Arkansas Trauma System & Related Measures Saving Lives, Improving Stats
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ON THE COVER
Arkansas Trauma System & Related Measures Saving Lives, Improving Stats

WHAT HAVE WE DONE FOR YOU LATELY?
DAVID WROTHEN, EXECUTIVE VICE PRESIDENT

A Closer Look at Quality
Winner of the ASAE Excellence in Communications Award

THE Journal
OF THE ARKANSAS MEDICAL SOCIETY
Volume 112 • Number 11
March 2016

Managing Pulmonary Complications in Children with Neurodisabilities
Farrah Jones, RRT, CPFT; Robert H. Warren, MD

Sister Mary Joseph Nodule: A Case Report and Review
Cathryn Coleman; Amy Hudson, MD; Sandra Marchese Johnson, MD, FAAD

Absurdities From the Wrong Side of the Sheets
Part 1-Becoming A Patient
Vickie Henderson, MD

PEOPLE + EVENTS
ERRATA: J Ark Med Soc. 2015 Dec; 112(08):134-137; Author Michelle R. Smith, PhD, MPH should be listed as Director, Office of Minority Health and Health Disparities, Arkansas Department of Health

Clarification: In the article “Connecting More than Flesh and Bone: State’s First Primary Care Sports Medicine Fellowship Promotes Athletics & Community,” appearing in the January 2016 issue of The Journal of the AMS, [J Ark Med Soc. 2016 Jan; 112(09):152-154] we should have noted that the UAMS program is the first ACGME-accredited primary care sports medicine fellowship. At least one other program exists in the state, accredited by the AOA and was started by Dr. Chris Dougherty, the Arkansas Center for Arthroscopy, in 2010.
Act 1232 of 2015 – Improving the Credentialing Process

(This is the last in a series highlighting legislation passed by the AMS in the 90th Arkansas General Assembly)

You have all heard the story. A new physician submits a network credentialing application with a major insurance carrier. Three months go by. Receiving no response, the office staff contacts the carrier and is informed “we didn’t receive an application for Dr. Who.” You submit it again or maybe hand deliver it. When you don’t hear back your staff calls again only to be told again, “we don’t have an application for Dr. Who.”

I won’t go into all of the problems this creates for physicians and more importantly, patients seeking their services. You already know them. Fortunately, most carriers do an excellent job at processing credentialing and recredentialing applications. But for some carriers there seems to be a periodic lapse in their ability to manage the process.

A few years back, AMS sponsored legislation requiring carriers to process credentialing applications within 90 days. Dr. Gene Shelby, AMS past president and at the time a state representative, sponsored what became Act 350 of 2009. Apparently, it didn’t go far enough. Just in the past couple of years, AMS has had to assist numerous clinics, working in conjunction with the Arkansas Insurance Department, to overcome seemingly insurmountable problems, primarily relating to one particular insurance company.

So in 2015, Senator Cecile Bledsoe sponsored a major amendment to the legislation that became Act 1232 of 2015. In general, the new law shortened the allowed time from 90 to 60 days and in a major improvement, levied fines of $1,000 per day for each day exceeding the 60 days.

The statute contains several other provisions designed to keep carriers from abusing the credentialing process. The carrier:

- Shall provide written acknowledgement that they received an application – within 10 days.
- Must provide a notice with details if an application is incomplete – within 15 days; failure to send the notice within the time frame deems the application as complete.
- Shall not require a new application when a previously credentialed physician changes address, employment, joins a new group or opens an additional location. They may only require the submission of the additional information necessary to reflect the changes listed above.
- Is required to reflect any changes (as listed above) in the carrier’s system within 30 days.
- Must notify a physician at least 90 days before a deadline for submitting a recredentialing application;
- Must notify the physician at least 45 days before termination for failure to submit a recredentialing application; if the application is submitted before the 45 days, the termination is cancelled; during the 45 day period the carrier is prohibited from representing to patients or others that the physician has been or will be terminated (unless the termination is unrelated to credentialing).
- Must notify a physician in writing of the effective date and reasons for termination for any reason.

Finally, one of the major problems with credentialing delays is the impact on billing and misapplied deductibles and co-pays. Some carriers would only recognize a physician as in-network for dates of service “after” the application was approved. To provide some relief from these problems the statute requires the carrier to process claims as in network, back to the date of submission of a complete application, once that application is approved.

Let me say again that most of our carriers in Arkansas do a really good job of processing credentialing applications and any delays are usually the result of missing or inaccurate information. But for the bad actors, Act 1232 not only provides a more detailed process, it contains some pretty nasty teeth in the form of fines levied at $1,000 per day. AMS
As I took the role of medical director for the Chronic Disease Branch at the Arkansas Department of Health a few years ago, a couple of statistics stood out. The percent of Arkansans with uncontrolled hypertension and diabetes were 50% each. The underlying causes of poor management of hypertension, diabetes, or for that matter any chronic disease are non-adherence to medications and lifestyle modification. The percent of Arkansans with either uncontrolled hypertension or diabetes that are nonadherent to medications and/or lifestyle modification is estimated to be 50% based on some national estimates. Recently, one of my colleagues went through a difficult time in his long term relationship. In the process of coping, he mentioned to me that, “50% of long term relationships end up in a divorce…!” This statistic rang a bell of all too familiar numbers I have been hearing on hypertension and/or diabetes control. As I thought more about it, it became clear to me on how chronic disease management and long term relationship work alike and need the same kind of solution.

The traditional medical model where a physician works one-on-one with the patient has not improved population metrics on hypertension or diabetes control. This is partly because it takes more than physicians providing preventive services such as blood pressure or A1c checks; initiating or changing medications; age-appropriate immunizations; and referring for eye exam or to a podiatrist as needed. It takes the patient to check his or her blood pressure or blood glucose; taking medications as prescribed; changing the diet; engaging in physical activity; and quitting smoking. Similarly long term relationships aren’t always easy. It takes constant work to nourish and grow the relationship. The American Psychological Association states that people in healthy relationships take time to check in with one another regularly; communicate their differences in a constructive way to work it out; and keep things interesting with laughter or dance nights.

At times, the traditional medical model does not work for all patients with chronic diseases. Some of the barriers for nonadherence to medications and/or lifestyle modifications are financial – inability to afford the medications, lack of perceived susceptibility or severity about their health condition due to poor health literacy, lack of patient motivation, competing comorbid conditions such as depression, and finally poor follow up with the physician. Similarly, in long term relationships, career, children, and commitments may make it difficult to stay connected, disagreements and withdrawing from discussing these in a constructive way, and simply boredom can have a negative impact.

