

Medical News of ARKANSAS

Your Primary Source for Professional Healthcare News

July 2010 >> \$5



PHYSICIAN SPOTLIGHT
PAGE 7

James Hunt, MD

ON ROUNDS

Creating an Electronic Foundation

Arkansas Foundation for Medical Care to help providers adopt HIT

Unless they want to see reduced Medicare payments, medical practices across Arkansas will be replacing their paper charts with health information technology, and they'll be working with the Arkansas Foundation for Medical Care (AFMC) to make it happen ... **3**



Arkansas Specialty Orthopaedics Moves to Electronic Medical Records

Arkansas Specialty Orthopaedics (ASO) had the NextGen software it needed to adopt an electronic medical records system in 2008, but none of its 20 providers had made the switch from paper charts until this spring ... **4**

ONLINE:
MEDICALNEWS OF ARKANSAS.COM



Improving Asthma Outcomes

New \$2.2 Million NIH Grant Explores How Telemedicine May Help Schoolchildren Control Asthma

By LYNNE JETER



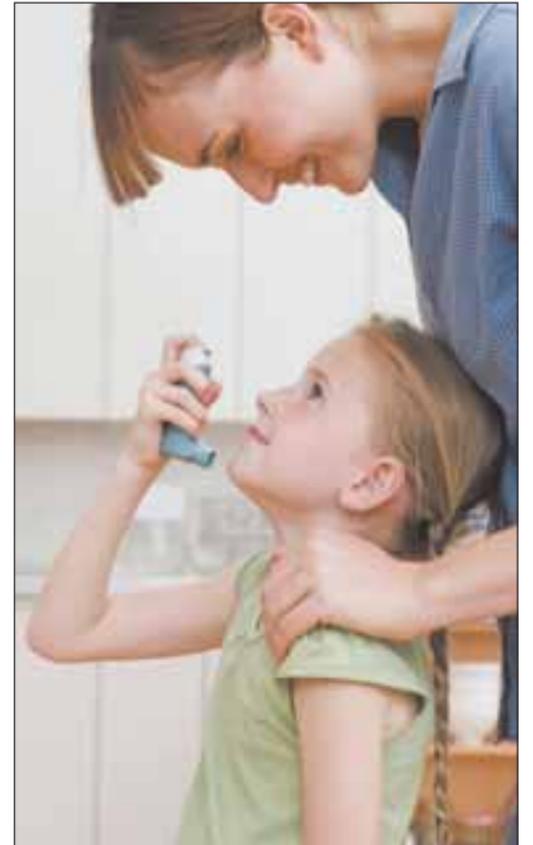
Dr. Tamara Perry

LITTLE ROCK—Investigators at the Arkansas Children's Hospital Research Institute (ACHRI) are embarking on a long-term project to explore whether school-based telemedicine sessions with doctors may help children in rural areas control their asthma, thanks to a 5-year, \$2.2 million grant recently awarded by the National Institutes of Health (NIH).

The most common chronic childhood disease, asthma disproportionately affects minority and low-income children, greatly impacting those families with asthmatic children who live great distances from asthma specialists.

ACHRI investigator Tamara Perry, MD, is leading the Reducing

(CONTINUED ON PAGE 10)

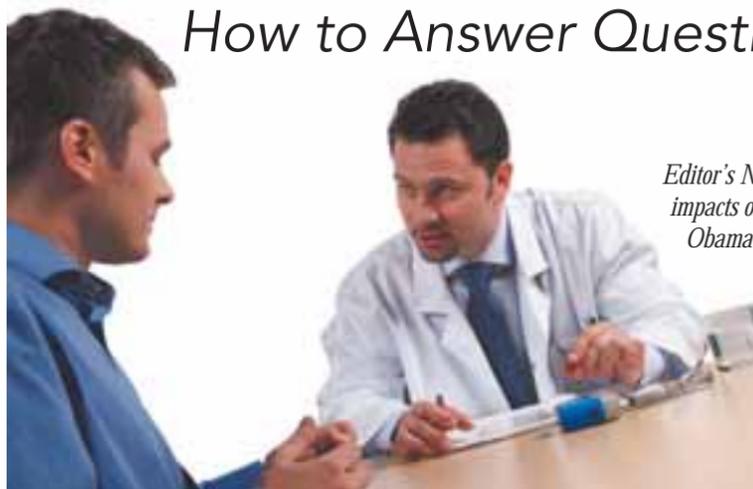


Healthcare Reform Affects Medicare Patients and the Under 65 Set Differently



How to Answer Questions from Your Patients

By SHARON H. FITZGERALD



Editor's Note: This story is the second in a three-part Medical News series examining some impacts of sweeping federal health-reform legislation signed into law in March by President Obama. The series looks at three groups of stakeholders – providers, patients and third-party payers. This month: patients.

If you're a physician, chances are you have already fielded a bevy of questions from patients about healthcare reform. Rest assured, the questions will keep coming. Experts say that doctors need to be up to speed, and fast, about how reform will affect their patients' healthcare and their insurance options in the future.

(CONTINUED ON PAGE 6)

Medicine in Practice >

PREMIER EDITION IN 2010

For more information, contact Rebekah Hardin at 501.580.8903 or email to rhardin@medicalnewssofaransas.com

PRSRRT STD
U.S. POSTAGE
PAID
FRANKLIN, TN
PERMIT NO. 357

PRINTED ON 100% RECYCLED PAPER



Arkansas' Natural Choice



*Frederick J. White, III, M.D.
Cardiologist & Arkansas native
Policyholder since 1988*

*Building Enduring
Partnerships*

LAMMICO

800/452.2120
www.lammico.com

**Ramsey,
Krug, Farre
& Lensing**
*A tradition
of Insurance and
Bonding Excellence*

A Division of
BancorpSouth
Insurance Services, Inc.

