

THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

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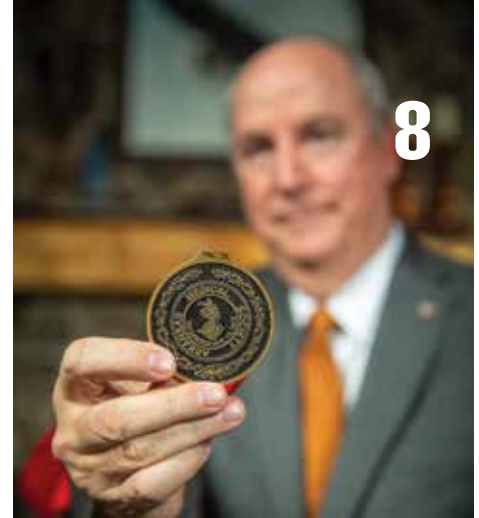
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ON THE COVER

The 142nd Annual Meeting of the Arkansas Medical Society was held the first weekend in May at the DeGray Lake Resort State Park in Bismarck. Members came together for business and a celebration of leadership and service to the betterment of health care in Arkansas.

The event kicked off with the induction of the 2018-19 AMS President, Lee Archer, MD, of Little Rock. An accomplished neurologist and chair of the UAMS Department of Neurology, Dr. Archer is known for his great intelligence, kindness, professionalism, and leadership. Learn more in our cover story, page 8.



by CASEY L. PENN



BY DARRELL OVER, MD, MSC, FAAFP **4**

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Winner of the ASAE Excellence in Communications Award

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Will Medical Marijuana Help Reverse the Opioid Crisis?



Darrell Over, MD, MSc, FAAFP
Associate Professor
UAMS (South Central)
Family Medicine Residency

For my colleagues who have been practicing medicine at least 20 years, the path leading to the current opioid crisis

is familiar. With the conceptualization of pain as a “fifth vital sign” by the American Pain Society in 1996 and its endorsement by the Veteran’s Health Administration, pain management achieved *cause célèbre* status. In 1998, the Federation of State Medical Boards assured physicians they would not receive excessive scrutiny for prescribing notable amounts of opioids, and in 2001, the Drug Enforcement Agency announced it would follow a “balanced policy” in evaluating physician prescribing practices. These decisions — coupled with the pronouncement by the Joint Commission on the Accreditation of Healthcare Organizations that pain assessment and treatment of all patients in accredited health care settings was mandatory in order to receive federal health care dollars — created a “perfect storm” wherein physicians were encouraged to aggressively treat pain and indeed were warned that failure to do so could result in sanctions.

Moreover, physicians were reassured by two influential retrospective studies suggesting low risk for opioid addiction when these drugs were used for treatment of pain. In a 1980 one-paragraph letter published in the *New England Journal of Medicine*, Jane Porter and Herschel Jick described narcotic use in nearly 12,000 hospital patients and reported that only four of these patients had become addicted — only one case was considered severe. A 1986 report in the journal *Pain* by Russell Portenoy and Kathleen Foley described 38 patients treated with opioids for chronic non-malignant pain over a number of years and reported “no toxicity ... and management became a problem in only two patients, both with a history of prior drug abuse.” Both of these studies

were cited hundreds of times in the peer-reviewed and non-peer-reviewed literature to support the assertion that chronic opioid therapy for pain had low risk of addiction. This view guided the training of young physicians and other health care providers.

An unfortunate consequence of increased opioid prescribing was an acceleration of opioid-related mortality. In 2016, there were >63,600 drug overdose deaths in the U.S. and the age-adjusted rate of overdose deaths (19.8 per 100,000) was 21% higher than the rate in 2015 (16.3). The rates of drug overdose deaths were highest for persons aged 25-34 years (34.6 per 100,000); 35-44 years (35 per 100,000); and 45-54 years (34.5 per 100,000).¹ Interestingly, a public policy option that may have the unintended (but fortuitous) consequence of mitigating against the devastating effects of the opioid crisis is the legalization of medical cannabis.

Two recently published clinical trials from Israel (where medical cannabis is legal) have reported intriguing findings. One trial assessed the safety and efficacy of cannabis in 2736 patients (mean age 74.5 ± 7.5 years) with pain (66.6%) or cancer (60.8%). At six months, about 94% reported a decrease of pain score from 8 to 4 (10 point scale) and 18% reported either reduction or cessation of opioid use.² Another study reported the safety and efficacy of medical cannabis in 1211 patients (mean age 59 ± 16 years) with differing cancers. At six months, about 96% reported an improvement in their condition, with 36% reporting cessation of opioid use and almost 10% having decreased their dose.³

Two recent studies evaluated the association between medical cannabis laws and opioid prescribing patterns in Medicare Part D populations⁴ and Medicaid enrollees.⁵ Compared to states with no medical cannabis law, access to a medical cannabis dispensary was associated with a decrease in

» Compared to states with no medical cannabis law, access to a medical cannabis dispensary was associated with a decrease in prescribing of 3.742 million daily opioid doses (14.4%) annually in Medicare Part D populations.

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prescribing of 3.742 million daily opioid doses (14.4%) annually in Medicare Part D populations. Among Medicaid enrollees, implementation of state medical cannabis laws or “adult use” cannabis laws were associated with lower opioid prescribing rates, 5.88% and 6.38% respectively.

