Child Care and Early Education and $35,000 from the Arkansas Department of Health' Division of Comprehensive Cancer Control Services and Tobacco Cessation and Prevention Program.

Three of the 202 teachers trained through the program in the last year worked with their preschool and Head Start students in Beebe, Berryville, and Fayetteville to offer "Healthy Hearts & Lungs" plays for the students' parents. A total of 159 parents and family members attended these plays put on by 54 students.

Burns, who has been the sole trainer for the PIHS outreach program since 2001, travels the state offering workshops in community settings, affording teachers a short drive to attend the professional development sessions. They participate in a highly interactive three-hour class and are given kits to help relay that information in their classrooms.

Research shows that early intervention is not only the best prevention of smoking, but important in other key health factors, Burns said. A study done by Burns and published in 2011 on the program's impact shows that more than 98 percent of the workshop's participants strongly agreed to continue using the tools learned by the PIHS outreach. It also showed a large number of participants used materials and knowledge from the PIHS workshop to develop their own lessons to teach students.

Participants from every county in Arkansas have attended the programs or received instruction through it. Through live video conferences, teachers in Florida, Montana, Texas, New York, West Virginia, Louisiana, and California as well as Taiwan also have taken part.

Researcher Awarded Grant for Pancreatic Cancer Drug Treatment Improvement

Wolf E. Heberlein, MD, an assistant professor of radiology in the University of Arkansas for Medical Sciences (UAMS) College of Medicine, received a two-year $150,000 Research Scholar Grant from the Radiological Society of North America (RSNA) Research and Education (R&E) Foundation.

Heberlein's research is focused on improving the treatment of drug delivery for pancreatic cancer. The goal is to overcome the current surgical and drug barriers for treating pancreatic cancer with a minimally invasive, image-guided approach using electric probes.

Pancreatic cancer is the fourth-leading cause of cancer deaths in the United States, and one of the main challenges is drug delivery. With regular methods, the chemotherapy would go into the patient's bloodstream but rarely make it into the cancer because the tumor creates an environment that shields it from drugs entering the cells.

Heberlein will use the Irreversible Electroporation (IRE), a technique known as "NanoKnife," that uses very short but high-voltage impulses to selectively facilitate drug penetration. Better drug penetration and high-voltage impulses should kill the tumor cells more reliably while reducing side effects. Heberlein chose this area of research due to its challenges and its potential of immediate benefit for patients. Heberlein said if the treatment is successful it can lead to improvements in patient care that also can be used in other types of cancers.

The grant proposal was developed under the mentorship of Michael Borrelli, PhD, professor of radiology and biophysics in the UAMS College of Medicine and associate director of the Arkansas Nanomedicine Center. Peter Crooks, PhD, chair of the UAMS College of Pharmacy Department of Pharmaceutical Sciences, also will serve as Heberlein's mentor.

Baptist Health Family Clinic-Gurdon Gains AAAASF Accreditation

Baptist Health Family Clinic-Gurdon has demonstrated its commitment to patient safety by gaining accreditation from the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), which is recognized nationally as the gold standard in accreditation.

To earn its accreditation, Baptist Health Family Clinic-Gurdon — like every AAAASF accredited rural health clinic — must comply with federal, state, and local regulations of location, physical plant and environment, organizational structure, staffing and staff responsibilities, provision of services, and patient health records.

The end result is that the accredited clinic makes a commitment toward maintaining safety and quality. As the leading accrediting organization for rural health clinics, AAAASF has developed the systems to effectively monitor and implement

the latest advances in rural healthcare clinics that directly benefit patients.

With this accreditation, Baptist Health Family Clinic-Gurdon can demonstrate that it has met the highest standards in patient care and safety. Meeting the gold standard requirements elevates the patient-safety awareness of every member of the staff and improves the quality of care.

AAAASF is the accrediting authority for Medicare-participating rural health clinics. The mission of AAAASF is to develop and implement standards of excellence to improve quality of patient care and safety through a program of inspection and accreditation that serves both the medical community and the public interest.

Two New UAMS Researchers Win Funding for Asthma, Cardiovascular Studies

Two University of Arkansas for Medical Sciences (UAMS) researchers, Joshua Kennedy, MD, and Elvin Price, PharMD, PhD, are the newest recipients of the UAMS Translational Research Institute KL2 Scholar Career Development Awards, which will provide them with salary and research support for two years.

The pair of new investigators was selected from a competitive pool of applicants this summer. Kennedy is striving to reduce asthma-related hospitalizations by reducing the exacerbating effects of cold viruses on asthma. Price is studying promising genetic predictors that he hopes will help doctors prescribe the right cardiovascular medicines for their patients.

The prestigious national KL2 program supports promising new researchers to advance their research so they can compete for more sustained federal funding.

Kennedy and Price are among 13 KL2 Award recipients selected by the Translational Research Institute since 2010. The award helps them quickly develop their research programs with 75 percent salary support (up to $52,000 a year) that allows dedicated time to their research. They receive up to $25,000 a year in research funds, as well as travel funds, graduate-level tuition support, and assistance from mentors.

Price earned his Doctor of Pharmacy degree from Florida A&M University in Tallahassee and his doctorate in clinical pharmaceutical sciences from the University of Florida in Gainesville.

Kennedy, a Hot Springs native, is an internal medicine and pediatrics physician who earned his medical degree and completed residency training at UAMS. He joined the UAMS faculty in July after completing his allergy and immunology fellowship at the University of Virginia.

Women Accused of Exploiting Nursing Home Residents

Attorney General Dustin McDaniel announced that former employees of a Perry County nursing home have been arrested for multiple felony counts of exploitation for allegedly using residents' personal funds to buy clothing, jewelry, shoes, and makeup for themselves.

Jewel Darlene English, 48, and Sharla Renea Christie, 35, both of Perryville, were arrested following an investigation by the Attorney General's Medicaid Fraud Control Unit. English was formerly the administrator of Perry County Nursing and Rehabilitation. Christie had been the nursing home's office manager. Both are accused of stealing from a trust account established to pay for residents' personal expenses and needs.

English is alleged to have stolen from eight residents and she was charged with six Class C felony and two misdemeanor exploitation counts. Christie is accused of stealing from four residents and has been charged with three felonies and one misdemeanor. The total amount taken from the trust account was $4,604.

An investigator with the Attorney General's Office found that English and Christie made a series of unauthorized withdrawals from the trust account between Sept. 21, 2012, and Nov. 21, 2012. They are accused of writing and signing checks from the account, cashing the checks, then using that money for their personal benefit.

Money taken from the account was used for purchases at Dillard's, Merle Norman, and The Buckle. None of the items purchased were authorized by the nursing home residents or their families and none of the items were found in possession of the residents.

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

Ford Joins St. Vincent Family Clinic Chenal

Michael Ford, MD is currently taking appointments to treat patients at St. Vincent Family Clinic Chenal at 16221 St. Vincent Way in Little Rock. Ford is a board certified family practice physician with more than 30 years of experience. He most recently treated patients at Baptist Arkadelphia Medical Clinic.

Ford is also certified in advanced trauma life support, advanced cardiac life support, and as a U.S. Federal Aviation Administration medical examiner. His medical interests include general medical care, disease management, wound care, minor surgery, sports medicine, and minor dermatologic procedures.

Ford earned his medical degree at UAMS and completed post graduate training in family medicine at the U.S. Naval Regional & Aerospace Medical Center in Pensacola, Fla.

Local Woman Arrested For Medicaid Fraud

Attorney General Dustin McDaniel announced that a Little Rock healthcare provider was arrested for felony Medicaid fraud following an investigation by the Attorney General's Medicaid Fraud Control Unit.