“LAMMICO offers local claims handling service throughout Arkansas. When you are insured by them, you own a piece of the company.

“I’ve been aware of LAMMICO since my residency at the University of Arkansas for Medical Sciences. My trust with LAMMICO allows me to focus my attention on what matters the most: the patient.”

CONSENT TO SETTLE | PHYSICIAN ADVOCACY | FINANCIALLY SECURE COMPANY
RISK MANAGEMENT | PERSONALIZED CLAIMS HANDLING | AGGRESSIVE LEGAL DEFENSE

Creating an Electronic Foundation

Arkansas Foundation for Medical Care to help providers adopt HIT

By STEVE BRAWNER

Unless they want to see reduced Medicare payments, medical practices across Arkansas will be replacing their paper charts with health information technology, and they'll be working with the Arkansas Foundation for Medical Care (AFMC) to make it happen.

AFMC will serve as one of 60 regional extension centers across the country after being awarded a two-year, \$7.4 million grant by the Centers for Medicare and Medicaid Services.

The regional extension centers serve both as consultants and authorities. First, they will help providers qualify to meet "meaningful use" requirements in their adoption of health information technology. They also have the authority of certifying which providers meet those requirements.

The term "meaningful use" had not been fully defined as of press time, but the foundation will be working with general practitioners and others who have prescriptive authority to help them choose a workable electronic medical records system that can receive and transmit data and can meet other clinical criteria.

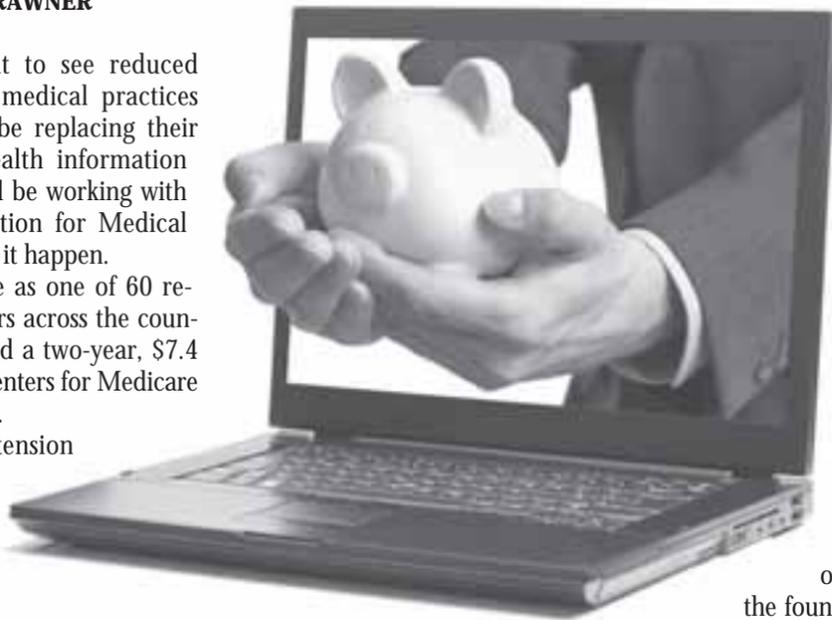
According to AFMC Chief Operating Officer Jonathan Fuchs, AFMC staff members will begin working with doctors' offices in July. About 400 physicians from 120 unique sites have already submitted preliminary applications, which are available at the foundation's website, www.hitarkansas.com.



Jonathan Fuchs

The goal is to move from paper charts to electronic records that instantly can be transmitted to other providers to save costs and improve care – a systemwide digital transition that already has been made by many other sectors of the economy. That means providers across Arkansas will need both appropriate onsite technology as well as broadband internet access capable of transmitting the data. AFMC is responsible for the onsite technology side of the equation.

The federal government is taking both a carrot and stick approach to encourage this transition. The carrot? Providers who achieve meaningful use by December 2011 are eligible for grants under the American Recovery and Reinvestment Act, otherwise known as the government's stimulus package. They can choose to take advantage of either Medicare or Medicaid funding depending on their patient load. Those who choose the Medicaid route are eligible for up to \$63,000 for up to 10 practitioners, for a possible total of \$630,000. Providers that choose the Medicare route are eligible for up to \$44,000 per practitioner, for a total of \$440,000. Providers



that achieve meaningful use during the two-year period after December 2011 will be eligible for smaller grants.

The stick? Providers that have not achieved meaningful use within five years could see reductions in their Medicare reimbursements.

There's another carrot – or stick, depending on how you look at it. The foundation's \$7.4 million grant covers about 90 percent of the cost of operating the program, which will serve a maximum of 1,280 practitioners during the first two-year period. The rest probably will come from fees charged to participating practices. During the following two-year period, which also will serve a maximum of 1,280 practitioners, AFMC expects only to receive \$1 million from the federal government and will have to make up the difference with higher fees for participants. After that, AFMC must be completely self-sustaining.

"The key is, get in now, because if you're at the end of the line, I can't make any guarantees," Fuchs said.

According to Fuchs, the definition of "meaningful use" probably will change during outlying years, which will force providers to change with it to maintain their certification. Providers who achieve meaningful use during the first two years can continue to pay membership fees in order to take advantage of AFMC's consultative services.

Providers do not have to be members to be certified by AFMC as having achieved meaningful use. But Fuchs said the foundation will be providing services that won't be available elsewhere as cheaply, including consultation on safety, security and privacy issues. AFMC will have access to preferred vendors provid-

ing health information technology support and will be able to identify lenders that understand providers' financing needs.

Fuchs pointed out that, apart from the federal government's inducements, there will be other pressures on providers to go digital. Malpractice carriers will begin to charge higher rates to those providers still relying on paper systems. Patients also will demand providers use the technology and will take their business to providers that have it.