I tell the family medicine residents at the University clinic that three to four of 10 patients with hypertension or diabetes or any chronic disease for that matter, will manage their condition per physician advice; one to two of 10 patients will not follow the advice no matter for variety of reasons; the remaining three to four are like the ‘cat on the fence’, who when extra support is provided for medication adherence or lifestyle modification will improve their blood pressure or diabetes control. This extra support can be offered through a team-based care approach. Physicians can identify most of these three to four of 10 patients who are ‘cat on the fence’ either by observing them (they always forget to bring their blood pressure or blood sugar logs during office visits, run out of their medication, or miss several days of medications, do not make recommended lifestyle changes), using a risk-stratification tool, or through a ‘teach-back’ method particularly for those with low health literacy. Often, these individuals end up with a heart attack, stroke, or renal failure due to poor management of their chronic diseases, and utilize significant health care dollars. A team-based care approach is an evidence-based model that is comprised of the patient, patient’s primary care provider, and another person such as a nurse, pharmacist, dietician, social worker, or a community health worker. In other words, the physician should identify these individuals and offer them case management or co-management. This evidence-based model has been shown to improve hypertension and diabetes control in several studies. Likewise, in long-term relationship, some resort to marital education or counseling services successfully to work out their differences and enhance their relationship.

An advice to my physician colleagues is that chronic disease management is similar to a long term relationship, it needs patience, work, and perseverance; and at times if this is not enough resorting to team-based care approach might help.
Seeing improved health care statistics on a page comes in second to watching them play out in patients' lives. When it comes to the results of the Arkansas Trauma System (enacted in 2009), the state is – for once – getting to have a little cake and eat it, too.

“On numerous occasions, I’ve treated children injured in remote areas of the state whose CT scans showed significant brain injury. My patients’ hospital acceptances were coordinated through the trauma system call center, their images pushed through the image repository, and they had trauma specialists and an operating room waiting on their arrival – saving precious minutes and eventually their lives,” said Arkansas Children’s Hospital Trauma Surgeon Todd Maxson, MD, of his experiences with ATS in place.

“This kind of coordination did not occur in Arkansas prior to 2009 and still does not occur in many places nationwide.”

Dr. Maxson also serves as ATS Consultant to the Arkansas Department of Health. Turning his attention to numbers on a page, he shared how, in just a few years, the state has significantly improved its response to trauma. “In a four-year period, Arkansas has seen an almost 50% reduction in preventable mortality, the most rapid improvement in care ever seen in the United States,” he said, quoting a figure from the health department’s most recent preventable mortality analysis. The study compared preventable injury-related deaths after versus before the system. “Preliminary findings also showed a 57% increase in appropriate care provided in the four-year period studied.”

Getting Patients to the Right Place FIRST

Implemented with the passage of Act 393 (Trauma System Act), the ATS is managed by the Arkansas Department of Health’s Trauma Injury and Violence Prevention Branch.

An AMS member since moving to Arkansas in 2009, Dr. Maxson attended medical school at UAMS and returned to the state after many years of successful work in Texas’ trauma system. “After learning in Texas for many years, I came to assist the Department of Health with trauma development and help ACH become designated as a Level 1 Pediatric Trauma Center.”

Including ACH, Arkansas has 65 designated trauma centers – 11 comprehensive-care level one and two centers (L1, L2), 18 L3 centers (mild to moderate single-system injuries), and 36 L4 centers (stabilization, prepare for transfer usually required). Most traumatic injuries can be treated at an L3 facility, according to ADH officials.

In addition to the trauma centers themselves, some of the significant ATS components include the aforementioned “call center,” officially named the Arkansas Trauma Communications Center (ATCC); the state’s emergency personnel; the Trauma Image Repository; the Trauma Registry; Trauma Advisory Councils (TACs, statewide and regional); and the Arkansas Trauma

Arkansas Trauma System
& Related Measures Saving Lives, Improving Stats
Acute Care Success Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Level I/II, CY 2014</th>
<th>NTDB, CY 2012</th>
</tr>
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<tbody>
<tr>
<td>Hospital length of stay*</td>
<td>2 4 6 9</td>
<td>2 4 5 7</td>
</tr>
<tr>
<td>ICU length of stay*</td>
<td>2 3 4 6</td>
<td>3 3 3 6</td>
</tr>
</tbody>
</table>

*median days

Resource Utilization Data slide shows hospital length of stay and ICU length of stay in the state’s L1 and L2 trauma centers (level 1 and 2) compared to data captured in the National Trauma Data Bank (NTDB); numbers also reported by Injury Severity Score (1-8, 9-15, 16-24, 25+) - the more severe the injury and higher risk of death, the higher the severity score. Arkansas is in line with the national trends (2015 data still being collected).

Education and Research Foundation (ATERF), which coordinates trauma education throughout the state for pre-hospital providers, nurses, and physicians.

Ron Robertson, MD, has worked at UAMS for more than 20 years, much of that time heavily involved in trauma education and development. He was trained under trauma expert John Cone, MD, was good friends with Dr. Maxson from residency days, and has worked for many years now with Director of UAMS Trauma Services Terry Collins, RN.

“We all dreamed that one day Arkansas would have a true trauma system,” said Dr. Robertson. “Fortunately, former Gov. Beebe and our legislature saw the tremendous value a trauma system would have for our state and pledged funds to its development. I am proud of what we have accomplished and excited about the future of trauma care in our state.”

Now that ATS is a reality, Dr. Robertson acts as medical director and chief of the Division of Trauma, Critical Care, and Acute Care Surgery for UAMS, the state’s only adult level 1 trauma center. He is also the state chairman for the American College of Surgeon’s Committee on Trauma, a member of the Governor’s Trauma Advisory Council, and chairman of the Central Arkansas Trauma Regional Advisory Council.

Like Dr. Maxson, Dr. Robertson and others credit ATCC as a huge driver of the state’s improved system. A statewide “dashboard” for use by hospitals, emergency medical technicians, paramedics and physicians, ATCC has helped reduced trauma-patient processing time from an hour or more, on average, to a matter of minutes. “The call center allows triage of nearly every trauma patient to the appropriate center at the appropriate time,” said Dr. Robertson, recalling days past. “Our state used to experience trauma patients going to multiple centers before they arrived at a place that could provide definitive care. This led to poor outcomes. This rarely happens in our new system. All hospitals in the system are designated, and the ATCC dashboard shows real time capability/capacity, so patients are sent to the correct facility from the start.”