Tequila Fitzgerald, 21, turned herself in to Pulaski County authorities after the Attorney General's Office had issued a warrant for her arrest. Bond was set at $2,000. Fitzgerald is accused of billing the Arkansas Medicaid program for attendant-care services that she did not render. She is alleged to have falsely billed Medicaid for $17,340.48.

Fitzgerald worked as a personal care attendant

HEALTHCARE BRIEFS

for a Medicaid beneficiary in Pine Bluff. She was responsible for submitting her own claims for payment to the state's Medicaid program. The spouse of the Medicaid beneficiary told investigators that Fitzgerald stopped assisting the beneficiary in August 2012, and that Fitzgerald had moved to Little Rock earlier this year.

Investigators reviewed documents and determined that Fitzgerald had made false claims to the program from August 2012 to April of this year.

Pharmacology and Toxicology Program Wins Training Grant

The Department of Pharmacology and Toxicology in the University of Arkansas for Medical Sciences (UAMS) College of Medicine will receive $665,000 over five years from the National Institute of General Medical Sciences (NIGMS) to support a research training program for predoctoral fellows.

UAMS research leaders say the prestige of the hard-won T32 Training Grant is as significant as the money behind it, putting the department in the company of schools like Harvard, Yale, Stanford, Duke, and Vanderbilt. The NIGMS funds only 31 such pharmacology and toxicology training programs across the country.

Philip Mayeux, PhD, professor and director of education in the Department of Pharmacology and Toxicology, said the department's track record for developing predoctoral students into successful research professionals was a major factor in winning the T32. The other factor was demonstrating that the department had a training program in place, which the UAMS Translational Research Institute enabled with financial support of the department's Systems Pharmacology and Toxicology (SPaT) Fellowship program. The T32 is also matched nearly dollar for dollar by a combination of funds from the Translational Research Institute, the College of Medicine, and the chancellor's office. "That was also viewed favorably in our application," Mayeux said.

The T32 grant will support one SPaT fellow this year and two fellows each year thereafter through 2017. In addition to a stipend, T32 fellows enjoy perks such as health insurance, travel funds, and career development opportunities through the Translational Research Institute and the National Center for Toxicological Research (NCTR). The SPaT fellows chosen from within UAMS will come from three feeder programs:

- Interdisciplinary Biomedical Sciences, William D. Wessinger, PhD , director
- Pharmacology Graduate Program, Paul Gottschall, PhD, director
- Interdisciplinary Toxicology program, Lee Ann MacMillan-Crow, PhD, director.

Cancer Drug Awarded FDA Approval

Valchlor, a breakthrough gel for treating lymphoma developed with the help of University of Arkansas for Medical Sciences (UAMS) College of Pharmacy Professor Peter Crooks, PhD, recently won marketing approval from the U.S. Food and Drug Administration.

Valchlor gel is for the topical treatment of stage 1A and 1B mycosis fungoides-type cutaneous T-cell lymphoma (CTCL), a rare form of non-Hodgkins lymphoma. Developed by Ceptaris Therapeutics, the gel is the first and only FDA-approved topical formulation of mechlorethamine, commonly known as nitrogen mustard. Patients can apply Valchlor once a day, and it dries on the skin.

Mycosis fungoides is the most common type of cutaneous T-cell lymphoma. It has no cure, and its cause is unknown. The malignant T-cells migrate to the skin, causing lesions to appear. Lesions first appear as a rash and then may grow into disfiguring tumors.

"The big problem with this skin condition is that if it is not treated, the affected T-cells can move into the lymph system," said Crooks, who worked on the drug before joining UAMS as chair of the Department of Pharmaceutical Sciences in the College of Pharmacy. "Not only does Valchlor help treat people who have these lesions from a fungal source or ionizing radiation, with early diagnosis it can prevent CTCL."

Crooks was a cofounder and chief scientific officer (CSO) of Yaupon Therapeutics, the company that later became Ceptaris, which is located in Malvern, Penn. He began developmental work on Valchlor in 2004. He helped solved such problems as how to chemically stabilize the drug in the topical gel formulation, and how to keep it from entering a patient's bloodstream. He stepped down as CSO of the company in 2011 when he joined UAMS.

During his work on Valchlor, Crooks said he learned a tremendous amount about drug development, manufacturing, and the FDA approval process. He is applying that knowledge to new research and new projects at UAMS, such as clinical development of new drugs for the treatment of acute myelogenous leukemia (AML), the most common form of leukemia, and for the treatment of Alzheimer's disease.

Living Lung Innovations Aid $11.9 Million NIH Asthma Study

Living human lungs donated to the University of Arkansas for Medical Sciences (UAMS) are helping a multi-center team of researchers begin testing potential breakthrough asthma treatments as part of a five-year, $11.9 million study funded by the National Institutes of Health (NIH).

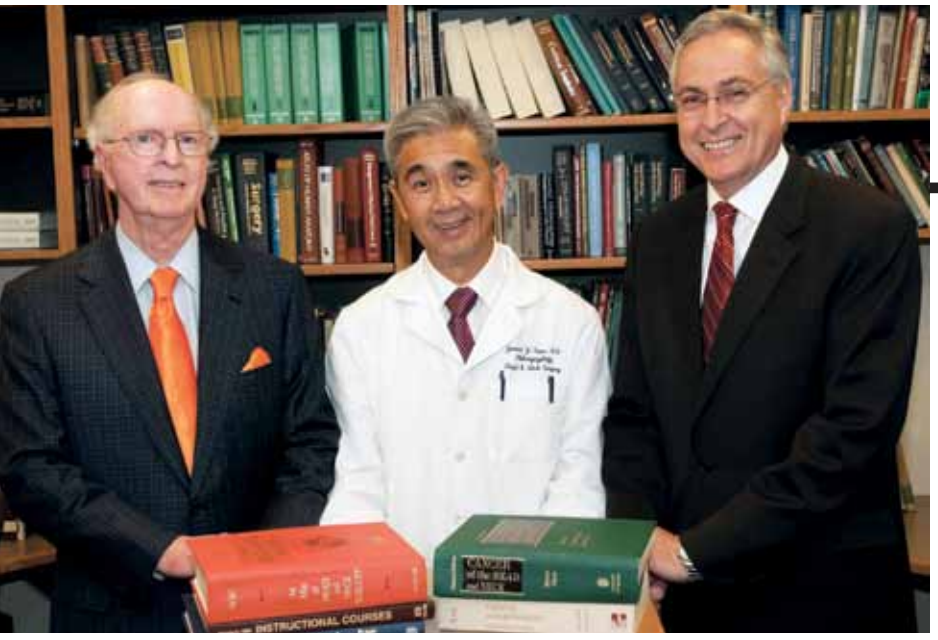
The large study was made possible in part due to innovations in the processing and preservation of the lungs by UAMS' Richard Kurten, PhD, a cell biologist who credits the UAMS Translational Research Institute's support for enabling his participation in the study.

Kurten has helped open the door to exciting new research opportunities by extending the lifespan of donated lungs. Remarkably, they behave as if they were in a living person during experiments – even when the lung has been divided into hundreds of tissue samples.

Based at the Lung Cell Biology Laboratory at the Arkansas Children's Hospital Research Institute, Kurten works closely with the study's principal investigator, Reynold Panettieri Jr., MD, at the University of Pennsylvania School of Medicine in Philadelphia.

Other collaborating institutions are Johns Hopkins Bloomberg School of Public Health in Baltimore; the University of Maryland in Baltimore; Kimmel Cancer Center at Thomas Jefferson University in Philadelphia; and the University of South Florida in Tampa.