Debbi Karwoski, director of AFMC's HIT Arkansas, said the foundation is working on getting the word out about its mission. "One of our biggest goals right now is just to get out there and get some recognition and attention so that these providers can get enrolled early and we can reach them so they have the time to do that," she said. "So right now, we're all about getting noticed, so to speak."

According to Fuchs, the program ideally would serve rural and underserved providers that seemingly would be the last able to adopt this kind of technology. Un-

fortunately, through no fault of their own, many may not yet have the broadband access they will need to qualify as achieving meaningful use. The state of Arkansas has received a grant to expand health information exchanges, while the group Arkansas Connect is working to expand broadband access throughout the state.

AFMC previously has helped more than 200 physicians adopt electronic medical records technology. Fuchs said this transition from long-established office practices can be difficult. The workflow changes, and there are questions of job security for staff members. A few longtime physicians who always have used paper charts will choose to retire rather than change. "The major challenge is acceptance and commitment to doing it because it's too easy to walk away," he said.

But Fuchs said the benefits of moving to electronic technology are well worth the costs. "Once they do change and once they get into it, they find that it really improves their efficiencies," he said. "It eliminates a lot of error as it relates to medication errors. It gives prompts relative to wellness and health improvements. So there are a lot of positives to it. It just requires a great deal of effort and commitment, and our job has been always to make it as painless as possible."



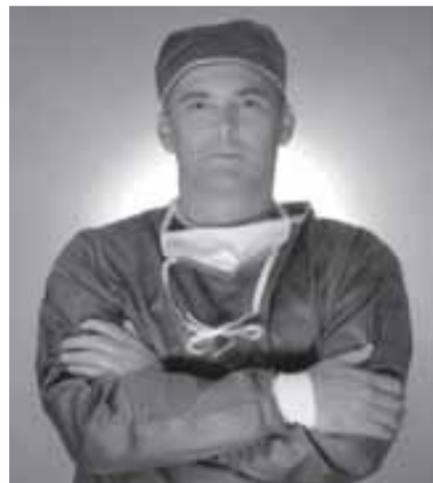
American Physicians Insurance Company

We are API.

Committed to Protecting You and Your Practice.

Having API on your side means you can focus on what is important — your patients.

With more than 30 years of writing medical professional liability insurance policies tailored for practices like yours, API is unrelentingly committed to you and guarding your professional investment.



"We didn't get into the business to run a business; we got into it to take care of people. Choosing a company like API for medical liability makes it easier to do that."

Orthopaedic Surgeon

REPRINTS: Want a reprint of a *Medical News* article to frame? A PDF to enhance your marketing materials? Email subscribe@medicalnewsinc.com for information.

Speak to a member of our team call: **877-API-7007 (877-274-7007)**
e-mail: info@api-c.com

Visit us: www.api-c.com



Going Digital

Arkansas Specialty Orthopaedics Moves to Electronic Medical Records

By STEVE BRAWNER

Arkansas Specialty Orthopaedics (ASO) had the NextGen software it needed to adopt an electronic medical records system in 2008, but none of its 20 providers had made the switch from paper charts until this spring.

That's when Gordon Newbern, MD, an orthopedist who specializes in knee and hip reconstruction, decided to do it.

Newbern went digital without telling ASO Executive Director Jennifer O'Brien or Cara Petrus, electronic health records coordinator. They were surprised to learn what he had done but not surprised that he was the trail-blazer.

"He drives a Prius," explained O'Brien.

While Newbern's switch was somewhat sudden and unexpected, O'Brien and Petrus had been laying the groundwork for a practice-wide transition for quite some time. ASO was using NextGen's practice management software that it had purchased along with the electronic health records system, and they were trying to prod the physicians to take advantage of the medical records capabilities. But it wasn't until a single, typically forward-thinking doctor took the plunge this spring that the momentum began to build. "There are a couple of reasons it took so long," O'Brien said. "I don't know that the organization was really ready. I don't know that the physicians were really ready."

Once Newbern proved it worked and became an ambassador, others were willing to change. Sports physicians



Jeanine Andersson, M.D., who specializes in hand surgery, and the rest of the 20 physicians at Arkansas Specialty Orthopaedics are using a NextGen electronic medical records system instead of paper charts.

next went digital, with the rest of the practice's 20 physicians and 175 staff members quickly following. "We have very competitive physicians here, and so when one does something, they all want to do it," Petrus said.

O'Brien and Petrus at times have had to hold hands and at times have had to give a gentle little push in order to bring everyone on board. One key to success has been understanding personalities – in particular, knowing who was enthusiastic and who was reluctant. In one case, one of each who worked beside each other were a perfect pair because the reluctant adopter could get advice and help from a peer. Meanwhile, Petrus responded immediately once physi-

cians showed interest so they quickly saw the benefits. She is always ready to answer questions and has worked with physicians at all hours of the day and on weekends to help them set up their templates.

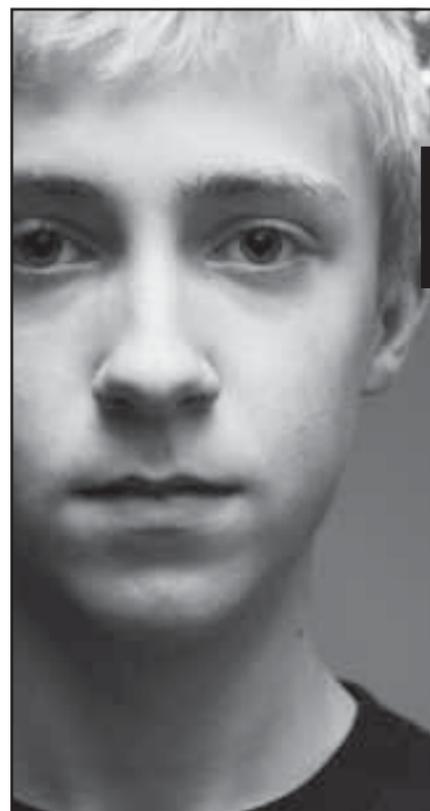
O'Brien and Petrus say the advantages of a digital system already are being realized. It allows physicians to instantly call up a patient's records rather than rely on hard-to-find printed charts and a patient's memory. The practice is adopting a discrete data system with drop-down menus and templates so physicians not only can easily find information about a single patient but also can compare data across patients for research purposes. Later, the NextGen software will be in-

stalled on doctors' iPhones so they'll be able to access information when they are out of the office. Petrus estimates that the practice's records consume the equivalent of about 10 packed two-car garages – storage that costs a lot of money. All of those records eventually will be digitized and destroyed.