The use of medical marijuana is not without controversy. While numerous reputable physicians and professional organizations have acknowledged the observed or potential benefits of medical cannabis, questions and concerns still abound. Marijuana remains a Schedule I agent according to the Drug Enforcement Agency and is illegal under federal law. Numerous physicians are concerned that, even if they could prescribe or recommend cannabis for their patients, uncertainty remains about the most effective strength or dose to use, or which route of administration is most effective. Others have expressed concern that medical marijuana may actually serve as a gateway to opioids. Over time cannabinoid receptors proliferate and tolerance can increase. I share these concerns with my colleagues; however, the studies above are encouraging. If medical cannabis will enable us to fight the scourge of opioid abuse, I could become a fan.

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AFMC Welcome Reception & President's Inaugural Gala

Highlights from the 142nd Annual Session



AMS past presidents stand in honor of the office of president and to show their support of this year's inductee, Lee Archer, MD.

This 142nd Annual Meeting of the Arkansas Medical Society brought members to the relaxing DeGray Lake Resort State Park in Bismarck, Ark. Attendees enjoyed the scenery as they gathered for the Arkansas Foundation for Medical Care-sponsored Welcome Reception and President's Inaugural Gala, which featured recognition of sponsors and vendors, an exceptional meal, and entertainment by Glen Ward, an inspirational humorist.

The Society expressed special thanks to this year's contributors and exhibitors (listed, this page). Their participation was invaluable to this year's successful annual session.

After the meal, outgoing AMS President Amy Cahill, MD, invited past AMS presidents in attendance to join her in completing the most important task of the night – that of inducting into office the 2018-19 AMS President, Lee Archer, MD.

Led to the podium by his peers, Dr. Archer accepted the charge and – after a standing ovation – shared his gratefulness on being selected. "It's truly a blessing to have this honor," he said before sharing some of his most valuable blessings with the room. These included the privilege of being a physician in Arkansas and being part of a medical society that works on behalf of physicians.

Dr. Archer is a practicing neurologist and the chairman of the UAMS Department of Neurology. Learn more about him in our presidential profile, page 8. AMS

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by CASEY L. PENN



ROBERT LEE ARCHER, MD

Forty years ago, Dennis Yelvington, Joe Cloud, and I started medical school,” said Lee Archer, MD, the newest holder of the gavel as your 2018-19 AMS President. “It’s been quite a journey.”

Dr. Archer’s ongoing journey as a physician began in the early 1980s. After attending the University of Arkansas at Fayetteville on a track scholarship, the science-minded young man graduated with a Bachelor of Science in Natural Sciences and entered UAMS Medical School (1978). “I liked the idea of combining my love and respect for science with personal interactions with people,” recalled Dr. Archer on choosing the

field of medicine. “Every time I see patients, I am drawing on the scientific aspects of their problems and the humanistic aspects of how I will shape a treatment plan to fit their situation.”

AMS President-elect Dennis Yelvington, MD, said of his medical school classmate, “Lee was one of the smartest students in the class. He was friendly and outgoing, and he had a serious side to him that we all appreciated. He’s a very compassionate man. When he was a professor of neurology, my mother was ill, and I chose him for her to see. It was a great experience with his clinic. I have a lot of respect for Dr. Archer.”

Joe Cloud, MD, shared his fond memories, too. “I think I can speak for the class,” he explained of being a first-year medical student.



Dr. Lee Archer of Little Rock, is sworn in as president of the Arkansas Medical Society by immediate past president, Dr. Amy Cahill of Pine Bluff.

“Everybody’s a little nervous. When it came time for election of officers, nobody wanted to step forward. I did and was elected class president. BUT

I [soon] had all I wanted, and Lee Archer became class president after that. He did an excellent job and was instrumental in organizing an end-of-sophomore-year snow ski trip for all of us to Colorado. It was a big undertaking – we rented a bus and one of our classmates drove. It is one of my fondest memories.

“In your junior years, you’re working your separate paths; you’re not as close as during those first two years. But years later, I can say that as a physician, I’ve always had the utmost confidence in Lee Archer. When I was diagnosed with MS, he was the first call I made. He proved that diagnosis to be incorrect, by the way. So, he went from being a classmate to being a physician I would confidently refer patients to, and then he became my own physician.”

Athena Davis, practice manager at Davis Neurology in Russellville, is a self-professed testament to Dr. Archer’s kindness and compassion. “My first job in the medical field was in the UAMS Neurology Clinic almost 15 years ago,” shared Davis. “Dr. Archer fostered my career at UAMS. He also helped me through a personal medical issue. He has been a mentor and my doctor, but I am happiest to call him my friend.”

Long before receiving all that admiration, the young Dr. Archer chose his medical specialty based on one of his own role models. He explained, “When I rotated through the Neurology service as an intern in 1983, I was so impressed with the chair of the department, Dennis Lucy, MD, that I decided to be a neurologist. He embodied everything that I wanted in my career. His primary concern was always what was best for each patient, he practiced evidence-based medicine, and he exhibited kindness and generosity to everyone he worked with.”

A practicing neurologist for 32 years and chairman of the UAMS Department of Neurology for the past year, Dr. Archer has been instrumental in making the neurology program at UAMS regionally recognized and one that covers all subspecialties. Sleeves still rolled up, he’ll continue to work toward firsts in Arkansas. “We want UAMS to have the first comprehensive stroke care center in Arkansas,” he elaborated, “and we want to establish the first neurocritical care unit in the state that is staffed by trained neurologists.”

A civic-minded professional, Dr. Archer is involved in numerous medical, community, and religious affiliations. He and his wife are active members of Pulaski Heights United Methodist Church;



Dr. Cahill passing the gavel to new AMS President Lee Archer, MD.

they have led medical mission trips to Honduras and participated in similar trips to Guatemala.