Another point of pride in Arkansas’s system is the state’s data registry. “Our statewide trauma registry allows the tracking of patients from the pre-hospital setting all the way through discharge,” continued Dr. Robertson. “This allows us to examine every aspect of the system and make changes based upon data and not just a hunch. Improvements can be made much more cost effectively and efficiently because our data guides our changes and improvements.”

Trauma Registry Administrator Austin Porter explained the work of another valuable ATS component, the Trauma Image Repository. Giving a case in point, Porter said, “Let’s say that a patient is in a bad crash. Prior to ATS and the image repository, the patient would be sent to Hospital A – a small, community-based hospital. A CT scan and x-rays are taken to better understand the injuries. When they decide the patient needs to be transferred, they send him along to Hospital B with an image CD. Unfortunately, it won’t open, leading to repeat tests, additional costs and prolonged care of the patient.

“With the TIR in place, images are transmitted from hospital to hospital through a central, online hub. In this instance, before the patient gets to Hospital B, his images are there, and Hospital B is prepared to provide appropriate care when the patient arrives.”

Porter also shared with The Journal the latest statistics on patients admitted to L1 and L2 trauma centers in Arkansas. The report looked at patients critically injured from car crashes and compared the transfer of such patients two years before the system as opposed to two years after its implementation. “The second set of numbers showed a 10% increase in the number of severely injured patients...

Injury and Violence Prevention Success Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline, CY 2013</th>
<th>National Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mortality¹</td>
<td>Inpatient Admissions²</td>
</tr>
<tr>
<td>Suicide*</td>
<td>16.6</td>
<td>55.8</td>
</tr>
<tr>
<td>Motor vehicle crash*</td>
<td>15.7</td>
<td>60.9</td>
</tr>
<tr>
<td>Unintentional poisoning*</td>
<td>7.7</td>
<td>33.8</td>
</tr>
<tr>
<td>Assault*</td>
<td>7.1</td>
<td>17.8</td>
</tr>
<tr>
<td>Falls*</td>
<td>6.5</td>
<td>216.5</td>
</tr>
<tr>
<td>Falls among ≥65 year olds**</td>
<td>40.9</td>
<td>1210.8</td>
</tr>
</tbody>
</table>

*Age-adjusted rates per 100,000
**Age-specific rates per 100,000
who were admitted first to L1 and L2 centers,” he
summed. “This means that we’re doing better at get-
ting patients to the right hospital first – a feat that
speaks volumes the work being done throughout the
system.”

More Encouraging Numbers
Porter’s job at ADH is to work with all trauma
data. In many ways, it has been an encouraging
picture.

“When I started here, the death rate from motor
vehicle crashes was 25 per 100,000 people – one
of the highest in the nation,” recalled Porter, putting
the numbers into perspective. “Just imagine get-
ting 100,000 Arkansans together in one crowd, and
knowing that 25 of them will die from car crashes
this year. With 2.9 million people in the state, that’s
substantial.

“Regarding injury as whole here in Arkansas,
we’ve had a lot of success,” said Porter, of improve-
ments since 2009. “It can’t be attributed to one thing,
but to the entire system working as it should. The
trauma system has taken shape, and with associ-
ated injury prevention measures in place, we’ve seen
a decrease in motor-vehicle-crash-related deaths in
Arkansas. We’re down to about 17 per 100,000 peo-
ple – while still too many, it’s a substantial decrease.”

The associated measures Porter alluded to in-
clude the primary seatbelt law and the graduated
Gene Shelby, MD (Hot Springs, 2007-2011) was a
sponsor of those bills and has long been a proponent
with the Medical Society of prevention and safety
measures. He also sponsored Act 393 and its primary
funding source, Act 180 (The Cigarette Tax).

“In the past few years, there has been a signifi-
cant reduction in traumatic deaths, especially from
motor vehicle crashes. I feel some of this is due to
the development of a fully funded, statewide trauma
system,” said Dr. Shelby, who also attributed some
decreases to safer cars and better highways. “In addi-
tion, strengthening our seat belt laws has resulted
in a 10% increase in seat belt use. Also, the gradu-
ated driver’s license puts greater restrictions on 16
and 17-year-old drivers. Over the past few years, we
have seen an average of 32 less teenage deaths in
Arkansas in auto crashes than before 2009.”

Future Updates &
Physician Involvement
As well as ATS has functioned to date, there is
room to improve. Continuing improvements, accord-
ing to Dr. Maxson, may include using state data to
improve effectiveness, clinical practice management
guidelines to advance consistency of care statewide,
and revisions to trauma system rules to align them
more closely with national standards. (The newest
Arkansas Trauma System Rules and Regulations, for-
mulated in 2014, are more in alliance with the trauma
rules of The American College of Surgeons.)

There are also new rules in place that govern
urgent trauma transfers. “Many of our rural areas of
Arkansas are covered by EMS agencies with limited
resources,” said Dr. Maxson, explaining their pur-
pose. “Too many times a patient with an urgent trau-
matic condition could not be transported out of a fa-
cility that lacked capability or capacity to care for the
injury, because no transporting vehicle was available
at the time (many times due to non-urgent transpor-
teds in progress). The Urgent Trauma Transfer Rule (UTT),
was created to allow the treating physician to declare
an emergency, give the local ambulance company
an opportunity to execute the transport urgently or if
unavailable for the hospital/treating physician to call
other EMS agencies for support.”

In an effort to keep moving in the right direction
in Arkansas, ADH’s Trauma Section has developed a
number of quality improvement (QI) measures (some
implemented; some coming soon) to help guide and
improve system policies. These include QI-focused
TAC/TRAC meetings, periodic population-based
trauma preventable-mortality studies, TRAC review
of regional trauma-related deaths, contracted out-
side data analysis, and a contract with the Ameri-
can College of Surgeons to participate in its Trauma
Quality Improvement Program (TQIP).

Arkansas is the first state to require all trauma
centers to participate in the TQIP, which ADH de-
scribes as a way to “benchmark participating Ar-
kansas trauma centers against those in other states
in order to identify opportunities for improvement
within our centers.”