Jeanine Andersson, MD, who specializes in hand surgery, said she expects the system to lead to more efficient patient visits and improved care. "It's got pros and cons," she said in between seeing patients. "I think any time you do any new system, it can be quite difficult to get used to a transition. But now, it's much more efficient as far as looking up patient records. Everything's centralized. There aren't charts that get lost. It's quicker to send letters in our dictation to our referring physicians."

Lessons learned? Petrus said she won't implement anything unless she is completely sure it will work. O'Brien said it's best to avoid Band-Aid solutions. One such quick fix seemed to work for a time but then caused more problems. "It means brainstorming what are all the possible ramifications of an implementation, even the smallest implementation, and then figuring out what could possibly go wrong and asking all the follow-up questions of 'If, then, what?' And then being 150 percent sure that it's going to be solid," she said.

Change is never easy, especially in a profession where lives can hang in the balance. But now that everyone in the office has gone digital, O'Brien, who said she has provided practice management consulting for 24 years, doesn't expect anyone to return to paper. "I've worked with a lot of physicians that went to (electronic medical records)," she said. "Every single one of them hated every step of the way, but if you said to them afterwards, 'OK, we're going to take it back now and give you your old paper charts back, they would say, 'Oh, no way.' Nobody wants to go back."



Vista Health Services wants to help you and your child or adolescent with emotional or behavioral problems, and this summer may be the best time to do it.

This Summer Can Affect The Rest Of Your Child's Life

Children and adolescents often need help coping with divorce, a death, depression, anxiety or low self esteem.

We have the confidential, caring environment to provide appropriate treatment for problems that may be affecting families, schools, careers, marriages and relationships.

Vista Health offers:

- Free individualized assessments to determine the right treatment for your child and family.
- In-patient, out-patient, residential or day treatment.
- Multi-disciplined approach under direction of a psychiatrist and including psychologist, nurses, social workers and teachers.
- 24-hour/seven-day a week monitoring in a safe environment.
- Therapeutic Day Treatment summer program
- AR Medicaid accepted

Call today for an assessment:

Fayetteville: 800-545-HOPE (4673) Fort Smith: 866-813-HOPE (4673)
www.vistahealthservices.com



Fayetteville – 4253 Crossover Road, Fayetteville, AR 72703
Fort Smith – 10301 Mayo Drive, Ft. Smith, AR 72903

Comprehensive Behavioral Medicine
& Psychological Services

REPRINTS: Want a reprint of a Medical News article to frame? A PDF to enhance your marketing materials? Email subscribe@medicalnewsinc.com for information.

Arkansas Health Providers Break “Bold New Ground” with Social Networking

By BECKY GILLETTE

LITTLE ROCK—When the Arkansas Children’s Hospital launched its Facebook page in September 2009, initially it had six fans. It took off faster than anyone expected.

“Within 30 day’s time we leapt 15,000 fans and soon thereafter we had 30,000 fans,” said Dan McFadden, communications director, Arkansas Children’s Hospital.

McFadden believes a big reason the site got popular so fast is because of the public health crisis with the H1N1 virus. The site was used to communicate key prevention tips and information to parents.

Unlike a press release in a newspaper, a Facebook site is interactive. Arkansas Children’s Hospital has used the Facebook live chat forum feature to tap into the growing group of people using Facebook. Parents have the ability to ask questions of the experts.

The hospital can post information, but also receive feedback from patients and parents of patients.

“It is a great opportunity for patients to share their incredible stories of hope and inspiration,” McFadden said. “The ones that really tear you up are the parents who have had a loss, but have gained inspiration from the care they got at the Arkansas Children’s Hospital.”



Dan McFadden

Arkansas Children’s Hospital Web Manager Tamia Vayson said social networking such as the Facebook page and Twitter are very inexpensive and effective ways to communicate.

“We post to Facebook and Twitter several times a week,” Vayson said. “It is definitely worth the amount of time it takes. It doesn’t take a lot of time for staff to monitor it several times a day to see what some of the parent’s comments are.”

An example is a post June 1 from Leah Helms: “I just want to say thank you to the whole transplant team in the CVICU unit. Dr. Jake, Ebbble, Saib, Garcia, and all nurses. I miss you guys and you did a wonderful job taking care of my little Pierce while we were there.”

As of June 1, the Arkansas Children’s Hospital had 47,702 fans on Facebook.

The Arkansas Department of Health (ADH) began a Facebook page in April.



Tamia Vayson, Web manager for Arkansas Children’s Hospital (ACH), maintains the ACH Facebook fan page.

Ed Barham, public information officer for ADH, said Facebook and Twitter are exciting new ways to get connected with people who are otherwise pretty hard to get in touch with. The ADH can’t afford to advertise on television, but has an important message to get out.

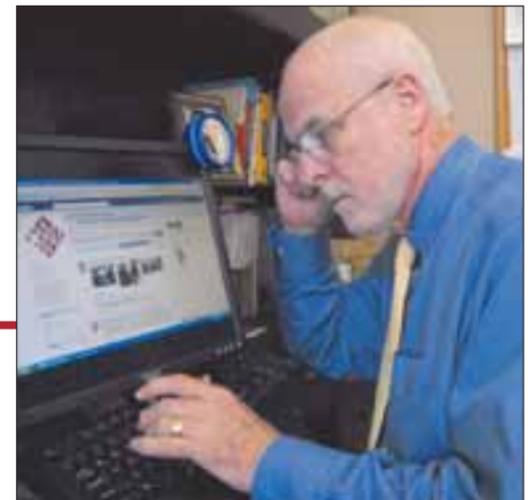
As of June 1 the ADH had 369 fans, and more than 100 friends.