Dr. Archer is greatly regarded for his research and speaking abilities in his field of study. A recognized and awarded authority on multiple sclerosis and other aspects of neurology, he has held the titles of Best Neurologist in Arkansas (2007 and 2010, *Arkansas Times*) and Arkansas Business Health Care Hero (*Arkansas Business*, 2015). His achievements have included numerous medical student awards for teaching as well as the Helen May Compassionate Care Award (2015). The latter is given in honor of the late Helen May, an advocate of patient rights, dignified and respectful patient care, and a safe care experience.

» **“Every time I see patients, I am drawing on the scientific aspects of their problems and the humanistic aspects of how I will shape a treatment plan to fit their situation.”**

– Dr. Robert Lee Archer

As the face of the Society, Dr. Archer wants to promote increased involvement by the physicians of this state – starting on his own home turf. “Medicine is stronger when physicians work together. If someone is not a member, I want them to join. If someone is a member, I want them to participate,” he stressed. “Being a faculty member at UAMS, I plan to recruit more physicians from here. We have been underrepresented as a group ... that makes no sense because, just like those in private practice, we need the help that organized medicine provides. Here in Arkansas, organized medicine – AMS members and staff – has advanced many of the issues that are important to all physicians.

“The biggest issue right now is tort reform,” said Dr. Archer, of the issue that AMS was instrumental in getting on the November ballot for a vote. “I will be actively supporting this as much as I can and will work to help other physicians understand the value of organized medicine.” (AMS is in full support of the Arkansans for Jobs and Justice campaign and its support of Senate Joint Resolution 8, a constitutional amendment referred to the voters by the Arkansas General Assembly.)

HIGHLIGHTS *From The Gala*



Left to right: Bill Archer, Evelyn Deese, Sonya Archer, Susie LaRue, Mike LaRue, Nancy Archer, and Lee Archer, MD.

At the President's Gala that kicked off his tenure as AMS president, Dr. Archer humbly shared with attendees the joy he receives from serving patients, colleagues, and mankind in general. "It's a blessing to be a doctor and to practice medicine, and it's a real blessing to have a society like this that helps us look after medicine in Arkansas," he said. "These guys work hard. David, I'm so proud to have you at the helm leading this Society. It seems flawless the way you guys work. You've represented us so well, won so many battles for us in the Legislature. We thank you for that.

"It's a blessing to be able to work with you all, my colleagues. Today, I was driving here, and my wife saw me smiling. She asked, 'what are you smiling about?' I said 'well, I got in an argument yesterday.' And she said, 'why would an argument make you smile?' I said, 'we were arguing about the best way to treat a patient and

we were both very passionate about why we each knew the right thing to do. It was fun to recognize that we were arguing about the welfare of somebody else."

Reflecting on his career and this profession he shares with fellow members, the new leader counted off a few more of his greatest blessings. "The biggest influence in my career has been my wife of 41 years, Nancy Archer. Her love and support has kept me going through the ups and downs, and I would not have accomplished half of what I have done without her," he said. "I had a great childhood. My siblings and I were raised in a family where our parents encouraged us to do the best we could, to have faith in God, and to treat others with kindness. It was a real blessing to be raised in this family ... most important is the blessings of our heavenly father, from whom all blessings flow. I share that with you, and I thank you for tonight." AMS



Connie Riley with AFMC and Dr. Lee Archer



Dr. Archer presents Dr. Cahill with gifts of appreciation for her service.



Lee Archer, MD

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Increase Screening of Depression and Alcohol Use Disorders

BY CAITLIN FENERTY MOORE,
MPH, CPHQ

Nearly 20 percent of Medicare beneficiaries live with at least one mental health or substance use condition, according to the National Council for Behavioral Health and the Institute of Medicine. However, less than 40 percent of these older adults receive treatment.¹ In the Medicare population, depression has a higher inpatient readmission rate than all other conditions, except heart failure.²

A major concern of the medical community is the prevalence of undetected or misdiagnosed alcohol use disorders (AUD) and depression. As the population of adults over age 65 grows, identification through screening, within primary care practices, is the first step to help improve the lives of Medicare beneficiaries with these conditions.

Alcohol is the most commonly abused substance and can cause serious medical complications.³ AUDs coupled with depression can be even more life-threatening among older adults. These mental conditions often go undetected when physical ailments are being treated.⁴ Older adults are also less likely to seek mental health care because of a stigma about mental health treatment.

A MULTI-STATE APPROACH

The TMF Quality Innovation Network Quality Improvement Organization (QIN-QIO), partnering with AFMC to serve Arkansas, is addressing these concerns through its Behavioral Health project, with a grant awarded by the Centers for Medicare & Medicaid Services (CMS). Community coalitions of primary care clinicians, inpatient psychiatric facilities (IPFs), hospitals, specialists, partners and other stakeholders throughout Arkansas, Missouri, Oklahoma, Puerto Rico and Texas, are working to increase screening for depression and AUDs in primary care settings and reduce the 30-day readmission rate for patients discharged from IPFs. They also want to increase the number of Medicare beneficiaries who have an outpatient visit with a behavioral health provider after an IPF hospitalization.

Since the project began in June 2015, more than 1,000 participating practices have joined the Behavioral Health Learning and Action Network (BHLAN). These providers are working to reach a goal of screening 75 percent of their Medicare patients annually for depression and AUD. Since the beginning of the project participants in Arkansas have screened 77,764 beneficiaries for AUD and 107,866 beneficiaries for depression, through mid-2017, according to CMS' reports.