Through advisory councils, physicians have
a wonderful opportunity to impact and shape the
direction of the system, according to Dr. Maxson.
“The ADH relies on the advice and assent of the
stakeholder groups that make up the Governor’s
Trauma Advisory Council,” he said. “Most issues af-
festing the governance of the system are brought
up through the Regional Advisory Councils (TRACS).
Physicians advocate for the wellbeing of the injured
patient and will be an effective voice for them.”

As part of the ATS, education is available
that may prove helpful for physicians. The Arkans-
as Trauma Education and Research Foundation
(ATERF), a not-for-profit educational arm of the
system, has been responsible for bringing base-
line and continuing education to the physicians of
Arkansas. “Through courses such as ATLS, Rural
Trauma Team Development, physicians get compre-
ensive trauma education at a nominal cost, close
to home (with the benefit of category 1 CME),” said
Dr. Maxson. “Recent published data has shown that
Arkansas facilities that participate in these courses
improve quality and efficiency of care in their com-
nunities. The Advanced Surgical Skills for Exposure
in Trauma (ASSET) course has trained the majority
of the state’s surgeons in life-saving rapid control
of major vascular hemorrhage.”

If there is a kink in the system that physicians
can help with, it’s happening in smaller hospitals but
can be fixed with a little applied knowledge, indi-
cated Dr. Robertson. “The biggest problem that we
have in the state is the dwell times in Level 3 and
4 hospitals,” he explained. “It is over 210 minutes
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Not All Injury Death Rates Down

Unfortunately, there is one category of injury-related death in Arkansas that is not decreasing—and it’s an area of major concern among health officials. While the death rate from car crashes is going down in Arkansas, the state’s death rate from suicide seems to be on a slow, but steady increase in recent years.

“It’s an interesting and unsettling phenomenon,” said Gene Shelby, MD, “to be seeing a decline in non-natural deaths by automobile crashes, but an increase in suicides.”

“For the first time in the foreseeable past, there are more people dying of suicide than from car crashes, poisonings and other accidental injuries,” said Trauma Registry Administrator Austin Porter, MPH, of the Arkansas Department of Health. “That’s a huge problem that is an emerging issue that we have been able to track and identify as a high focus for injury and violence prevention efforts.”

In next month’s Journal, we will look at Arkansas’s slowly rising suicide rate and related prevention efforts.

Related Links:
Arkansas Trauma System Update
(Oct. 1, 2015)

Arkansas Trauma Section,
Arkansas Department of Health
healthy.arkansas.gov
Whether you are an established doctor or a resident in need of a line of credit, Onebanc provides a broad range of services to help you manage your practice, business and personal banking all in one place. With Onebanc, you only need one bank.
Are you taking advantage of the incentive programs available to providers who become “meaningful users” of health information technology? In February 2009, the American Recovery and Reinvestment Act (ARRA) established incentive programs for eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs).

To promote the adoption and Meaningful Use (MU) of health information technology, ARRA specified three main components of MU:
1. Use of a certified electronic health record (EHR) in a meaningful manner
2. Electronic exchange of health information to improve health care quality
3. Use of certified EHR technology (CEHRT) to submit clinical quality and other measures

The ARRA legislation includes the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was created to stimulate the adoption of EHRs and supporting technology. Beginning in 2011, the HITECH Act stipulates that healthcare providers be offered financial incentives for demonstrating the MU of EHRs.

The HITECH Act established two payment paths to earn incentive payments. One payment path is the Medicare EHR Incentive program, managed by the Centers for Medicare & Medicaid Services (CMS). The Medicaid EHR Incentive program, managed at the state level, is the second path. EPs participating in incentive programs may select either the Medicare or Medicaid payment path. Some hospitals were eligible to receive payments from both incentive programs based on CMS’ criteria. In the event an EP qualifies for EHR incentive payments from both incentive programs, they must select only one payment path.

The first EHR incentive payments began in 2011. Since then, more than 551,000 EPs, EHs and CAHs have actively participated in EHR incentive programs. CMS’ Medicare and Medicaid incentive programs have made payments totaling more than $31 billion through October 2015.

Arkansas EPs, EHs and CAHs have received approximately $341 million in incentive payments. Figure 1 shows payments to EPs only between January 2011 and October 2015.

Participation in the MU program is voluntary, although MU is rapidly becoming the foundation for alternate payment models and practice transformation. MU requirements do not differ between the Medicare and Medicaid programs. However, the timelines and incentive payments available to providers do vary. EPs may no longer enroll to participate in the Medicare EHR Incentive program because it ends in 2016. Enrollment is open through 2016 for the Medicaid EHR Incentive program, which runs through 2021.

Medicaid allows providers to qualify for an initial incentive payment of $21,250 by adopting, implementing or upgrading to a certified EHR system during their first year of participation. Eligible professionals may choose to attest to MU in the first year of participation, which requires a 90-day EHR reporting period and attestation to MU. For subsequent years, there is normally a 12-month EHR reporting period and providers may qualify to receive incentive payments of $8,500.

Figure 1. Payments to Arkansas Eligible Professionals, Jan. 2011–Oct. 2015

<table>
<thead>
<tr>
<th></th>
<th>COUNT</th>
<th>PAYMENTS</th>
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</thead>
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<tr>
<td>Medicare</td>
<td>5,173</td>
<td>$62,173,030</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2,614</td>
<td>$40,220,599</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7,787</td>
<td>$102,393,629</td>
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</table>

SOURCE: CMS payments by state by program by provider
Providers who participate in the full six years of the Medicaid EHR Incentive program may earn up to $63,750 in incentive payments. Incentives are paid to the individual provider, not to practices or medical groups.

In 2015, AFMC was awarded a contract with the Arkansas Department of Human Services to provide MU assistance for Medicaid EPs in Arkansas. In the five years before the Medicaid award, AFMC’s HealthIT team (formerly HITArkansas) provided technical assistance to both Medicare and Medicaid EPs as Arkansas’ designated regional extension center. The hands-on technical assistance focused on helping smaller primary care practices, often located in rural and underserved areas, overcome challenges associated with achieving MU. This technical assistance is available to all Medicaid-eligible practices, including specialists, and will continue through the Medicaid MU contract.

EPs, regardless of where they are in their MU journey, may qualify for subsidized technical services. CMS defines Medicaid EPs as:

- MDs and DOs (including specialists)
- Dentists
- Nurse practitioners
- Certified nurse midwives
- Physician assistants who furnish services in a federally qualified health center (FQHC) or rural health clinic (RHC) that is led by a physician assistant

In order to qualify for participation, an EP must have a minimum of 30 percent Medicaid patient volume, or 20 percent for pediatrics. If an EP practices predominately in an FQHC or RHC, the EP must have a minimum of 50 percent of their patient encounters at that location over a six-month period in the reporting year.