“This is a small start, but as we go along I think we will begin to see a stronger and stronger following as

Ed Barham, public information officer for the Arkansas Department of Health (ADH), says ADH’s new Facebook page is allowing them to break bold new grounds communicating important information to the public at almost no cost.

people who are interested in health related issues will be turning to us for more content and information,” Barham said. “There is a huge amount of information the health department is responsible for, and people can find it by connecting through our new website, www.healthyarkansas.gov or through Facebook. Facebook and Twitter are nice tools that let us stay in touch with people on a more frequent basis at almost no cost to us. It is very much bold new ground for us to break. We’re excited about it.”

Barham said Twitter might be especially useful for communicating information such as swim advisories because of unsafe E. coli levels at state swimming areas after rainfalls.



WONDERING HOW TO MANAGE YOUR WEALTH?



Ralph Broadwater, M.D., CFP®, (left), Mary McCraw, CFP®, Rick Adkins, CEO, CFP®, ChFC, and Kristina Bolhouse, CPA/PFC, CFP®

THE DOCTOR IS IN.

As a medical professional, you understand the rigors and demands of your daily life. So does surgeon, educator and CERTIFIED FINANCIAL PLANNER™ Dr. Ralph Broadwater. Since 1996 he has worked with both established and young physicians to help them achieve their financial and personal goals.

For more than 25 years, Dr. Broadwater has practiced medicine and been a passionate mentor to young physicians. He has gained the respect and confidence of his peers in the medical world as a surgical oncologist who treats patients with complex cancers. In his planning practice Dr. Broadwater identifies the unique needs of physicians with a focus on wealth creation, money management and wealth preservation in retirement.

Dr. Broadwater is one of only four physicians named to *Medical Economics* list of “150 Best Financial Advisers for Doctors.” In fact, the only other Arkansan on the list is his colleague, Arkansas Financial Group CEO Rick Adkins, CFP® and ChFC.

If you are interested in a holistic, fee-based approach to wealth management, please give the Doctor a call today at 501.376.9051. And, Dr. Broadwater makes house calls too.



THE ARKANSAS FINANCIAL GROUP, INC.

1001 NORTH UNIVERSITY, SUITE 200
LITTLE ROCK, ARKANSAS 72217-7757
(501) 376-9051
RALPHB@ARFINANCIAL.COM
WWW.ARFINANCIAL.COM

Healthcare Reform Affects Patients Differently, *continued from page 1*

"For those under age 65 especially, the physician becomes not only the confidant of what's happening in patients' lives with their health, but also the one who is being asked about insurance problems," said J. James Rohack, MD, president of the American Medical Association. That's a role some physicians don't relish, he acknowledged, but the ability of a doctor to talk to patients knowledgeably about reform is an avenue to improve doctor-patient rapport. "There are good things in this legislation that will be helpful to patients," added Rohack, a Texas cardiologist and professor at Texas A&M Health Science Center College of Medicine.

Effects on Medicare Patients

How reform affects patients depends in large measure on their age – 65 and older or 64 and younger. For patients on Medicare, Rohack said the main question is, "Doc, will I still be able to see you?" And that's one of the toughest questions to answer because the reform legislation failed to address the Medicare physician-payment formula. "The conversations across the country are very honest, and some physicians are answering, 'I'm not

sure I can see you,' " Rohack said. "If I get a bill from the utility company and I pay them 20 percent less than the bill is, they're going to turn off the lights. But the expectation of Congress is that our ethics as physicians will always save the day. We will do what we can, but at some point, doing what's right still doesn't pay the bills, and one has to make some pretty difficult decisions." Congress recessed for the Memorial Day holiday without delaying a 21 percent Medicare physician payment cut.

Otherwise, Jordan McNerney, AARP's media relations manager for health issues, said the new law makes no cuts to guaranteed Medicare benefits that patients already have. "In fact, there are improvements to those benefits with better preventive services, in that patients won't have to pay a co-pay when they go to the doctor for preventive care," he explained, suggesting the physicians should be well-versed in the new preventive care benefits.

Patients on Medicare Advantage plans could see some shifts. "You won't see any of the plans drop below what everyone gets in Medicare benefits, but you may see some changes," McNerney

said. Reform means that the federal government will bring payments to Advantage plans back in line with traditional Medicare costs, and plans may therefore adjust premiums and benefits offered. Yet, Medicare will be paying bonuses to plans that meet certain quality measures, so Advantage plans have opportunities to make up potentially decreased payments.

Another important benefit, McNerney noted, is the eventual closing of the "doughnut hole" in the Medicare drug benefit. Starting this year, Medicare begins closing that gap between when initial coverage ceases and when a senior spends enough out of pocket to qualify for catastrophic coverage. "Anybody who falls into it (the doughnut hole) this year gets a \$250 rebate check just as a little bit of a down payment," he said. In fact, those checks were already appearing in Medicare patients' mailboxes before the June 15 deadline.

McNerney said another benefit of reform legislation – and one that hasn't garnered much media attention – is the first-ever national long-term care insurance plan, called Community Living Assistance Services and Supports. Financed through payroll deductions, the voluntary long-term care plan would be managed by the U.S. Department of Health and Human Services. Once someone has paid into the system for five years, he or she is vested in the program and can collect benefits when needed. "This will pay a cash benefit for a caregiver, a nursing home or assisted-living care," McNerney explained. Enrollment should start early next year, he added.