SHARING BEST PRACTICES

AFMC's quality improvement specialists consistently seek to identify high performers in the behavioral health work. Each quarter that new data is available, the AFMC team completes individual scorecards for each participating practice. The scorecard helps them work effectively with the facilities to review their rates, rate trends and goals. When a team identifies a particularly high-performing practice, they give the practice a chance to participate in a success story to share achievements, tips and best practices for other providers in the BHLAN.

One of Arkansas' high-performing providers is ARcare, with 38 practice sites in Arkansas. ARcare began focusing on improved depression screening by developing standing orders for nurses to perform Patient Health Questionnaire-2 (PHQ-2) and PHQ-9 testing and creating reminder alerts in the electronic health record (EHR). ARcare created monthly scorecards and shared them with all clinical staff. Within four months, screenings increased from less than 5 percent to more than 90 percent. Later, they added AUD screening and a plan for addressing positive screens. ARcare now averages more than 90 percent screening rates for both AUD and depression.

THE ARKANSAS FOUNDATION FOR MEDICAL CARE, INC. (AFMC) WORKS COLLABORATIVELY WITH PROVIDERS, COMMUNITY GROUPS AND OTHER STAKEHOLDERS TO PROMOTE THE QUALITY OF CARE IN ARKANSAS THROUGH EDUCATION AND EVALUATION. FOR MORE INFORMATION ABOUT AFMC QUALITY IMPROVEMENT PROJECTS, CALL 1-877-375-5700. • JULY 2018

AFMC quality improvement specialists work with clinicians to provide individualized technical assistance, including:

- Increase knowledge of screening instruments and billing for alcohol and depression screeners
- Build knowledge around using EHR to capture screenings and incorporate them into work flows
- Identify benefits of and how to use screens
- Discuss required or requested process-improvement tactics

In addition to technical assistance, practices are provided with multiple resources developed over the scope of work. Many of the patient handouts and clinician guidance tools were developed at the request of participating clinicians. Examples of tools developed and adopted by the BHLAN team include: (in English and Spanish)

- Depression Zone and Alcohol Use Disorder Zone tools
- Patient brochures to help self-identify AUD and depression symptoms
- PHQ-9 and AUDIT tools for patients and providers
- Low-literacy patient aids and patient tools

The TMF QIN-QIO hosts quarterly behavioral health webinars. Recent programs have included: motivational interviewing, alcohol misuse screenings and pharmacologic management of depression. Network members have access to a virtual community to discuss and share best practices, promote improvement strategies, and stimulate networking and sustainability.

IMPROVING BEHAVIORAL HEALTH CARE QUALITY

The 2016 quality strategy included an objective to improve quality of

and access to behavioral health care. In support of this objective, the TMF QIN-QIO recruited cohorts of existing providers in Arkansas, Missouri, Oklahoma, Puerto Rico and Texas to work within the Behavioral Health project. They were asked to participate in a Special Innovation Project focusing on treatment of depression and AUD. The project also focused on integrating behavioral health into primary care through Project ECHO (Extension for Community Healthcare Outcomes) and the Mental Health Integration model.

Project ECHO connects specialist teams at an academic hub with primary care clinicians in local rural communities. The TMF QIN-QIO has partnered with the Dell Medical School at The University of Texas at Austin to provide behavioral health subject matter experts. These experts mentor clinicians and give feedback on patient cases. At the core of the initiative are weekly teleECHO clinics where clinicians develop skills needed to treat specific behavioral health conditions.

Practitioners have agreed to make the following changes to their treatment of depression and AUD, based on teleECHO clinic participation:

- Change their treatment method or approach
- Make pharmacological changes
- Use more screenings and/or change how screenings are used
- Implement motivational interviewing

Most participating practitioners have indicated a positive outcome in their practices, based on this grant. The Behavioral Health project will continue to grow through August 2019 to provide informative resources and assistance to providers. The TMF

QIN-QIO plans to present awards to providers in the top percentiles of depression and AUD screening and continue Project ECHO education clinics. Additionally, the TMF QIN-QIO plans to launch radio and video campaigns to increase patient awareness and acceptance of mental health screening.

By joining the network, your organization will receive access to free resources and training to help increase Medicare beneficiaries' screening rates for depression and AUDs. Network resources can also help primary care practices reduce the 30-day re-admission rate and increase follow-up care for patients discharged from IPFs.

To learn more about the benefits of joining or to join, go to <http://www.tmfqin.org> and hover over the Networks tab to access the Behavioral Health page. The Resource Center tab provides access to a wide variety of tools and articles. To learn more about the projects, contact Julie Kettlewell, Arkansas' state program director, at jkettlewell@afmc.org. ▲

Ms. Moore is the project director, TMF Health Quality Institute.

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Harassment in the Workplace

An Educational Session Presented by Kathy White, FACMPE, PHR

In addressing the hot-button issue of harassment in the workplace, Kathy White, FACMPE, PHR stressed the importance of understanding the impact of any form of harassment on employees and employers. She discussed appropriate steps related to the proper investigation of allegations and complaints; the importance of establishing accessible channels for complaints; and the usefulness of a policy that is firmly backed, understood, and practiced by leadership. She shared the diminished value of stale, slightly written policies, and online training and instead recommended face-to-face, example-rich training attended by all levels of management.

Harassment in the workplace is illegal in any form per the Civil Rights Act of 1964. “It isn’t a new problem, even though it’s really moved into the limelight lately with the ‘Me, Too’ movement and many high-profile cases,” said White. “Sexual harassment is a big topic, but harassment can relate to many areas – namely, race, religion, national origin, disability, or other.

“The fact is, more than 33 million people have been victims of some form of workplace harassment,” summed White. “Harassment impacts employee morale, productivity, turnover, and reputation and can often be having an impact well before it comes to light. Harassment becomes unlawful when it becomes a condition of continued employment and/or is severe or pervasive enough to create an intimidating, hostile, or abusive work environment.”