When he first began working with the lungs



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J. Floyd Kyser, MD, (left) recently honored James Y. Suen, MD, (center) with a professorship gift. UAMS Chancellor Dan Rahn, MD, (right) thanked Kyser at a recent ceremony.

three years ago, Kurten said the tissue could be kept viable for about a week. Today incubated lung samples are viable for experiments up to six weeks. He can also freeze them and store them for a year, then thaw them and perform experiments. In addition, he has increased the number of lung slice samples available for study from 200 to 600 with the potential for up to 2,000.

The Translational Research Institute helped secure UAMS' portion of the NIH award – $353,130 over five years – by funding a $98,724 pilot study for the preliminary evaluation of lung tissue responses to medications. In addition, the institute paid for travel in January, 2011 that helped cement a collaborative relationship with Panettieri. The Translational Research Institute also supported the recruitment of asthma researcher and allergist/immunologist Joshua Kennedy, MD, by providing him two years of salary support and research funding through the institute's KL2 Scholar Career Development Award. Kennedy, a UAMS alumnus, is analyzing the role of rhinoviruses – cold viruses – in asthma.

In addition, Kurten's clinical collaborator, Stacie Jones, MD, co-director of the Lung Cell Biology Laboratory and chief of Pediatric Allergy and Immunology, will study the role allergies play in asthma.

Otolaryngology, Head and Neck Surgeon Honored

Retired Little Rock otolaryngologist J. Floyd Kyser, MD, recently gave $500,000 to the University of Arkansas for Medical Sciences (UAMS) for a professorship to honor the surgeon who trained with him as a resident and went on to become an international leader in otolaryngology and head and neck surgery at UAMS.

The professorship honors James Y. Suen, MD, professor and chairman of the Department of Otolaryngology – Head and Neck Surgery in the UAMS College of Medicine. Kyser, a 1962 graduate of the UAMS College of Medicine, has maintained close ties with UAMS and has been a longtime supporter of the department.

The endowment will be known as the Patricia and J. Floyd Kyser, MD, Professorship in Otolaryngology-Head and Neck Surgery.

Suen, a 1966 UAMS graduate, has chaired the department since 1974. While Suen was a resident at UAMS, he spent a six-week training rotation in Kyser's private practice. In addition to his residency at UAMS, Suen trained at San Francisco General Hospital as an intern and later as a fellow in otolaryngologic pathology at the Armed Forces Institute of Pathology in Washington, D.C. He completed advanced training as a senior fellow in head and neck surgery at M.D. Anderson Cancer Center in Houston, where he briefly served on the staff before being recruited to UAMS in 1974.

Suen worked with Kent Westbrook, MD, and other colleagues to develop comprehensive cancer programs at UAMS that culminated in the Arkansas Cancer Research Center (now the Winthrop P. Rockefeller Cancer Institute), where Suen served as executive director from 2002 to 2007. Meanwhile, Suen became widely known for his expertise in head and neck cancers, vascular lesions of the head and neck, and diseases of the larynx. He has authored six medical textbooks, including "Cancer of the Head and Neck," which is used by medical schools worldwide.

Kyser grew up in Camden and attended what is now Southern Arkansas University in Magnolia before entering the UAMS College of Medicine in 1958. He graduated with honors and was inducted into Alpha Omega Alpha, a national medical honor society.

Two of Kyser's four children followed his footsteps to UAMS – Greg Kyser, MD, a 1987 graduate who practices psychiatry in Nashville, Tenn., and Steven Kyser, MD, a 1997 graduate who completed residencies in pathology and family medicine and now practices family medicine at the Central Arkansas Veterans Healthcare System.

Kyser said that gratitude to UAMS for providing all three with the opportunity to study medicine also contributed to his decision to fund the new professorship.

Former Nursing Home Worker Convicted For Theft of Pills

Attorney General Dustin McDaniel announced that a Saline County man accused of stealing a nursing home resident's prescription painkillers has been convicted of obtaining drugs by fraud.

Jeremiah Rabon, 36, of Bryant pleaded guilty Monday in Saline County Circuit Court in Benton. Circuit Judge Bobby McCallister sentenced Rabon to three years of probation and assessed $1,450 in fines and costs. Obtaining a controlled substance by fraud is a Class C felony. Rabon is a licensed practical nurse.

Rabon was employed as an LPN by Southern Trace Rehab and Care Center in Bryant. The center began an internal investigation into Rabon on Nov. 2, 2012, after colleagues said he was behaving abnormally. He later admitted having stolen the prescription medication intended for a resident.

To report Medicaid fraud or abuse and neglect in nursing homes, call the Medicaid Fraud Control Unit's tip line, (866) 810-0016. ■

One Hundred Years of Public Health in Arkansas

Our state is currently working to meet the daunting challenge of expanding healthcare coverage for Arkansans. We can gain inspiration for success in this effort by reflecting on many tremendous health advances that have been made in our state in the last century.

While advancements in modern medicine cannot be discounted, it is also important to note that many improvements are the result of a strong public health system. In fact, public health is credited with adding 25 years of life expectancy in the United States. During the 100-year history of the Arkansas Department of Health (ADH), Arkansas's public health professionals have had a tradition of being on the leading edge of new strategies to detect and control disease outbreaks, to eliminate preventable illnesses by immunizing children and adults, and to ensure safe food and drinking water.

The world was a very different place in 1913, when the law creating the first permanent state Board of Health was signed by Governor Joe T. Robinson. Imagine a time when a creek called the Town Branch ran through Little Rock carrying dead animals, putrid with decay and human waste overflow from privies. Such poor sanitation frequently led to deaths from dysentery and cholera; therefore, it is not surprising that when the Board of Health was formed in 1913, improving sanitation was a priority. "Privy inspectors" were deployed by the Board to assure that privies were clean and met specific standards. Today, environmental health specialists in each county oversee the installation and management of septic tanks and wastewater systems to protect the public's health and safety.

Inadequate sanitation was not the only problem Arkansans faced in the early 1900s. They also had to deal with illness and death

Nathaniel Smith is
Director and State
Health Officer, Arkansas
Department of Health

by new challenges that pose major obstacles to healthy living in today's world. Most experts agree that we currently face a real health crisis in America, and we as public health professionals have our work cut out for us as we begin the next 100 years serving the people of our state.

Numbered among the current significant challenges before us are the obesity epidemic, tobacco use, teen pregnancy, poor dental health, lack of health insurance, high infant mortality, and poor health literacy. Dedicated public health professionals working in a variety of scientifically-based disciplines are already addressing these problems. Our public health workforce is working every day at the local level through a statewide service network to provide prevention services and to address threats to the public's health.

But just as the advances of the first century of the health department were not made without the cooperative efforts of many other dedicated health professionals, we know that all of the state's health problems will not be solved by one individual or group. We are collaborating with a wide variety of partners in the public and private sectors to address the health problems facing our citizens. Together, we will create a good beginning on the next century of progress.

As ADH Director, I look forward to bringing you more information on how the Arkansas Department of Health helps individual Arkansans improve their health, protects the public from epidemics, and provides preventive health services in our communities. ■

from tuberculosis, pneumonia, malaria, smallpox, and typhoid fever. In addition to the constant threat of these life-threatening illnesses, there were dramatic increases in deaths from epidemics of cholera and yellow fever.

Addressing smallpox is an early example of public health working to expand one of the modern advances in medicine throughout the state. By 1920, the smallpox vaccine was available in Arkansas, and dedicated public health nurses and others began a vaccination campaign to ensure that even those in the most remote parts of the state were vaccinated. The efforts were so successful the number of smallpox cases fell to zero.

The world was a very different place in 1913, when the law creating the first permanent state Board of Health was signed by Governor Joe T. Robinson.