Patients under 65

For patients not yet eligible for Medicare, Rohack said the advice he's giving is "hang on." Rohack discussed one of his patients, a man in his 50s who Rohack had been treating for a decade. Self-employed, the patient bought his own insurance – and the premium recently jumped up nearly 50 percent. "I told him to hang on 'til 2014, because that's when state-based health insurance exchanges will be up and coming," he said. These exchanges will create insurance pools that will allow people to choose among affordable coverage options. All insurance companies in the exchange must provide a minimum benefit package and additional coverage options beyond a basic plan. Here's other good news regarding coverage:

- Beginning this year, an insurer can no longer drop a patient if the patient gets sick.

- Beginning this year, children 18 and younger can't be denied private insurance coverage if they have a pre-existing condition.

- Beginning this year, young adults up to age 26 can remain as a dependent on their parents' private plan. Several insurance companies already are offering this service.

- Beginning this year, health insurance benefits can't run out anymore because of a long or expensive illness.

- Medicaid coverage will be expanded in 2014 to all eligible children, pregnant women, parents and childless adults under age 65 who have incomes at or below 133 percent of the federal poverty level.

- In 2014, U.S. citizens and legal residents can't be denied private health-insurance coverage for any reason.

Federal subsidies through tax credits or vouchers will be provided in 2014 to people who can't afford the full cost of coverage.

Yes, patients will be required to have some sort of health insurance coverage in 2014, and Rohack said that's a top concern in many patients' minds. When they ask, he first assures patients that there's federal aid available and then he explains, "The bottom-line message is, for you whose employer has decided not to provide health-insurance coverage, you now have the ability to get it through a pooling of everyone like yourself into a massive pool that never existed before."

This year, a high-risk insurance pool kicks in for uninsurable individuals who can't obtain insurance on the open market because of a pre-existing condition. To help subsidize the premiums and set up the pools for the participating states, the reform law allocates \$5 billion. "Some states aren't going to do it, and others are saying thank goodness for the help," Rohack said. "If your state isn't participating, I think that's an important question to ask the elected leaders."

In closing, Rohack recommended leaving patients with this one assurance: "The law does not create a mechanism where a federal bureaucrat will interfere with what a physician believes the patient needs to get."



Call today to insert
your sales fliers
into next month's
Medical News!

Rebekah Hardin > 501.580.8903

You provide the images. We provide the answers.



SRP
SPECIALIZED
RADIOLOGY
PARTNERS

- Board certified, fellowship-trained radiologists
- Rapid, high quality subspecialty radiology interpretations/reports
- CT, MR, ultrasound and x-ray image archiving/storage
- HIPAA compliant electronic transmission of images and reports

www.radiology-partners.com
901-473-6404

SRP is a division of
Mid-South Imaging & Therapeutics, P.A.

James E. Hunt, MD

Anesthesiologist, ACH Division of Pediatric Anesthesiology and Pain Medicine, ACH Burn Center; Assistant Professor, UAMS Department of Anesthesiology.

By LYNNE JETER

When James Hunt was growing up, he never thought about a medical career, much less specializing in anesthesiology for burn patients.

"No one in my family was medical," said Hunt. "No one in my family ever had a college degree. My family was, is, poor—not dirt poor, but trailer-livin' blue-collar poor—the kind of poor that takes pride in hunting and fishing skills, and sometimes measures wealth by the number and bloodlines of the dogs under the porch."

Hunt is the oldest of four boys—one birth brother and two stepbrothers—separated in age by a total of four years and together as a family since preschool. "My stepmother liked to brag to strangers that 'her boys were the best behaved in the churchyard,' but every other mother in the area knew different," he said. "The truth was that we were as loud and scrappy as beagle puppies—all clumsy, dirty, and hungry."

Hunt started working as a phlebotomist at Baptist Medical Center in Little Rock while still in high school, "not because I was interested in a medical profession," he explained, "but because I was interested in having a car, cash, and girlfriends."

After taking some college, Hunt enrolled in the Baptist Health School of Nursing, "again, not because of interest in medicine, but because of interest in better cars and more expensive girlfriends," he explained. "About that same time, divine Providence introduced me to two women: one, Dianna Wilson, who encouraged and shepherded me through RN school; the other, DeAnn Marchi, who encouraged and shepherded me into marriage."

While studying nursing, Hunt first glimpsed the possibilities of a profession in healthcare.



DeAnn, their son Al and Dr. Hunt

PHOTO: C. WAYNETTE TRAUER

"It was also in nursing school that I discovered my own curiosity about human physiology and pathophysiology," he said. "It would be several years later, after working as an RN, and after finishing my BSN, that my wife and I would make the decision to enter medical school. My experience as a critical care RN (at Baptist Medical Center in Little Rock) had already exposed me to the attractions of anesthesiology. Divine Providence again seems to have played a role in my choice of specialty."

Even though Hunt's career path had been determined, the road to practicing medicine remained long. While working full-time, he completed core requisites for the UAMS College of Medicine at the University of Arkansas in Little Rock throughout the mid-1990s. He graduated from medical school in 2003, and completed his residency at the UAMS College of Medicine in 2007.

"During my senior year of medical school, my wife and I were gifted with our first and only child. His name is Al; he has Down syndrome," said Hunt. "His presence has taught us gratitude and responsibility. His arrival introduced us to whole communities of special needs advocates, educators, families, philanthropists,

and volunteers. His life leads us to community involvement and service. DeAnn and I both volunteer service to Easter Seals Arkansas. I currently serve on Easter Seals Arkansas' Board of Directors, as well as serving on the Arkansas Governor's Commission for People with Disabilities.

Additionally, as an Assistant Professor of Anesthesiology for the University of Arkansas for Medical Sciences (UAMS), I've been allowed the unique opportunity to participate in building a medical home for genetics patients in Arkansas. Currently, I coordinate and provide anesthesia services to those UAMS Genetics Clinic patients unable to tolerate diagnostic exams without sedation, as well as those needing surgical interventions."