MU objectives are grouped into five domains that relate to health outcomes’ policy priorities. Each objective aligns with one of the following domains:

- Improve quality, safety and efficiency
- Engage patients and families
- Improve care coordination
- Improve public and population health
- Ensure privacy and security for personal health information

There have been several modifications to the MU final rule since its release in 2010. In October 2015, CMS announced a new set of MU regulations. The new final rule brought many changes to the MU program, beginning with the 2015 reporting period. The new final rule will be in effect through 2017, with slight changes in requirements every year.

Keeping abreast of the ongoing changes and updates to MU, coupled with the myriad quality improvement and practice transformation initiatives, can be a daunting task for any practice. AFMC provides hands-on, practical expertise needed to guide providers through MU requirements designed to support quality improvement and transform health care.

AFMC’s technical services include coaching and mentoring, both virtually and in the practice setting. Services include:

- MU education and guidance
- Analysis of EHR functionality to participate in multiple initiatives (e.g., PQRS, MU, PCMH)
- Practice/workflow redesign
- Clinical quality measures
- Public health reporting requirements
- Complimentary webinars and e-newsletters
- Vendor selection and issues management
- Patient engagement strategies
- Guidance to support attestation documentation
- HIPAA security risk assessment

The annual Health Insurance Portability and Accountability Act’s (HIPAA) security risk assessment (SRA) is a critical component of MU and can be audited separately. The Office of Civil Rights recently announced they would begin HIPAA audits in early 2016. AFMC’s annual SRA will provide a thorough analysis of security risks, review policies and procedures, and provide coaching for best practices with regard to creating, storing, transferring, managing and destroying protected health information (PHI). AFMC also provides practices with a plan of action to correct and mitigate identified inadequacies.

When performed by experienced professionals, a SRA supports HIPAA compliance for administrative, physical and technical safeguards. This includes data integrity and security by identifying areas where PHI could be at risk, potentially inhibiting successful achievement of meaningful use, or other initiatives. AFMC will also provide security awareness training, customization of policies and procedures, and attestation and audit preparation.

The final year to begin participation in the Medicaid EHR Incentive program is 2016. Don’t miss the opportunity to take advantage of expert, subsidized MU technical assistance for your practice. To learn more, visit afmc.org/healthit.

Ms. Easterly is AFMC’s outreach manager of HealthIT.
Managing Pulmonary Complications in Children with Neurodisabilities

Farrah Jones, RRT, CPFT; Robert H. Warren, MD

Children with neurodisabilities may be subject to acute and chronic respiratory illness due to the degree of neurological and anatomical dysfunction that is present. Contributing factors include chronic aspiration, ineffective cough and retention of airway secretions. These lead to recurrent pneumonia, atelectasis, bronchiectasis, and restrictive lung disease. The Respiratory Technology Dependent Program (RTDP) at Arkansas Children’s Hospital (ACH) is dedicated to providing the highest quality of care for these children. Children in the RTDP are routinely followed in the pulmonary clinic at ACH. When these children develop an acute respiratory illness the challenge of implementing or adjusting a respiratory management plan is often presented to the primary care physician (PCP).

Assessment

At each visit in the pulmonary clinic the RTDP patient’s pulmonary function and respiratory care program is evaluated. Several diagnostic assessment tools that do not require patient cooperation are used to determine pulmonary function in those unable to perform spirometry. Resting tidal volume, end-tidal CO₂, and capillary blood gas values are routinely assessed. Sputum cultures are often performed to identify colonizing bacteria in the lungs. There are several methods of airway clearance that are used as part of the respiratory care program. Manual chest physical therapy (CPT), high frequency chest wall oscillation devices (such as The Vest), intrapulmonary percussive ventilation (IPV) and mechanical insufflation/exsufflation (Cough Assist) are the most commonly used methods. Technique, frequency, and efficacy of airway clearance methods are reviewed. Respiratory medications are also included in the management plan. The type, amount, and method of delivery of all inhaled medications are assessed during the pulmonary clinic visit. The most commonly used respiratory medications and their indications are listed (Table 1). If the patient requires ventilator support this is also assessed during the pulmonary clinic visit. The type of ventilator or BiPAP, ventilation settings, patient interface, patient synchrony and adherence are evaluated. All of this information is sent to the primary care physician in the pulmonologist’s clinic report. If the PCP does not have a current report, it can always be obtained from the pulmonary office.

The first step in managing an acute respiratory illness is performing the normal assessment of the child. When obtaining the medical history, ensure that the current respiratory management plan and secretion descriptions are available. If the patient has had any change in secretions, a sputum culture should be obtained. If it is not possible to perform a sputum culture at the time of the child’s visit, the most recent culture information can be obtained from the pulmonary office. If the child presents with fever or history of fever the etiology of the fever should be investigated and treated. Information should be obtained regarding any underlying diagnoses that could be contributing to the current illness. GE reflux, dysphagia, and seizure activity can all increase secretions if not well controlled. If a chest x-ray is indicated previous films are available for comparison from the pulmonary office if needed. RTDP patients will usually have a chest x-ray performed at least once a year at ACH.

Patients using metered dose inhalers should always be instructed to use a spacer to reduce side effects and increase drug efficacy.

Treatment

The first step in treatment for the RTDP patient is optimizing airway clearance. Airway clearance is routinely performed twice daily to maintain stability for these patients. If the patient has an acute respiratory illness the frequency of these treatments should be increased; up to four times daily if necessary. If a bronchodilator is used prior to airway clearance it can also be increased up to four times daily. In addition to increasing the frequency of treatments, medication adjustments may need to be made to optimize airway clearance. A child with an increase in the amount of secretions may benefit from the addition of Atrovent (see Table 1). On the other hand, a patient with thick secretions that are difficult to clear may benefit from the addition of a mucolytic to the management plan. Patients using metered dose inhalers should always be instructed to use a spacer to reduce side effects and increase drug efficacy. Patients using nebulized medications should always use a mouthpiece, aerosol mask, or trach mask. “Blow-by” is not an effective delivery method of a nebulized medication. Optimizing airway clearance may be the only treatment necessary for some acute respiratory illnesses. In the cases where airway clearance has been increased and the patient is not improving antibiotics are the next step. Antibiotic selection should be based on sputum culture data when possible. Remember that the RTDP may have culture data history if needed. In addition to oral antibiotics, some inhaled antibiotics are available for these patients. Inhaled antibiotics can be used in conjunction with oral antibiotics. The decision to use oral versus inhaled antibiotics is not one easily made. And, selected patients may already be on intermittent aerosolized antibiotics. Information from the caregiver is an excellent source of information for this decision. They will know what has been effective in the past, as well as any...
insurance requirements or financial barriers. Patients that require mechanical ventilation or oxygen therapy may need to have these adjusted to provide more support during an acute respiratory illness. This decision should be discussed with the child’s pulmonologist.