Kathy R. White, FACMPE, PHR

White’s presentation included several examples of harassment – sexual and otherwise – and findings from a 2016 EEOC Task Force Study. “Simply having a couple of paragraphs as your policy for your practice and having initial training or sporadic training for your staff related to behavior issues and harassment in the office is no longer adequate,” said White. “Statistics show that over 80% of true victims of some form of harassment in the workplace never actually talk to anyone about it. The first time you hear about it may be later when they have talked to an attorney or gone straight to the EEOC with it.”

White left listeners with useful in helping organizations improve their clinic’s approach to harassment in the workplace. First, organizations need to refresh their policies and training procedures. Second, they need to rethink using online-only training. “When I do training in medical practice, I seldom see participation by the leadership. And when the leadership is not supporting the core values / mission statement, then you’re going to fall short of objectives,” said White. “Online training was found to be the least effective option. Instead, develop robust training that involves leadership, including accountability to your employees regarding the policies you have in place.”

White shared core principles for employers per the EEOC. In short, a good organization-wide approach to harassment should include:

- 1) Commitment from engaged leadership
- 2) Consistent and demonstrated accountability from management
- 3) Strong and comprehensive harassment policies
- 4) Trusted and accessible complaint procedures
- 5) Regular, interactive learning based on audience

For more on specific, ongoing, or unfolding events within your practice, White recommended that practices have and regularly consult a designated legal team. She also shared three checklists publicized by the EEOC:

Leadership and Accountability

https://www.eeoc.gov/eeoc/task_force/harassment/checklist1.cfm

An Anti-Harassment Policy

https://www.eeoc.gov/eeoc/task_force/harassment/checklist2.cfm

A Harassment Reporting System and Investigations

https://www.eeoc.gov/eeoc/task_force/harassment/checklist3.cfm

Reach White at kathyw@svmic.com. AMS



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Board of Trustees Meeting

An Overview



As is custom, the AMS Board of Trustees met during the annual session. Amid the routine business was a report from Executive Vice President David Wroten that informed members of pertinent topics requiring their interest or action; among them were tort reform, the Arkansas State Medical Board Regulation 2.4 (excessive prescribing), and misleading local press related to cash contributions to Arkansas physicians for prescription drugs.

Tort Reform

As *The Journal* reported in February, tort reform legislation hasn't had the lasting effect for which it was designed. The possibility of change is still alive in the form of Senate Joint Resolution 8 (SJR8), a constitutional amendment referred to the voters by the Arkansas General Assembly. The outcome will depend on the voters of our state. In addition to your vote, AMS needs your voice.

Wroten appealed to the trustees to support tort reform by contributing to the associated Arkansans for Jobs and Justice campaign. "You all have been asking for this for so long," he said. "This is the best chance – the only

chance – you're going to have in your lifetime to pass tort reform in Arkansas. If the election were held today, we would win, but it's not. As far as fundraising for the amendment, we need physicians to take the lead on this. The opposition – the folks who are suing you all – are throwing a lot of money at this."

Wroten credited current supporters that include the Society, The Arkansas Hospital Association, the nursing home and trucking industries, the Arkansas State Chamber of Commerce, Arkansas Farm Bureau, malpractice carriers, and several county societies and specialty groups.

Vocal support followed from the outgoing and incoming presidents. "This legislation has



some teeth, and we have enough people on our side that we have a chance to push this through," said Immediate Past President Amy Cahill, MD. "However, the negative, direct-to-patient propaganda is about to start. We need money to combat it. We are asking you to contribute \$500 or more and to ask your colleagues back home to also contribute."

AMS President Lee Archer, MD, offered support for the measure as well as his willingness to attend society meetings held by physicians around the state to explain his support, "It's key for us to be the leaders. If we're not out there leading, we won't make it. This is so important to help us improve our access."

(Later in the annual session, Wroten shared that another \$27,000 was raised during the meeting. To add your contribution or for more information, visit Arkansans for Jobs and Justice on Facebook or call AMS at 224-8967.)

Regulation 2.4. Excessive Prescribing

Regulation 2.4 is the Arkansas State Medical Board's recently adopted measure on excessive prescribing. "I recently wrote a commentary about this (*The Journal*, June 2018) because there is a lot of misinformation and confusion out there about this issue," Wroten explained as he began to share what he saw and heard at ASMB's meeting related to the topic. "No physicians testified against the regulations, but a room full of patients testified against it. Most were catastrophic health cases. One poor guy came in who could barely walk and had had a run-in head on with an 18-wheeler about 15 years ago. These people were scared to death that they weren't going to be able to get their pain medications that they had been on for all this time. What they're hearing from their physicians back home – what they testified – was 'my physicians said with the medical board regulation, I can no longer write opioid prescriptions.'"

In reality, Regulation 2.4 does not prohibit physicians from prescribing pain medications, Wroten indicated. "What Regulation 2.4. does do is find *excessive* any prescription not medically



Drs. Lee Archer and Joe Stallings

justified in the medical record. If you write too many antibiotics for no reason, that's excessive," he said. "And as Dr. Joe Beck used to say, 'for some patients, one pill is excessive.' It just depends on what it is."

Wroten shared what the regulation says to those who are prescribing narcotics. "The rule discourages writing over 90 MME, but it doesn't prohibit it," he explained. "For those writing more than 50 MME per day for chronic pain, this rule establishes a list of things that must be documented in the medical record. Most are common sense items that you're already documenting anyway."