Celebrating a century of achievement and progress in no way diminishes the much needed role that public health must play as we embark upon the future. Even though improved public health conditions and advances made in modern medicine have eliminated many of the threats from days gone by, those problems have been replaced

Healthcare: A System in Transition

The Patient Protection and Affordable Care Act of 2010 (ACA) represents the most substantial changes to U.S. health care since Medicare and Medicaid were established.

In less than two months major provisions of the ACA will go into effect. Beginning January 1, 2014, the more than 500,000 working-age Arkansans currently without health insurance will be able to take advantage of the core intent of the federal law. With this come far-reaching implications for Arkansas including our ability to provide services to a significant influx of newly insured and to cover the cost of expansion.

As political positioning continues to swirl around much-needed health care transformation in our country, we are fortunate to have Arkansans on both sides of the aisle willing to work together to craft solutions that balance the needs of patients, providers, and both public and private payers.

Unlike many other states, Arkansas began a comprehensive evaluation of our health care system's needs even before the ACA became law. The first step was to establish a vision for a better future health system to serve as a guide moving forward. This vision is patient-centered, team-based, and optimizes the use of new developments in health information technology. Thanks to many months of work on the part of providers, payers, consumers, educators, and policymakers, from both the public and private sectors, some innovative solutions have been designed and are approaching full implementation. Solutions are focused on improving quality, access, and cost, with interrelated programs that address strategic planning for our health workforce, accelerating use of health information technology, expanding health coverage, and moving from a fee-for-service-based provider payment system to one that promotes better coordination of care, quality outcomes, and cost containment. Importantly, consideration was given to how we could maximize integration of the ACA into this essential plan to restructure our struggling system. Following is an update on the transformation of Arkansas's health care system.

Health Workforce

Do we have enough health care providers for all parts of the state? Will we have

Joe Thompson is Arkansas Surgeon General and Director, Arkansas Center for Health Improvement

enough to meet future demand? Can Medicare and Medicaid patients get the care they need? Development of a strategic plan for addressing these issues was undertaken by representatives from numerous entities throughout the state. In April 2012, Arkansas Health Workforce Strategic Plan: A Roadmap to Change was released, containing more than 50 recommendations related to four overarching goals. Work towards accomplishing many of these recommendations is now in progress. At the heart of the recommendations was development of team-based care through patient-centered medical homes. This led the way for Arkansas to be selected as a demonstration site for the Comprehensive Primary Care Initiative by the Center for Medicaid and Medicare Innovation—69 practices across the state are currently piloting a new way of delivering care centered around the patient.

In March 2013, Arkansas Health Care Workforce: A Guide for Policy Action was released, providing a more empirical look at the access challenges faced by rural Arkansans. Findings in the report shed new light on a number of previous ideas and concerns. For example, much discussion has centered on the idea that we have a serious statewide shortage of health care providers. Information in the report quantifies our statewide shortage but highlights a far greater problem—maldistribution of providers with an excess supply in urban areas and critical shortages in rural areas. Both reports are available at www.achi.net.

Expanding Health Care Coverage

Last month the ACA's main vehicle for expanding insurance coverage, the Health Insurance Marketplace, opened for enrollment with coverage beginning in January 2014. Competitiveness in rates available through the Marketplace was improved with implementation of the Health Care Independence Act of 2013, or "private option," which doubled the number of people eligible to purchase private plans.

The private option is a prime example of both innovation and working together across party lines. The ACA offers an opportunity to provide health care coverage to about 250,000 extremely low-income Arkansans—roughly half of our state's currently uninsured population—by expanding Medicaid eligibility. Rather than expanding the traditional Medicaid program, Arkansas took a much different approach. The private option is a first-of-its-kind program that will provide premium assistance to those otherwise eligible for Medicaid expansion, enabling them to purchase private plans through the Marketplace. An overview of the Health Care Independence Act of 2013 is available at www.achi.net.

While increasing the participant pool helped to improve competitiveness in the number of carriers participating and rates offered in the Marketplace when compared with projections, rates in Arkansas were among the highest when compared with other states. This is a significant reflection of the disease burden and overall health risk of our population. An overarching objective of Arkansas's health system transformation efforts is improving health in our state.

Expanding health care coverage is expected to help improve overall health and will save more than 2,300 lives per year. In addition 6,200 jobs are expected to be created. Financial barriers to health care services are most pronounced in rural parts of the state where the number of uninsured is the highest. More people with a payment source provides opportunities to stimulate business growth in health care services and support in our rural communities.

Health care providers who have been helping uninsured patients can now direct those patients to www.arhealthconnector.org where they can enroll in a plan or find a licensed, registered guide to help them through the process.

Bending the Cost Curve

In July 2012, after 18 months of research, data analysis, and public workgroup and town hall meetings, the first phase of the Arkansas Payment Improvement Initiative (APII) was launched. The APII shifts health care payment from fee-for-service that rewards volume of care to incentivizing effective care coordination, superior outcomes, and cost containment. Major components of the APII are the episodes of care payment structure and establishment of patient-centered medical homes. Originally undertaken by Medicaid to address rising costs and improve

Rather than expanding the traditional Medicaid program, Arkansas took a much different approach. The private option is a first-of-its-kind program that will provide premium assistance to those otherwise eligible for Medicaid expansion, enabling them to purchase private plans through the Marketplace.

quality, the APII now has the strength of multiple payers including the state's largest insurance carriers.

For more information on APII visit www.paymentinitiative.org.

Health Information Technology

The American Recovery and Reinvestment Act of 2009 is stimulating the adoption of electronic health records and health information exchanges across the clinical spectrum. In response, Arkansas began planning a coordinated health information technology system including statewide adoption of electronic health records (EHR) and development of the State Health Alliance for Records Exchange (SHARE). This system will help improve the quality of care as those providing medical services to patients will have secure, real-time access to patients' health records from anywhere patients have been treated. The patient experience will be improved and costs will be controlled by avoiding duplicate testing and procedures.

More than 3,000 primary care providers and hospitals are now committed to EHR adoption and receiving a total of more than $167 million in federal stimulus funding. In addition, there are currently more than 2,300 individual Secure Messaging users from about 271 health care locations (hospitals, physician practices, labs, etc.) taking advantage of SHARE, resulting in nearly 500,000 Arkansans benefiting from increased information for their clinicians. For more information visit www.ohit.arkansas.gov and www.hitarkansas.com.

The national gaze has been focused on Arkansas as we continue implementing innovations that may serve as a model for other states wrestling with the need for system transformation. While some providers and patients have already experienced the positive impact of these efforts and costs are beginning to show containment, full realization of a transformed health care system will take time. There are bound to be some bumps along the way, especially in the launch of the highly intricate new Health Insurance Marketplace. In the meantime, significant progress has been made in lockstep with increased health care coverage that will begin on January 1, 2014. We have stakeholders across the state committed to working together to complete the shared vision of a healthier and more productive Arkansas with a sustainable health care system that will truly meet the needs of our citizens. ■