Hunt thoroughly enjoys both jobs—working in the Burn Center and with the Genetics Clinic.

"I can't imagine doing something else, which is an odd sensation for me, as I never intended to pursue medicine," he said. "As a young man, I thought I wanted to be an English or history professor in some small liberal arts college somewhere. I also toyed with the possibility of studying law. My father's father told me I'd be lucky to get out of high school. I'm grateful for the Hand of Providence."

Hunt has specific public health goals he'd like to see accomplished in Arkansas during his lifetime. At the top of the list is an expanded Burn Center, with more dedicated space to accommodate adults and children in Arkansas who need those services—including reconstructive plas-

tics. "We need money and staff to conduct more burn-related bench and clinical research," he said.

He'd like to see a medical genetics home established for Arkansans with special needs, a place in which those patients can find primary and specialty services—whether medical, surgical, or therapeutic—and follow-up care across their lifespan. "Part of that model should include anesthesia services, perhaps even an anesthesia subspecialty service," he said.

Hunt would also like to see more comprehensive transition and adult services for Arkansans with special needs. "We need ongoing adult education, socialization, and therapy services so that our loved ones can function in the community at their highest possible level of independence," he explained. "Secondary and vocational education opportunities should be available to every person with special needs, regardless of age."

Hunt admits he has little spare time. "My son has recently taken up playing Miracle League baseball, and he's hounding me lately about going fishing; my spare time is often his time," he said. "My father-in-law and I do like to canoe and hike the rivers and mountains of north Arkansas. Sometimes we head out to the Rockies or the Trinity Alps; we even went to Peru and the Galapagos last year. Of course, finding time for date nights with my wife is always desirable. I'm carrying around my golf clubs in the Jeep, but that's about as close as I seem to get to the golf course."

Hunt's dad, a brother and his family, and "Granny Darla" live nearby; his in-laws reside in northwest Arkansas. Hunt remains the only family member with a college degree.

With his life virtually an open book, if folks are surprised to learn anything about Hunt, it's usually "that my (deep baritone) voice doesn't quite match my appearance; that's about all I have to say about that," he joked.

This page sponsored by

Riverside
BANK

Member FDIC

Little Rock • Chester @ Markham • 501-614-6161 • myhomeloanbank.com

Focus on Efficiency

Bladder Health Network Handles Continence Lab Testing

By LYNNE JETER

A pelvic health solution that helps women's health specialists tap into pelvic health therapies with their practice via a flexible combination of software tools, efficient services, and high-tech products has been making headway in Arkansas.

With multiple partner clinics located in Helena, Batesville, Little Rock, Con-

way and El Dorado, Bladder Health Network (BHN) has a strong and growing presence in Arkansas. Four interpretation providers are available to each partner clinic.

"Our goal is simple. BHN wants to improve pelvic health care in Ar-



John Spivey

kansas and across the country. Every day, we strive to this end, and develop creative solutions to get us there," said John Spivey, president and CEO of BHN.

Bob Harris, MD, a board-certified urogynecologist in Jackson, Miss., came up with the idea for BHN in 2002. He collaborated with John Spivey, an entrepreneur, IT guru and fellow Mississippian who had launched several successful startups.

"I quickly fell in love with the business concept and with healthcare services in general," said Spivey. "Bob's expertise on coding and business drivers within medical practices was great fuel for my business development engine."

The first challenge was to find ways to make BHN work successfully in today's healthcare landscape, Spivey said.

"To grow the business, we started in our own backyard, getting more than 75 percent of the OB/GYN offices in Mississippi to participate in BHN in the first two years," he said. "From there, we began to slowly expand across the southeast into neighboring states. Pretty soon, we had a proven business model that was only missing one key component—a national sales partner who could position and sell BHN across the country."

Because BHN is dependent on "sales clustering"—selling the solution to multiple groups in generally concise geographical areas—assistance was needed to market the network outside the southeastern United States.

"You have to have local nursing talent and basic economies of scale for the service model to work," explained Spivey. "This challenge has been with us from the beginning, but grows more and more as we expand across the country."

Last year, BHN secured a national co-marketing agreement with Boston Scientific Corporation (NYSE: BSX), allowing BSC sales representatives the exclusive right to sell the BHN solution in their respective markets across the country. In 2009, BSC tripled the size of BHN, which now contracts with roughly 140 clinics in 26 states.

Robert Wood, MD, a urogynecologist from Mobile, Ala., had been handling continence lab testing for six doctors, including his own cases, in a busy OB/GYN practice when he discovered BHN.

BHN, he learned, sends certified urodynamic technicians to perform studies in the clinic, using the most updated equipment and supplies available for urodynamic evaluations. The service partners with board-certified, fellowship-trained specialists in female continence care to provide professional interpretations on every study performed. Getting started required signing a simple 2-page agreement; there was no upfront cost. Testing could begin within 45 to 90 days.

"The testing started to eat up a good bit of my time in the office," admitted Wood, "yet I was skeptical because testing is very patient-dynamic, and I was hesitant to give up physically doing the testing myself. I was concerned that it might impact my ability to do surgery. Not so."

Once Woods' concerns were allayed,

(CONTINUED ON PAGE 10)



Dr. Bob Harris

HIT Arkansas

Health Information Technology Regional Extension Center

www.hitarkansas.com

You may be eligible for bonus payments

Arkansas now has a Health Information Technology Regional Extension Center, set up to offer technical assistance, guidance and information on best practices to help health care providers achieve meaningful use of certified EHR technology. You and your practice may be eligible for incentive payments or reimbursements of \$44,000 to \$63,750 from the federal government's stimulus program to offset the costs of launching an EHR system.