Finally, Wroten shared that ASMB is working on a rule requiring one hour of CME on prescribing narcotics each year as part of the already required 20 hours (not in addition to).

Misleading Press Relating to Open-Door Contributions

Wroten asked members to share their wishes related to recent press that portrayed physicians in a bad light related to contributions from pharmaceutical companies.

According to a CMS open-door policy, pharmaceutical companies must report all contributions to physicians and other provider groups to a national database. Such information can prove misleading. As a for instance, Wroten used the hypothetical example of a pharmaceutical company sponsoring our event. "If they were to sponsor our event," he supposed, "say they decided to give us \$300. They have no control over our agenda. They are not speakers. Their exhibits are out in the hall, and they're not in the room as we're

➤ "We are asking you to contribute \$500 or more and to ask your colleagues back home to also contribute."

— Dr. Amy Cahill

meeting right now. Still, they must report their contribution to this database, and they must list every physician in attendance here today [rather than the Society as a whole]. That's very misleading.

"From time to time, a story comes out that capitalizes on this. Recently, a misleading story by CNN on opioids – it was a national story on money to physicians from opioid manufacturers; there was some relatively accurate reporting in it, talking about money contributed to physicians for research, clinical trials, etc., but then there were blanket statements that insinuated that doctors were getting cash contributions by the thousands. Shortly after this story, a reporter for the Democrat Gazette – not someone I'm familiar with – suggested that 1500 Arkansas doctors were getting money for opioid prescriptions. In the same way, that was very misleading, and we got a few phone calls about it. A couple of folks wondered if we should write an op-ed piece responding to it."

In asking trustees their thoughts on the matter, the consensus was that a carefully constructed rebuttal was a promising idea. The rebuttal should convey the considerable work Arkansas physicians are doing to address the opioid epidemic and show physicians that their Society is responding to poor press and protecting their interests in this way. Wroten agreed to have the Society work up a rebuttal and request that *The Arkansas Democrat-Gazette* print it.

Other matters discussed included concern by physicians over BCBS compensation initiatives. "We just ran an article in *The Journal* about this, and we're watching for more from BCBS soon," said Wroten. "We can't ignore this. We need to be aware of this and see what we can do to help."

Dr. Scott Ferguson asked trustees also for help and support for his bid as an AMA Board of Trustees member. To help with Ferguson's campaign, reach him at 870-735-5555 or refperg@aol.com. AMS

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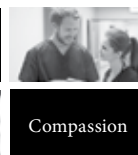
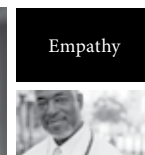
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2018 House of Delegates / AMA Update

This year's House of Delegates business included – among many important topics – discussion of the relevance of the House of Delegates (more on that later).

The meeting began with routine business, which included the election of district trustees, an update from the Board of Directors, a review of the bylaws, and other items of interest. This was followed by remarks from outgoing president Amy Cahill, MD. Throughout her tenure, Dr. Cahill has vocalized her ever-growing appreciation of the AMS and its role on behalf of members. She touched on that again. "It's been an honor to serve as president," she said, "but as many of you know, the president is a title and an avenue to represent the organization in many ways.

"I started with the Medical Society in my first year of practice. I came up through the ranks and – next thing you know – I'm the president. It's not because I'm better than any of you, but because the AMS needed a face. We all need to be our own best advocates. We cannot do what [the Society does] for us – with the AMA alone. From a solo practitioner's position, I have no idea the people to know and the chains to pull to make our voice

heard. Together, we can do [much] – by showing up and by paying our dues for people that are good at that. We hire people to do our IT, our EMRs, etc., because that's what they're good at. Making our voice heard is what the AMS is good at, and we're here to make their job easier."

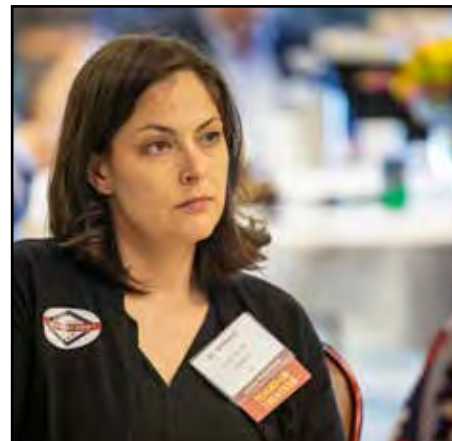
Sharing many fond memories from the past year, Dr. Cahill focused on getting to make a difference shortly after taking the office. "Days after the inaugural dinner last year, we got an email from David; he needed three people to go to D.C. the next week. I decided I could juggle that, and I went along with Steve Magie and Scott Smith. We flew there to meet with senators – the AMA had decided Arkansas was one of three key states to do so – to help keep the Affordable Care Act from being repealed. Before long, we were done [successfully] doing what we needed to do. The measure [to repeal] fell, all because AMS knew what to tell us to do when. So, even when it seems like you're beating your head against a wall, organized medicine does work. We're doing the right thing. Thank you all so much for this honor."

AMA Update Chair of the AMA Board of Trustees Gerald E. Harmon, MD

Scott Ferguson, MD, offered a warm introduction of the day's keynote speaker. "AMA Chair of the Board of Trustees Gerry Harmon is a great advocate for us in our practices ... he has a fishing boat, he's a family medicine doctor, he has worked at the AMA at every level, and he's the highest ranked military person we have at the AMA – he was a major general in the Air Force. He flies planes *still*. Please make welcome Dr. Gerry Harmon."