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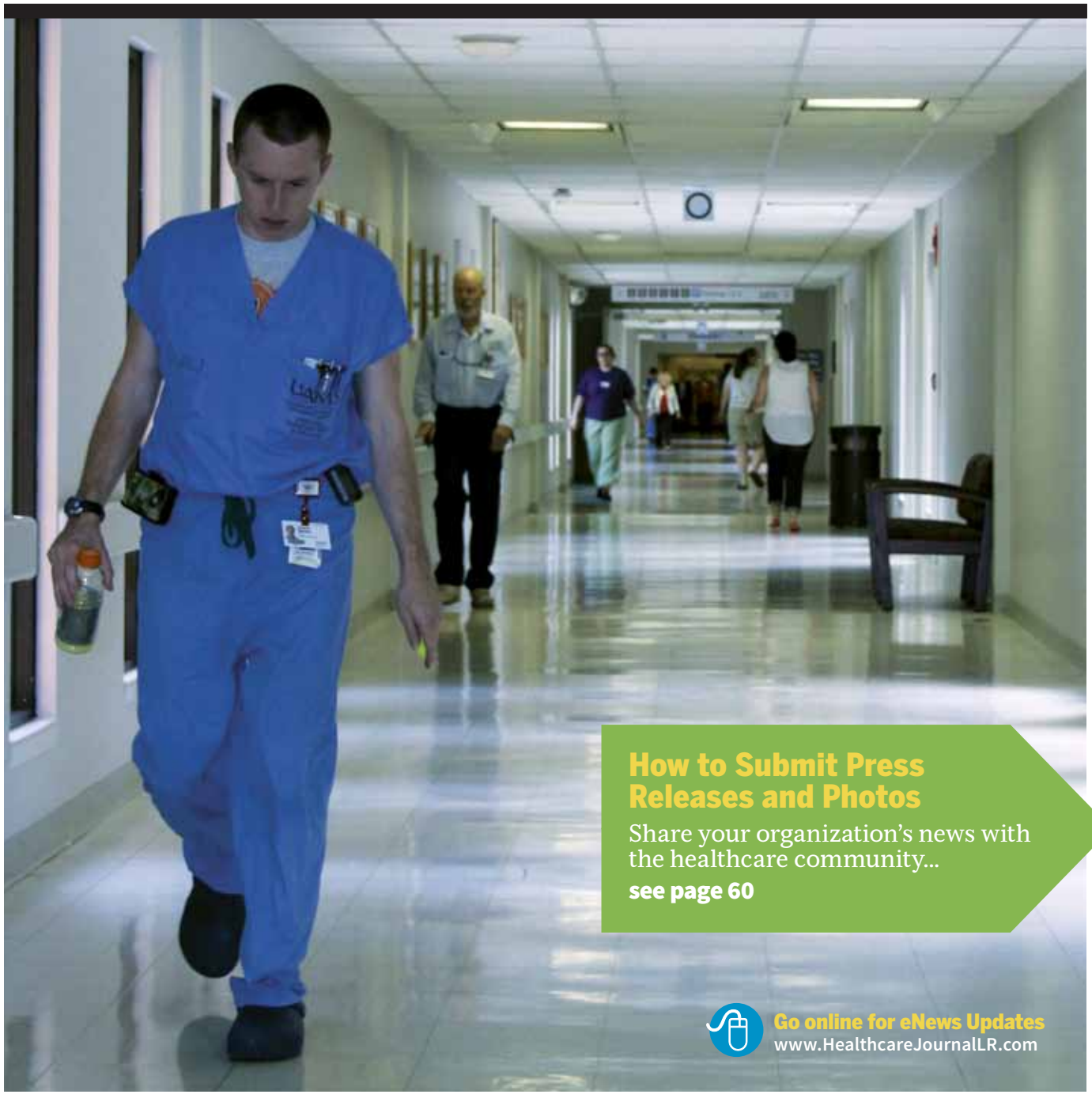

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Denise Looker, LSW, MA, and Betty Maddox celebrate St. Vincent Health System Visiting Nurse Association's 75th Anniversary. Maddox was with VNA from 1968-1994. She was President/CEO from 1976-1994.

UAMS, AR Children's Participate in Peanut Allergy Study

Researchers at the University of Arkansas for Medical Sciences (UAMS) and Arkansas Children's Hospital are enrolling children ages 1-4 in a federally funded collaborative study of a possible new treatment for children with peanut allergy.

UAMS Department of Pediatrics Professor Stacie Jones, MD, study co-chair, will work with colleagues in allergy and immunology research to conduct the study at UAMS and ACH, as well as at the University of North Carolina-Chapel Hill, Johns Hopkins University in Baltimore, Mount Sinai School of Medicine in New York, and Stanford University in Stanford, Calif.

"Oral Immunotherapy for Induction of Tolerance and Desensitization in Peanut-Allergic Children" will be the first major study to examine whether a therapeutic approach using oral immunotherapy can lead to durable lasting tolerance to peanuts among young, peanut-allergic children.

The study is sponsored by the National Institutes of Health-National Institute of Allergy and Infectious Disease-funded Immune Tolerance Network (ITN). Wesley Burks, MD, chair of the University of North Carolina-Chapel Hill Department of Pediatrics, will lead the study with Jones. A new aspect of this study is the very young patient population.

Allergen immunotherapy administers an allergen under tight medical supervision to train a patient's immune system so the patient will no longer have allergic reactions to that particular allergen. Oral immunotherapy for food allergies such as eggs, peanuts, and milk, has shown promising results in several small studies.

In this randomized study, 144 peanut-allergic children will receive either peanut oral immunotherapy or a placebo. After 134 weeks of peanut consumption, the children will enter a six-month avoidance phase during which they will not consume peanuts.

There are two possible outcomes to allergen immunotherapy. In the first outcome, children may become desensitized as they take the daily, oral doses of the food allergen. In this case, participants would not experience an allergic reaction to the food during the study period but the adverse reaction would resume after the study is ended. The second possibility is for the development of tolerance, in which a participant can stop eating that particular food for a long time and afterward still be able to eat the food without having an allergic reaction.

To test for the latter possibility, after an extended period of receiving allergen immunotherapy during the study, the children will stop therapy for 6 months (during a period of dietary peanut avoidance), after which they will have a final peanut challenge to evaluate whether they have become tolerant to peanuts. An equally important component of this study is the corresponding studies of immunologic markers, which could help predict which children can become tolerant during a course of oral immunotherapy.

Winthrop P. Rockefeller Cancer Institute Collaborates with Highlands Oncology Group

A new collaboration between the Winthrop P. Rockefeller Cancer Institute at the University of Arkansas for Medical Sciences (UAMS) and Highlands Oncology Group will advance research in Arkansas and give greater access to care. The collaboration will allow the Cancer Institute, located in Little Rock, and Highlands, located in Fayetteville and Rogers, to work together in providing the highest-quality care for Arkansas patients and families living with cancer while remaining close to home.

"Virtually all of the successful cancer treatments we have today are the result of clinical trials," said Laura Hutchins, MD, director of clinical research at the Cancer Institute and a professor in the Division of Hematology/Oncology in the UAMS College of Medicine. "Working together with Highlands to enroll patients in trials not only has the potential to benefit these individuals, it also can have a dramatic impact on the future of cancer treatment."

Patients at Highlands will now have a more expedited process for enrolling in research clinical trials offered concurrently through Highlands and the Cancer Institute, giving them access to new and innovative treatment options unavailable at other cancer centers. Clinical trials are an important area of research in which patients work with doctors to find new ways to prevent, diagnose, and treat cancer. The Cancer Institute offers about 200 clinical trials to patients who qualify for participation.

Patients at Highlands also will benefit from the use of telemedicine, in which their physicians consult in real-time with their counterparts at UAMS via video conferencing. This use of technology will give patients in northwest Arkansas the expertise of UAMS specialists without requiring them to travel to Little Rock.

St. Vincent VNA Celebrates 75th

The St. Vincent's Health System Visiting Nurse Association recently celebrated its 75th Anniversary as a Legacy of Caring. Visiting Nurse Association (VNA) currently provides nursing and therapy care to over 1,800 homebound patients making more than 52,000 home visits to those patients in central Arkansas.

VNA has a volunteer and resource program to meet some non-medical needs of home care patients. VNA's focus on excellence has led to quality outcomes as evidenced by Medicare Home Care Compare scores. VNA scores above the state and national average on a majority of the 12 quality outcomes.