Summary
The pulmonary service at ACH is available 24 hours a day for the primary care physician who has the potential to be an important member of the team caring for these children. Initial evaluation and management utilizing the concepts presented in this article may allow the acute illness to be handled at home without the need for referral to ACH. When that is accomplished, not only does the child benefit but the entire family benefits by not having the total disruption that occurs with emergent trips to ACH and especially when hospitalization ensues. In this way the primary care physician provides a very important service not only to the sick child but also to the entire family unit. Thus the role of the primary care physician takes on special significance in the overall management of the patient.

Denise Willis is a respiratory therapist at ACH who is the clinical coordinator of the RTDP. John Carroll is Professor and Chief of the Pulmonary Medicine Division, Department of Pediatrics, UAMS and the medical director of the RTDP at ACH.

Farrah Jones is a respiratory therapist at ACH who works with RTDP patients in the pulmonary clinic. Presently 50 percent of her time at ACH is devoted to research, working with Dr. Warren, involving RTDP patients.

Robert Warren is an adjunct clinical professor in the Pulmonary Medicine Division, Department of Pediatrics, UAMS. He presently holds an honorary emeritus staff position at ACH.

### TABLE 1

<table>
<thead>
<tr>
<th>BRONCHODILATORS</th>
<th>CORTICOSTEROIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albuterol</strong></td>
<td><strong>Fluticasone Propionate</strong></td>
</tr>
<tr>
<td>Trade name: Proventil, Ventolin, Proair</td>
<td>Trade name: Flovent</td>
</tr>
<tr>
<td>Strength: 90 mcg / metered inhalation, 5 mg / ml solution for nebulization</td>
<td>Strength: 44 mcg, 120 mcg, or 220 mcg / inhalation</td>
</tr>
<tr>
<td>Dosage: MDI 2 puffs QID, Nebulized 0.03 ml/kg QID</td>
<td>Dosage: 2 puffs BID</td>
</tr>
<tr>
<td>Indication: Relief of bronchospasm</td>
<td>Indication: Relief of airway inflammation</td>
</tr>
<tr>
<td><strong>Levalbuterol</strong></td>
<td><strong>Budesonide</strong></td>
</tr>
<tr>
<td>Trade name: Xopenex</td>
<td>Trade name: Pulmicort</td>
</tr>
<tr>
<td>Strength: 45 mcg / metered inhalation, 0.31 mg, 0.63mg or 1.25 mg / 3.0 ml solution</td>
<td>Strength: 0.25 mg / 2.0 mL, 0.5 mg / 2.0 mL</td>
</tr>
<tr>
<td>Dosage: MDI 2 puffs every 4-6 hours, Nebulized 0.31, 0.63, or 1.25 mg every 6 hours</td>
<td>Dosage: 0.25 mg to 0.5 mg BID</td>
</tr>
<tr>
<td>Indication: Relief of bronchospasm</td>
<td>Indication: Relief of airway inflammation</td>
</tr>
<tr>
<td><strong>Ipratropium Bromide</strong></td>
<td><strong>Beclomethasone Dipropionate</strong></td>
</tr>
<tr>
<td>Trade name: Atrovent</td>
<td>Trade name: QVAR</td>
</tr>
<tr>
<td>Strength: 18mcg / metered inhalation, 500 mcg / vial</td>
<td>Strength: 40 mcg, 80 mcg / inhalation</td>
</tr>
<tr>
<td>Dosage: MDI 2 puffs QID, Nebulized 125 to 500 mcg 3 to 4 times daily</td>
<td>Dosage: 80 mcg to 160 mcg BID</td>
</tr>
<tr>
<td>Indication: Relief of bronchospasm, may decrease or dry secretions</td>
<td>Indication: Relief of airway inflammation</td>
</tr>
</tbody>
</table>

| **Ipratropium Bromide/ Albuterol** | **AEROSOL ANTIBIOTICS** |
| Trade name: Combivent, Duoneb | **Tobramycin** (IV preparation) |
| Strength: 20 mcg ipratropium bromide and 100 mcg albuterol / inhalation, 0.5 mg ipratropium bromide and 3.0 mg albuterol / vial | Strength: 40mg/mL |
| Indications: Relief of bronchospasm, may decrease and/or dry secretions | Dosage: 4ml nebulized BID |
| | Indication: Treatment of airway infection |
| | Duration: 10-14 days up to 30 days in some cases |

<table>
<thead>
<tr>
<th><strong>MUCOLYTICS</strong></th>
<th><strong>Sodium Bicarbonate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N-Acetylcysteine</strong></td>
<td>Strength: 8.4 %</td>
</tr>
<tr>
<td>Trade name: Mucomyst</td>
<td>Dosage: 1 mL in 3 mL of normal saline given up to 4 times a day</td>
</tr>
<tr>
<td>Strength: 10% or 20 % solution</td>
<td>Indications: Relief of bronchospasm, may decrease and/or dry secretions</td>
</tr>
<tr>
<td>Dosage: 1-3 mL TID – QID, ALWAYS given with a bronchodilator</td>
<td></td>
</tr>
</tbody>
</table>
A very pleasant 79-year-old white man was referred to our clinic for a 4-5 week “stinging” rash around his umbilicus that did not improve with topical triamcinolone 0.1% cream applied twice daily. He was healthy and his only medication was metformin for glucose intolerance. Clinically, there appeared a violaceous to erythematous firm plaque that encircled his umbilicus. See photo A. The clinical impression was cutaneous metastasis, consistent with past reports and descriptions of a Sister Mary Joseph Nodule. A 3 mm punch biopsy was performed. Histologic sections were prepared and revealed extensive dermal infiltration by well-formed glands/tubules, many of which contained mucin. The histologic features were most consistent with metastatic adenocarcinoma, and based on the morphology of the tumor glands, an upper gastrointestinal (including pancreatico-biliary) primary was favored. The patient and his primary care physician, PCP, were notified of the clinical and pathologic diagnosis. A further work up by his PCP revealed underlying pancreatic carcinoma. The patient enrolled in hospice and chose not to undergo further treatment. He expired 3 months after diagnosis.