From his first word, Dr. Harmon engaged members in a pragmatic discussion of the organization's work on their behalf. "One doctor can only affect so many people with one stethoscope," said Dr. Harmon on why he serves in the AMA. "What the AMA is trying to do is get physician leaders involved."

One thing he personally promotes is the AMA's representation of physicians – all of them. It's a matter that comes up often in his travels. Physicians see AMA on his lapel, and they begin a conversation. "They come up to me and say, 'Dr.

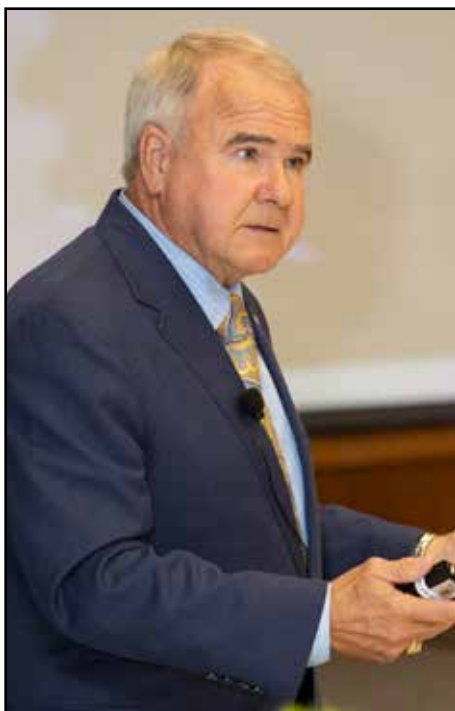


Dr. Gina Drobeno, District Trustee

Harman, I'm not a member of the AMA. I used to be, but they just don't represent me anymore.'

Rather than to challenge them, Dr. Harman listens to those who feel this way and engages them in conversation. He said, "I say, 'Tell me what your practice is like. I practice in South Carolina. I'm in Family Medicine in a group practice. I'm not a solo practitioner, but I've stayed very busy for almost 35 years there. What's *your* practice like?' ... I want to hear how they feel like the AMA's not representative of them. They'll tell me they're in academics, they're in a large group, they're employed, all the things that they're doing, and I'll say you know, listening to what you're telling me, I *do* think the AMA represents you.

"You may not be a member and you may not pay dues, but we represent you. Whether you're a student in training, a resident fellow, a young physician, a mid-career or advanced career ... whether you're retired or in the 50 plus club ... whether you're in academics or in research, whether you're a member of the board certification exam group or in administrative medicine working for an insurance company. We represent your specialty: you could be a dermatologist or a pathologist ... we have 190 different specialty types geographically represented at the AMA. We cover the entire spectrum. We represent you whether you're from Alabama, Massachusetts, California, or Puerto Rico. If you're male or female, we represent you. / represent you. The chairman of the board of the AMA represents you. Now, you may not want to be officially counted, but I think I can show you the value of that proposition."



Dr. Gerald Harmon, AMA



Dr. Harmon updated attendees about what the AMA has been doing on behalf of all physicians and patients. The AMA's work this past year included dialogue that helped prevent mergers that would have affected patient choices, halting bad policies on the part of insurers, reducing the burden of prior authorization in some states, continued prevention of APRNs and PAs from practicing independently from MDs, and improvement in medical records coordination across systems.

"One of us couldn't do it, but the entire AMA could do it," summed Dr. Harmon of the AMA as a difference-making organization. For more information about Dr. Harmon's address or being part of the AMA, contact him at Gerald.harmon@ama-assn.org.

President-Elect Dennis Yelvington, MD

The AMA report was followed by recognition of the 2018-19 president-elect. Accepting his appointment to fill the role, Dennis Yelvington, MD was escorted to the front of the room to speak. After a standing ovation, he said, "I'd like to thank the nominating committee for nominating me, and I humbly accept the challenge."

Addressing those he chose to escort him that day, Dr. Yelvington said, "Dr. Atiq was very influential in helping me become chairman of the board – thank you, Dr. Atiq. Dr. Stallings, for those that don't know, was my residency director 33 years ago. Not only was he my mentor, he was also my friend. If you get him alone and ask him about our duck and pheasant hunts, he's a very poor shot. *(laughs)* I have a lot of respect for the Arkansas Medical Society, and I look forward to this being a year that I learn under the tutelage of Dr. Archer."

House of Delegate Committee Report

Last year, the president and the executive committee appointed a committee to analyze the

relevancy of the House of Delegates. Dr. Atiq chaired the committee that also included Drs. Alan Wilson, Scott Cooper, Steve Magie, and Gene Shelby. The following is from Dr. Atiq's committee report:

"As you all know, the House of Delegates is the policymaking body of the AMS, with the Board of Trustees serving as the fiduciary body responsible for the business affairs in between the meetings. The House of Delegates is comprised of past presidents, members of the Board of Trustees, county and specialty society delegates, and any dues-paying member of the AMS. Despite this broad array of representation, the attendance at the House of Delegates has been declining over time. If you look at the attendance since 2009, attendance has gone from 78 down to 40 today. More importantly, [attendance by] the other delegates – those who are not members of the Board of Trustees or past presidents – has gone from 32 in 2009 to 1 today. This trend has been experienced all around the country. There were 14 societies that have done away with their House of Delegates.



Dr. Dennis Yelvington

"This annual session was designed to give ownership to the owners, and it really hasn't succeeded. You see essentially the same faces over and over and over – and I guess we get tired of each other at times – so the recommendations that we came up with were unanimously agreed to by the committee.