Niki Miner, RN BSN CNRN nurse manager Neurosurgery 5E/NSICU briefs visitors from King Faisal Specialist Hospital and Research Centre, located in Riyadh and Jeddah, Saudi Arabia. The team selected St. Vincent Infirmary as the site to review and observe the successful implementation of Clairvia - a management system for total hospital efficiency that encompasses patient flow, staffing, care coordination and equipment tracking to support analysis for excellent patient care.

King Faisal Specialist Hospital & Research Centre Tours St. Vincent

King Faisal Specialist Hospital and Research Centre, located in Riyadh and Jeddah, Saudi Arabia, selected St. Vincent Infirmary as the site to review and observe the successful implementation of Clairvia – a patient management system that encompasses patient flow, staffing, care coordination, and equipment tracking that aims to improve patient care while better managing the resources of the hospital

The team selected St. Vincent over 200 other hospitals in the country/world using Clairvia. In addition to learning about the Clairvia clinical applications, the team received briefings on Clairvia-supported financial planning and operations improvement, a day in the life of a St. Vincent Nurse Manager, and toured the neurosurgical ICU, the oncology unit, and the staffing office at St. Vincent Infirmary where Clairvia is used to manage patient care.

"We are truly privileged to be a showcase facility for other hospitals literally around the world to see how we are proactively addressing patient care, nursing, and care coordination. I'm sure the leaders from King Faisal Specialist Hospital in Saudi Arabia will learn from our experiences and enjoy our St. Vincent hospitality," said Peter D. Banko, President & CEO of St. Vincent Health System. "I don't think anyone could never have ever imagined 125 years ago when St. Vincent was founded that leaders from the hospital used by the royal family in Saudi Arabia would travel to Little Rock to learn how to improve patient care from our world-class organization."

Bacon Cookoff Benefits UAMS Patients

The Rock Town Bacon Throwdown in October featured 10 local professional chefs serving samples of their best bacon dish in a cookoff contest along with music from the Good Time Ramblers.

Proceeds from the event, which was held at War Memorial Stadium, will benefit the UAMS Patient Support Fund. The fund has helped hospital patients in need with a change of clothing or a travel voucher and awarded grants that have purchased hospital equipment and items such as car seats for patients in the neonatal intensive care unit and special pillows for heart patients.

Chef Greg Wallis of the Afterthought Bistro & Bar prepares what would be the winning dish, bacon-wrapped meatloaf with truffle mashed potatoes and caramelized onions.

The 12 UAMS Project SEARCH interns pose for a photo with the three staff members from ACCESS who meet with them daily at UAMS.

Gov. Beebe Praises Interns in UAMS Project SEARCH

A yearlong internship program for young adults with developmental disabilities is providing on-the-job training while helping the University of Arkansas for Medical Sciences (UAMS) serve its patients, employees, students and guests.

The 12 interns in UAMS Project SEARCH — a partnership between UAMS, ACCESS, and Arkansas Rehabilitation Services — started working jobs in patient transport, nutrition services, central supply, the mailroom, human resources, and other areas in mid-August. Gov. Mike Beebe, UAMS Chancellor Dan Rahn, MD, and leaders from ACCESS and Arkansas Rehabilitation Services praised the interns and program during an October celebration.

UAMS Project SEARCH, the first program of its kind at an Arkansas university, was modeled after the internationally successful Project SEARCH program started at the Children's Hospital Medical Center in Cincinnati, Ohio. A co-founder of the original program, Susie Rutkowski, MEd, co-founder of Project SEARCH International, also attended the event along with the interns, family members, UAMS coworkers, and mentors.

"Not only will these young adults be ready for careers after working with Project SEARCH, they'll also pave the way to success for other disabled Arkansans who are ready and willing to work," Gov. Mike Beebe said. "This partnership between UAMS, ACCESS and Arkansas Rehabilitation Services further enriches the lives of these interns and the strength of our state's workforce."

Andrew Aston, 24, a UAMS Project SEARCH intern working in patient transport, spends each day making sure wheelchairs are available for UAMS patients, delivering them to patient rooms or to the patient intake or discharge areas or to other places patients need to go. "I love it. I've learned so much about helping patients and taking them where they need to go. It's an amazing experience," Aston said about his job.

UAMS serves as the host business for the program, providing entry-level work experiences that match each intern's skills. ACCESS staff members meet the interns daily for vocational instruction, job coaching, and lessons in independent living skills. Arkansas Rehabilitation Services is providing financial support for the program, applied directly to vocational education and career development.

The interns work with a team that includes their families, an instructor, vocational advisor, and job coach along with Arkansas Rehabilitation Services counselors to create employment goals and support interns during the transition to work. The goal is to help participants build competitive, marketable and transferable skills to enable them to apply for a related job upon completion of the internship.

Founded in 1996, Project SEARCH has grown to an international one-year internship program for individuals with developmental disabilities who desire sustainable, competitive employment. Its proven training and employment model is used in more than 150 licensed programs spanning 42 states, four countries, and multiple industries.

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

Applications are now being accepted for the second UAMS Project SEARCH class that will begin in 2014. The applications can be found at http://projectsearch.uams.edu. The application deadline is Dec. 20, 2013.

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ADH Recognizes Hospitals for Stroke Care Performance

The Arkansas Department of Health has recognized three hospitals and two individuals for stroke care performance and other outstanding contributions to support the goals of the Coverdell Arkansas Stroke Registry.

The three hospitals receiving performance awards were: Piggott Community Hospital (low stroke volume group), White River Medical Center (medium stroke volume group), and Sparks Regional Medical Center (high stroke volume group). The two individuals receiving awards were Joanne Woodward (St. Bernard's Medical Center - Outstanding Presenter) and Janie Evans (White River Medical Center - Emergency Medical Services (EMS) Pilot Program). These awards were presented during the 4th Annual AR SAVES Telestroke Conference earlier this year.

Arkansas ranked first among states in 2010 for stroke mortality at a rate of 53.1 deaths per 100,000 population. In 2011, there were a total of 10,030 hospitalizations due to stroke in Arkansas, and approximately 1,560 stroke deaths at a rate of 46.7 deaths per 100,000 population. These figures provide evidence that improved quality of stroke care has helped to reduce deaths due to stroke. The ASR is pleased to recognize the efforts of their member hospitals and the EMS in coordinated efforts to better stroke outcomes.

The Coverdell Arkansas Stroke Registry is a quality improvement initiative implemented as a partnership among the Arkansas Department of Health, Centers for Disease Control and Prevention, Paul Coverdell National Acute Stroke Registry, and the American Heart Association/American Stroke Association's Get With the Guidelines Stroke Program. Named in honor of the late Senator Paul Coverdell of Georgia, who died of a massive stroke in 2000, the primary goal of the Arkansas Coverdell Stroke Registry is to optimize the care of acute stroke patients in the hospital setting.

The performance awards were given to those hospitals documenting the highest level of defect-free stroke care by stroke volume group. The defect-free measure demonstrates the percent of patients receiving all of the interventions for which they are eligible. Data from January 2012 - December 2012 were analyzed for this award.

The individual awards were provided to Joanne Woodward and Janie Evans. Woodward was recognized for her outstanding presentation on the St. Bernards' Code Brain Protocol which helps ensure rapid assessment of stroke patients. Evans was honored for her efforts in launching and managing the EMS pilot program which was developed as part of the Coverdell Arkansas Stroke Registry.

Visit www.healthy.arkansas.gov for more information on stroke prevention in Arkansas.