Review

Sister Mary Joseph Dempsey was born Julia Dempsey. She lived from 1856-1939 and was a Franciscan nun as well as the surgical assistant of William J. Mayo at St. Mary’s Hospital in Rochester, Minnesota from 1890 to 1915. While working with Dr. William Mayo, she noticed a correlation between umbilical tumors and advanced intra-abdominal cancers. In 1928, Dr. Mayo presented this information. However, it was not until 1949 that surgeon Sir Hamilton Bailey decided to give credit to Sister Mary Joseph by naming the nodule after her. This nodule typically presents as a firm, painless mass around the umbilicus with varying coloration and usually represents an umbilical metastasis usually from a primary gastrointestinal or gynecological tumor. Ulceration of the overlying skin or discharge from the lesion may also be present. The presentation of SMJ nodules may be confused with umbilical hemias, periumbilical cellulitis, or umbilical abscesses. In addition, benign umbilical tumors, endometriosis, and primary umbilical carcinomas should be considered in the differential diagnosis. Biopsy is needed to make a definitive diagnosis of an SMJ nodule. However, sonography is an inexpensive and efficient method to differentiate a SMJ nodule from cellulitis or an umbilical abscess.
The echogenicity of the tissues as well as the involvement of surrounding tissues can help distinguish between these diagnoses.4

Adenocarcinoma most commonly metastasizes to the umbilicus; specifically, gastric adenocarcinoma in men. Ovarian cancer is frequently seen in women with an SMJ nodule.3,5 These umbilical metastases may be the first and only presentation of an underlying malignancy. In addition, SMJ nodules can indicate recurrence in individuals with a history of an intra-abdominal or pelvic cancer. The frequency of cutaneous metastasis is only 5 to 9% making SMJ nodules an exceedingly rare physical finding.3 There is much debate over the mechanism by which metastasis to the umbilicus occurs. Lymphatics, the venous system, embryologic remnants, or direct extension have all been implicated in the formation of a SMJ nodule.2,3,4,6

Once the diagnosis of a SMJ nodule has been confirmed, the prognosis is poor. These patients have advanced metastatic disease and the average survival time is 10 months. Unfortunately, treatment is mainly supportive. Chemotherapy, radiotherapy, and surgery have not been shown to improve outcomes in these patients.2,3,6

References
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remember...
AMS memberships are considered delinquent March 1. Renew today if you have not already.
Absurdities From the Wrong Side of the Sheets Part 1- Becoming A Patient

Vickie Henderson, MD

After many years of envy when I saw road cyclists, I invested in a bicycle about three years ago. The road bike quickly became my passion. I don’t know if it is the wind in my hair, the social aspect of being able to exercise for hours and still carry on a conversation, or just simply the challenge.

Like most physicians, I am a goal setter. The first year I owned the “green machine,” I set a goal of pedaling 1,000 miles along the undulating hills of Arkansas. Instead, I logged 1,500 miles that year. The second year of riding, I trained for and completed a century. I chose a triathlon for the third year fitness goal. Unfortunately, I didn’t train as much as I had hoped because I was just working too much with a busy obstetrics/gynecology practice. Nevertheless, I completed a sprint triathlon.

This year I wanted to do a multi-day ride, something less grueling and more adventurous. I spent about three months planning the course for myself and my three riding buddies. I made reservations in five different towns along the way, as well as dinner reservations and points of interests. We would ride between 35 and 60 miles each day with no support. That was the adventure part, if the weather was bad, we would ride on to the next destination; if we had a flat, we would change it, and we would carry our own luggage on panniers on our bikes. We packed as lightly as we could: “T-shirt” dresses and sandals for wearing to dinner, swimsuits “just in case,” tools and supplies for the bike, raingear, toothbrushes, and of course tubes of mascara. We would have to wash our clothes each night.

We were in the best physical shapes of our lives. At nearly 50, we did high intensity interval training which resulted in all of us being exceptionally muscular, strong and fit. However, the day before we were scheduled to leave, I found myself on the wrong side of the sheets.

I’ve never been sick, ever. Practicing medicine for twenty years without a sick day, I’ve rarely even had an upper respiratory infection. Suddenly, I am the patient instead of the doctor. I can assure you, it is more fun to be the doctor. Unfortunately, I developed one of those rare diseases, treatable but incurable. One that always shows up on board examinations, but most have probably never actually had a patient diagnosed with it. It’s a weird disease, with variable, fluctuating symptoms. It’s also debilitating.

I clearly knew something was wrong with my body and yet, at the same time, I questioned my own sanity because of the nature of my symptoms. Fortunately, an astute physician recognized my initial symptoms as classic and diagnosed me immediately, which is unusual for my disease. The appropriate laboratory tests were ordered and the diagnosis was confirmed, or so I thought. My disease has two phases and I was in the first.

Everything culminated the day before we were scheduled to leave for the trip. I had been testing my limits because of my own uncertainty regarding my symptoms, or perhaps it was just a form of denial. Besides the progression in my symptomatology, my day started out typically. I got up and left the house early because I had a meeting. After my meeting I had two scheduled cases in the operating room. I was able to complete the first with a little difficulty. I uncharacteristically took the elevator to the lounge for breakfast, where two of my colleagues were eating. Seeing and knowing my struggle, one accompanied me to assist on my second case. I surrendered to my partner before skin closure and ended up sitting against the wall on the OR floor. By the time I was able to go change in the dressing room, I couldn’t open the door. Eventually, I could no longer stand and could hardly breathe, so I slid down the wall and relinquished my role as a doctor and became the patient. However, it was later that I would fully understand and admit that fact. Having an incurable disease is a hard thing to accept. Chronic is not a concept that most people fully understand.