"These three recommendations, if adopted by this House of Delegates, will be submitted to the Bylaws Committee. The Bylaws committee will then come up with the appropriate bylaws to answer questions that we raised. At the next House of Delegates, those bylaws amendments will be debated and voted upon. This is the initiation of the process, not the culmination. What we are going to start today could look very different a year from now. The committee decided that, based on data available to all of you, that we eliminate:

- 1) the House of Delegates and transfer its responsibilities to the Board of Trustees and/or the general membership.
- 2) Transfer the legislative and policymaking authority, bylaws amendments (go to the membership for input), and changes to membership dues (by the same process as for amendments.)
- 3) Transfer the election of the AMA officers and the delegates to the general membership at the same time as we elect the district trustees and to continue using the nominating committee for recommending a slate of officers that would go the membership for vote."

After some discussion, attending members voted to support the recommendations of the committee. These will be sent to the bylaws committee. For more information, contact David Wroten. AMS



Images from the 142nd Annual Session



Dr. Danny Wilkerson



Sharon Theriot, Mandy Holmes, Loretta Duncan, and Randy Meador with SVMIC



Drs. Dennis Yelvington, George Conner, and James DeRossitt



Dr. Scott Ferguson, Rep. Deborah Ferguson, Donna Corrado, and Dr. Joseph Corrado



Dr. Samuel Bledsoe, Kelly Bledsoe, and Scott Smith



Gloria Boone, Justin Villines and guest



Sharon Theriot and Dr. Robert Gullett



Humorist Glen Ward - Speaker

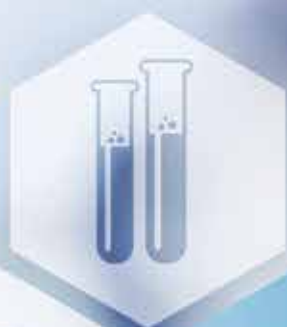


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Cyber Investigations and Training

William “Trey” Whatley, is a Federal Bureau of Investigation special agent and Cyber Action Team member who responds to large-scale cyber crimes and conducts national security investigations. Formerly a computer forensic examiner for the FBI, Whatley has extensive experience with data storage acquisition and recovery.

At the Society’s request, Whatley shared educational information with those in attendance at the 142nd Annual Session of the AMS. “I’m passionate about cyber security,” he said, “I want you to understand how hostile the environment is for medical information.”

To offer perspective about current threats, Whatley shared a comparison attendees may relate to – that of stolen payment card information or other Personally Identifiable Information, or PII. “I doubt there are many people here who have not lost or had stolen a credit card at some time, or your Social Security number, or something like that. I certainly have had that happen,” he said of the commonality of this type of theft. As bad as it is, credit card companies have gotten better at responding – notifying cardholders of shady card usage, reversing bogus charges, etc.

In comparison, what about medical information? “I would submit to you that health care is completely different, right? A credit card can be replaced, but health information is simply *private* or *public*,” said Whatley. “You can’t just change your medical history – your diagnosis, your prescriptions, your blood type, DNA; anything like that is intimately associated with you. When that loss happens, it’s a serious matter. The more that can be put into securing that information, the better that is. I feel like I have the best family physician one could have. But at the end of the day, if that information gets lost, who do you think the patient is going to be most annoyed with at that instance? The physician. Even though he would say, ‘I put the information in,’ that trust you have with your physician is affected.”

Awareness, Responsibility, Tested Backups

After touching on the importance of patients’ information, Whatley offered tips on protecting medical information from man-in-the-middle attacks, insider risk, and lack of preparedness. Physicians and clinic managers need to 1) be aware of where their data is and how it’s being protected; 2) take responsibility and take the steps you hope you’ll never have needed to take; and 3) have secure, tested, hack-free backups in place.

Touching on potentially preventable risks, Whatley warned physicians about open or unsecured Wi-Fi, vulnerable network connections, unvetted employees, and lightweight devices and technology that is easily tampered with. “In your clinics, technology is all around. If there’s a laptop in a room that is accessible by patients or other people – can it be physically removed? Is it encrypted? Is the data encrypted in place?”

You may not be a technology-adept person, but you can still make sure the conversation’s being had with the leadership of your clinic, hospital, or whatever it is so that there’s an understanding of the importance of protecting that information. Are you doing what you can to protect patient data? Further defenses to investigate include:

- » Whitelisting
- » Proper patch management (updates)
- » Reducing attack surface – limit what plugs into your network
- » Building a defendable network – segmenting
- » Managing authentication – frequently changed, complex passwords
- » Securing remote access
- » Monitoring your networking – keeping logs, testing backups

Of that last item, Whatley warned that sometimes breaches aren’t discovered for weeks or years while the criminal is, meanwhile, scouring the victim’s information for weaknesses. For more information, contact Trey Whatley through the Medical Society. AMS

SOMEONE SAID ... CYBERSECURITY QUOTES

“Security is always excessive until it’s not enough,”

– Robbie Sinclair / security officer

“Changing your password is super inconvenient, but if it ends up that someone’s password is DOG, and it’s been that way for 10 years, and it gets picked up in a brute-force attack, then it’s not enough.” – *Trey Whatley*

“Nobody ... is to blame ...”

“The OPM [Office of Personnel Management] breach affected my information 4 June of 15. The director of OPM [**Katherine Archuleta**] said, **‘Nobody at OPM is to blame for this massive data breach.’** Fifteen days later, she resigned. There’s always somebody that’s going to be responsible.” – *Trey Whatley*

“The user’s always going to click on the dancing pigs.”

– Bruce Schneier

“No matter how good or bad attempt it is, if your users/office personnel aren’t careful about what they click on or what they do on the computer, it can affect everything tied into your network. The user is that weakest link in a security paradigm.” – *Trey Whatley*



William “Trey” Whatley



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