Roc Stars Honored at Hogs Game

At the "You Are a Roc Star" pregame tailgate event in September, pediatric cancer patients from the UAMS Radiation Oncology Center and their families called the Hogs, sang the team's fight song with Razorback cheerleaders, and welcomed the team as they arrived at War Memorial Stadium for their game against Samford. The children received event t-shirts, footballs autographed by Razorbacks Head Coach Bret Bielema, and posed with cheerleaders for photos. They were also recognized during the game over the public address system.

The ROC Stars program marked its one-year anniversary Sept. 30. The UAMS Radiation Oncology Center, part of the UAMS Winthrop P. Rockefeller Cancer Institute, is now the only radiation treatment facility in the state that treats children.

Baptist Health Announces Real-Time Nerve Monitoring

Baptist Health Medical Center-North Little Rock announced the ProPep Nerve Monitoring System as the first, real-time nerve monitoring system specifically designed for use during robotic surgery in Arkansas. The system is a fast, accurate, and easy to use technology that aids surgeons in identifying hard-to-see nerves during minimally invasive robotic prostate cancer surgery.

In June 2005, Baptist Health Medical Center-North Little Rock (BHMC-NLR) performed the state's first minimally invasive treatment for

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HEALTHCARE JOURNAL of Little Rock

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.

patients with prostate cancer using a state-of-the-art robot in a procedure called the da Vinci Prostatectomy. The ProPep Nerve Monitoring System is used in conjunction with the da Vinci system.

For more information about the da Vinci Prostatectomy or the ProPep Nerve Monitoring System, contact BAPTIST HEALTH HealthLine at 1-888-BAPTIST or visit www.baptist-health.com.

Gov. Beebe Honored with Children's Health Champion Award

The University of Arkansas for Medical Sciences (UAMS) ANGELS (Antenatal and Neonatal Guidelines, Education and Learning System) and Women's and Children's Health Champion Award was presented to Arkansas Gov. Mike Beebe at UAMS' annual Perinatal Conference and Women's Health Update.

The Health Champion Award is an annual award given by the ANGELS awards committee to a women's and children's health advocate. Recipients have given their careers to public service and have a special interest in the well-being of women and children, with the award recognizing that service.

ANGELS also celebrated its 10th anniversary at the conference. ANGELS is a nationally recognized and awarded telemedicine network connecting UAMS maternal-fetal medicine specialists and genetic counselors with patients and community-based physicians. Its real-time video and audio teleconferencing technology allows UAMS physicians to see the patient and a sonogram. Initiated and headquartered at the UAMS Center for Distance Health, the ANGELS network through teleconferencing also facilitates the continuing medical education of Arkansas health care professionals and operates a 24-hour call center. ■

Paul Wendel, MD, receives the medallion from Chancellor Dan Rahn during the investiture ceremony as College of Medicine Dean Rick Smith looks on. ▶

Wendel Honored with Inaugural Chair in Maternal-Fetal Medicine

In a tribute initiated by a small group of thankful patients, the University of Arkansas for Medical Sciences (UAMS) invested Paul Wendel, MD, with an endowed chair in his name in maternal-fetal medicine. Wendel, a professor in the UAMS Department of Obstetrics and Gynecology, was recognized in front of family, friends, and colleagues in a ceremony at UAMS.

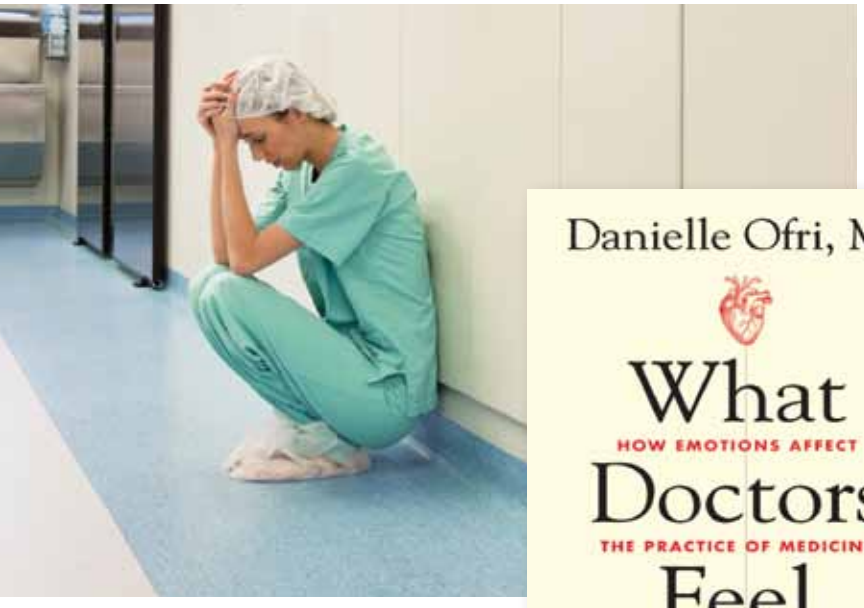
Funding for the Paul J. Wendel, MD Chair in Maternal-Fetal Medicine initially began in 2007 by seven of Wendel's former patients, many of whom had high-risk or abnormal pregnancies. More than 1,500 gifts helped complete the endowment.

A 20-year veteran at UAMS, Wendel graduated from St. Louis University with a Bachelor of Science in biology in 1984. He went on to attend the University of Missouri at Columbia School of Medicine. He then completed his residency in OB/GYN and a two-year fellowship in high-risk obstetrics at the University of Texas Southwestern at Parkland Hospital.

During Wendel's career at UAMS, the maternal-fetal medicine program has grown and developed into a nationally-recognized department.

BookCorner

REVIEWS BY **THE BOOKWORM**



He wasn't the doctor you normally see.

It really didn't matter, though. Choice of physician wasn't an issue in the ER, but pain and fear definitely were. You didn't care who you saw right then. You just wanted it over - stat, as they say.

When it was, and you were finally home safe, you realized something: you saw the doctor for about three minutes. He was caring, but cursory. Brief, and very businesslike. And in the new book "What Doctors Feel" by Danielle Ofri, MD, you'll get a glimpse of what might've gone through his head that night.

For decades, we've been conditioned to believe that doctors are supposed to keep an emotional distance from their patients. We expect a certain detachment and formality – but we also expect compassion. Is this a contradiction in demand?

Dr. Danielle Ofri says no. Though remaining businesslike may often be essential, the physician-patient interaction "is still primarily a human one." No matter how aloof the doctor or sick the patient, we still connect on a one-to-one basis.

We shouldn't be surprised, therefore, to note that doctors are mortals who sometimes "fall short on empathy" when an illness doesn't make sense or a wound isn't obvious, when patients don't follow advice, display entitlement, or steadfastly maintain bad habits. In those cases, frustration rises and remaining empathetic is "challenging," but as a young medical student, Ofri learned from "an act of compassion" that finding empathy is possible as well as essential.

We shouldn't feel surprised to note that medicine is like many professions, and certain clients are "problem" clients. As in many jobs, doctors use dark humor and "derogatory terms" to deal with personal discomfort, show solidarity, ease unpleasantness, or bring levity to the situation. And, as in every job, some topics are off-limits.

Doctors fear harming their patients, missing something important, making mistakes. They become overwhelmed by neediness and illness, and by reams and reams of paperwork necessary in today's medical world. They can succumb to the kinds of maladies and addictions they see every day, they can be stubborn in their decisions, they momentarily forget things, and they surely experience burn-out.

And yes, doctors do have favorite patients. And they cry when those patients die.