While I was still in the emergency department, one of the women who was scheduled to go on our Katy Trail bike trip came to get all of the reservation information so she could make cancellations. Ever the optimist, I insisted that we could just start a few days late and skip the first stop or two. With no medical training, she was smarter than that. She cancelled all of our dinner reservations and accommodations. One bed and breakfast gave us a rain check instead of a refund, stipulating that we redeem it before the year end. We made that trip to Rocheport on the Katy Trail one Saturday in November. We did everything in the town that was on my agenda, except ride bicycles. My awesome friends treated me like I wasn’t sick, put me in a wheelchair and pushed me down the Katy Trail. Not what we had planned, but we laughed a lot and made great memories. Isn’t that the point anyway?
process under the circumstances. Prior to being hospitalized, I had been told to consider giving up obstetrics and its inherent stress, fatigue, and sleep deprivation. Not that I planned to work forever, but honestly I had never seriously considered retirement. Having delivered about 5,000 babies, I still loved it, even at all hours of the day and night. But, I realized I could not continue the pace I had been maintaining. I planned to stop accepting new obstetric patients, and continue to see the established patients until they were delivered.

I was started on a very high dose of prednisone during this admission and about the fourth day, I will admit that I began to feel its affects. I got a little emotional, especially if I thought about phasing out my obstetric practice. I thought it was realistic to return to work in one week, make adjustments, and then continue practicing gynecology until I was ready to retire. Denial is a powerful thing. It’s also the first stage of grief.

I had one particular patient who was scheduled for a repeat Cesarean section. In many ways she represents my pivotal point. She had been my patient for many years. I was fond of her and she trusted me. She had already had more Cesareans than advisable and was known to have extensive adhesions, in addition to morbid obesity and gestational diabetes. I called her and told her the situation, she absolutely refused to let anyone else do her case. We were both planning for me to return to work soon. Against my advice, but with careful monitoring by my partners, we compromised on waiting one additional week. Surely, we thought, I would be back by then. My partners graciously covered my call and absorbed my appointments.

Finally I went home to rest. Rest is totally foreign to me, but I had no choice. Reality set in pretty quickly, simply because my physical limitations were so severe. Obstetrics and gynecology is a physically demanding specialty. I never understood how necessary strength and health were because I never had anything that couldn’t be overcome by effort. My disease gets worse if I push myself, so I rest. Everyone tells me to rest. I rest, I don’t have a choice. My partners graciously covered my call and absorbed my appointments.

Eventually, one of my partners did the C-section and everything went well. Within a short period of time it was inevitable that I would be unable to work at all. So I officially closed my practice. I had patients due every week, sometimes as many as five or six. I endeavored to call most patients personally. This was surprisingly rewarding. I had the opportunity to express my best wishes for a healthy baby and assure them they were in good hands. That’s a really good thing to do for your patients and your colleagues. Most seemed genuinely concerned about me and my health rather than the inconvenience of having to change doctors during their pregnancies. They said such kind things. The support I got from my patients was truly overwhelming. I had always felt it necessary to maintain some professional boundaries. Now none of that mattered if I wasn’t going to be the doctor any longer. I regret not doing that sooner. Boundaries create barriers, which limit the relationship. What I’ve learned more than anything is that the relationship is the most rewarding aspect.

I thought my identity would be more wrapped up in being Dr. Henderson than what it was. I have discovered there is a lot more to who I am than that. That’s a good thing to know. Before, I never really had time to think about it. I’m often asked if I miss working; so far I don’t. I cannot explain that, but I describe it as turning off a switch. I have a peace about it. I had a very fulfilling career and I am satisfied. I’m not sure if the abruptness made it easier or more difficult. And I will have to admit that I still haven’t cleaned out my office. I’ll try to get to that soon.

Since then, I have been hospitalized and had outpatient procedures and clinic visits in different hospitals and clinics in three states. My experiences on the wrong side of the sheets are meant to be somewhat tongue in cheek, but I think health care providers have a lot to learn from the absurd experiences of our patients. What we as physicians think happens to our patients and what actually happens are frequently very different. My sincere hope is that by sharing my perspective from the other side of the sheets, I can help bridge the misunderstandings that make healthcare suboptimal and even dangerous for our patients. Please don’t take me too seriously though. Whenever your life is turned upside down, it’s best to laugh at the absurdities. Laughter is truly the best medicine.

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**PEOPLE + EVENTS**

**PEOPLE**

**ALEXANDER** - William Lee Steele, MD, passed away December 19, 2015. Dr. Steele’s military service in several grades extended from 1942 to 1949. He graduated from the School of Aviation Medicine. His service included assignments in the Northwest USA, Western Canada and Alaska. He was attached to the 4-7-11 Troop Carrier Squadrons as flight surgeon and served in Air Rescue Operations and crash investigations. He received a commendation for an Alaska assignment and participated in the first jet-assisted takeoff (PBY) at McChord Field Washington. He was a board certified Orthopedic surgeon and a member of the American Academy of Orthopedic Surgeons, as well as a member of the Arkansas Medical Society Fifty Year Club. He is survived by his wife, Gypsy Dona Steele as well as his children Jacqui Lee Lincoln (Ivy), Karen Jane Hart (Bill), Cynthia Ann Moss, John William Steele, and his wife’s daughter Tammy Lynn Seeds (Bob), as well as seven grandchildren and nine great grandchildren.

**DARDANELLE** - Gene Dale Ring, MD, January 16, 2016. Dr. Ring practiced medicine in Dardanelle for 38 years where he co-owned the Dardanelle Family Practice Clinic until his retirement in 2000. Dr. Ring is survived his wife Bonnie, and two daughters, Kelly (Ed) Bulleit and Robin (Rob) as well as five grandchildren. After graduating high school, Dr. Ring joined the US Navy. He served as a medical corpsman during the Korean War, and then was transferred to the Marine Corp. Dr. Ring also served as the Chief of Staff, President of the Yell County Medical Society, and Medical Director for the Dardanelle Nursing Center as well as being a member of the Arkansas Medical Society Fifty Year Club.

**LITTLE ROCK** - Kimberly Grimes Adametz, MD, passed away January 12, 2016. She was born in Columbus, Georgia on May 3, 1962. Dr. Adametz attended North East High School in North Little Rock and went to Hendrix College and UALR for undergraduate. She received her medical degree and went on to complete her Residency in Physical Medicine and Rehabilitation at UAMS. She was Chief Resident and was Board Certified by the American Board of Physical Medicine and Rehabilitation. During her career, she practiced Rehabilitation Medicine at the Baptist Rehabilitation Institute and at UAMS, and worked for the Department of Social Security. She is survived by her two children, Laura and Grant Adametz. She had a genuine love and respect for her patients and was dearly loved by her family and friends. She affected many lives during her time and will be greatly missed.

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**ON PETIT JEAN MOUNTAIN**

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