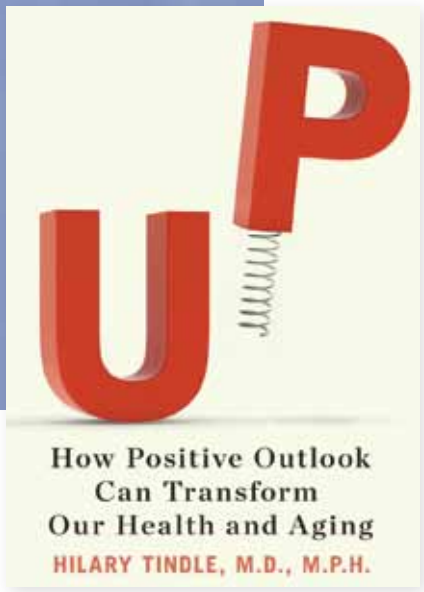
With incredible insight, lyrical beauty, humor and consideration, author Danielle Ofri, MD gives readers the kind of comfort we need when faced with any sort of medical anything by revealing exquisite vulnerability in an esteemed profession. She successfully portrays the processes of diagnosis and treatment as more human than clinical, and that's likewise soothing.

But not everybody will enjoy what's here.

Medical personnel might be unhappy that Ofri exposes certain, darker bedside manners. Indeed, the section on medical slang is uncomfortable to read – and yet, because that blunt truth follows with the spirit of this book, it belongs.

Overall, I couldn't let go of this graceful, elegant, honest book and I think you'll love it, too. If you're a doctor or if you're anyone's patient, "What Doctors Feel" is a book to read – stat. ■

TERRI SCHLICHENMEYER IS **THE BOOKWORM**



You're not getting any younger – and it makes you cantankerous.

Everything's changed since you were a kid (when things were better). Life goes 110 miles an hour, you've got aches where you didn't even know you had muscles, and you can never find your favorite anything anymore. Bah.

The thing is, you can't go backwards. Those years just keep piling on top of one another, and in the new book "Up: How Positive Outlook Can Transform Our Health and Aging" by Hilary Tindle, MD, MPH, you'll see how your attitude can make every one of them better.

Let's look on the bright side.

You've probably heard that sentiment several hundred times in your life; so much, perhaps, that it's basically meaningless to you by now. Honestly, can turning a frown upside down really make a difference?

According to Dr. Hilary Tindle, it can. Attitude has "the potential to influence every facet of our health..." Doctors, for instance, have long known that positive patients are more likely to follow medical instructions, "seize opportunities," and avoid sabotaging their own healing. In short, upbeat patients are easier to treat – which leads to less illness and longer lives.

Research further shows that quickness to anger can predict your likelihood for heart disease. That, and a snarly attitude, can also "predict... risk factors that are known to cause... major illnesses of aging" such as high blood pressure and diabetes. These factors, which can stem from a negative outlook on life, begin to manifest themselves as early as childhood and they can add up over the years.

To counteract a lifetime of sourpussness, Tindle says that change is necessary (just about everybody needs some change) and definitely possible. Learn how to manage responses to problems, first of all. If you're prone to descending into a "negative cycle," know how to escape it. Don't think you have to be sunshiny all the time; there are many "faces" of optimism. Acknowledge your accomplishments throughout every step of life, follow "typical" doctor advice, get in touch with nature now and then, and stop being so self-critical.

Then, buck up. Says Tindle, "... outlook can be one of our strongest allies in the aging process."

It would be way too trite and simplistic to say that "Up" is a book about positivity. No, author, researcher, and self-proclaimed optimist Hilary Tindle offers cutting-edge information on why it's never too late to seize change and seek a better outlook in order to reap the rewards of contented aging with fewer health issues.

Knowing that it's not that easy, however, Tindle gives readers tips on altering one's attitude, climbing out of the doldrums, and reaching for community as a bolster. I liked this book – though I think there's a lot here that I've heard before – and I liked that its advice is mixed with real evidence.

Curmudgeons, crabs, and grumps beware: this book could change your outlook and, says the author, every little bit helps. So smile once in awhile and grab "Up"... because if you do, the sky's the limit. ■

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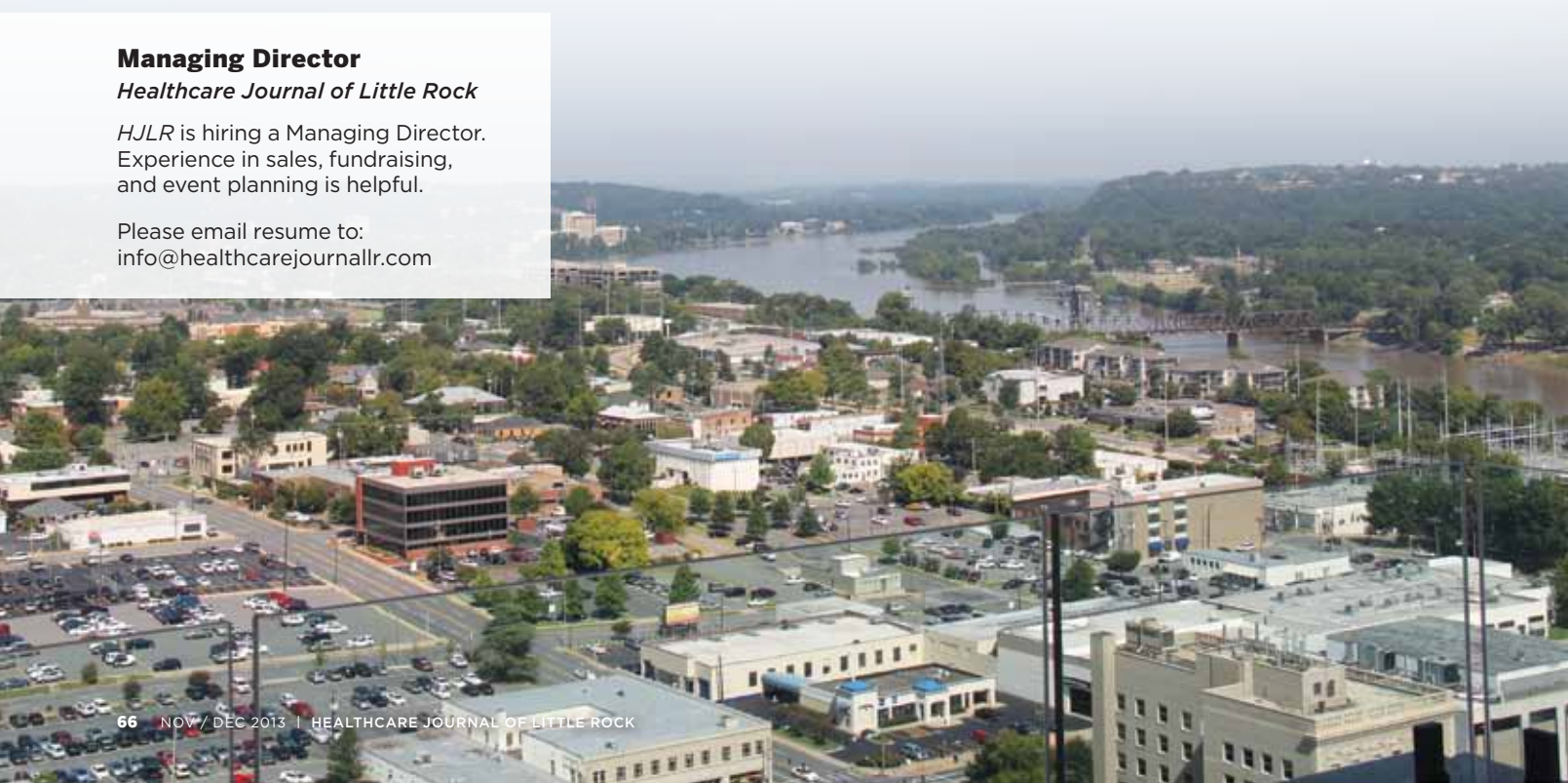

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