As the state's designated HITREC, the Arkansas Foundation for Medical Care will provide:

- On-site technical assistance with EHR adoption
- Education on selection, implementation and use of an EHR system
- Group purchasing of EHR systems and technical support to leverage volume discounts
- End-to-end project management support of EHR implementation
- Access to current information regarding meaningful use and best practices from around the country through the National Learning Consortium
- Support for practice and workflow redesign to achieve meaningful use of EHR system

Go to www.hitarkansas.com
to find out more!



This material was prepared by HITArkansas, a division of the Arkansas Foundation for Medical Care, in collaboration with the University of Arkansas for Medical Sciences. AFMC is a cooperative partner of the Office of the National Coordinator (ONC).

E-Mail Etiquette

By JENNIFER O'BRIEN

Recently I had a conversation with another practice administrator in Little Rock about the Physician Ownership Disclosure statement we had drafted. When I offered to e-mail her a copy, she said, "Oh, we don't have e-mail at our practice, can you fax it?" No e-mail? On a 75-email day I might wish I didn't have e-mail for an instant or two but over all it is efficient, environmentally friendly, and effective – if used properly.

Unlike the practice mentioned above, most of us depend on e-mail so much we can't imagine life without it. We receive 50 – 100 e-mails a day at work and still find time to check our personal e-mail to communicate with friends and family. We are able to keep in touch and communicate with people professionally and personally as we never have been before. It's true, e-mail is an alternative to the telephone, letters, even face-to-face conversations but it is not a *replacement* for them. Email has unique realities. Careers have been damaged and relationships destroyed because of the failure to recognize the unique attributes of e-mail.

We use email as though it is the most comprehensive communication tool available to us; but for true, complete communication, it is quite limited. Research has shown that 55 percent of interpersonal communication is body language, 38 percent is voice tone and only 7 percent is the words. All e-mail has is words. E-mail is completely devoid of body language or voice tone yet we often use it – perhaps fall back on it – to convey sensitive information and feedback or informal banter. Here are some tips for using e-mail appropriately and effectively.

Determine if e-mail is really the best mode of communication for what you have to say. E-mail is for convenience – both the sender's and the receiver's – and is considerably less personal. E-mail is great for basic interactions like setting meeting times, asking/answering straightforward, fact-based questions and positive communications like "Thank you" or "Well done!" Interestingly we often inappropriately default to e-mail to address a seemingly minor issue and regret it later because to the recipient the issue wasn't so minor after all. As well, we have probably all wished we could just, or made the mistake of sending an e-mail to address a large, difficult matter rather bolstering ourselves for a face-to-face conversation.

Do not use e-mail to avoid in-person interaction. I know a number of people who, when faced with addressing an issue with someone in their professional or personal life will write out all of their thoughts and feelings in an e-mail and hit send. While writing out our thoughts and feelings can be helpful in confronting a difficult situation, do it in your word processor as preparation for a conversation. If you cannot face having a real time conversation about something, you have no

business writing it in an e-mail.

Pay attention when e-mailing to a group. Know that a visible distribution list is part of the message. In business, it is very helpful and appropriate to know who else is receiving the same message. When e-mailing to more than one person, it is as though you are speaking to all those people gathered in a room (only without the benefit of tone, gestures or expression). People may feel embarrassed if they are singled out in a group e-mail. Even the most factual or benignly intended reference to a possible shortcoming can feel like a huge embarrassment to someone when referenced in a group e-mail.

Use an email editor. Much of your image depends on how you come across in e-mail. Most e-mail programs have automatic edit features that will alert you to misspellings or grammar errors.

Beware the Forward. Sometimes we read the most recent addition to an e-mail thread and pass it along to someone, not realizing that there is sensitive information in one of previous messages on the thread. Also, before forwarding an e-mail consider your intentions in doing so. When you forward an e-mail, the relationship(s) you are affecting become greater in number and more complex.

Check your e-mail box at least once a day. E-mail is the most common communication method; you could miss something important or appear nonresponsive, if you do not check your e-mail



frequently. Your practice should have a policy requiring employees to check their work e-mail once or twice a day to be sure they do not miss timely, important communication.

Use the automated response feature when you will be unable to check e-mail regularly. It automatically sends a message to all senders letting them know you are unable to check e-mail thereby managing the expectations as to your response time.

Be brief, concise and to-the-point without sacrificing kindness and courtesy. An e-mail that continues for several paragraphs, perhaps to the bottom of the screen or beyond, is daunting to the reader and frequently is skimmed rather than thoroughly read.

Do not, however, substitute brevity for clarity. If you are struggling to provide all the necessary details while still being brief, a phone conversation is likely the better communication mode.

Use the Subject:/Re: line effectively. Specificity in the subject line helps the recipient to gauge the urgency of your e-mail and assists in organization for storing and recalling e-mails.

ALL CAPS is the equivalent of SHOUTING and is difficult on the eyes. All lowercase is the equivalent of mumbling.

Highlight questions, action items or important facts by using spacing or italics for visual distinction. Sometimes it is difficult to keep up with all of the e-mails especially at work. Make it easier for recipients to respond to your requests by subtly distinguishing

them. If there is a deadline, politely include it in your message.

Use punctuation properly. It seems obvious, but bears reminding. Do questions end with question marks? And, statements end with periods? Correct punctuation helps the recipient process the information faster and respond appropriately and promptly. Exclamation points, however, often lead to interpretation problems unless they follow positives, "Super Job!" or "Good Luck!"

E-mail is not the mindless communication mode we sometimes use it as. Remember, every e-mail immediately becomes a permanent record. When you put something in e-mail, you have put it in writing. There's no shredding e-mails, they can be retrieved long after they have been deleted.

For governmental and many other institutions, e-mails are a matter of public record. Remember Alberto Gonzalez, former Attorney General, Michael Brown, former FEMA director, and Florida Representative Mark Foley? Their e-mails were the smoking guns of their respective careers. If you work for yourself or a private organization, know that civil litigators consider e-mail a fertile, unending field of discovery because people use it casually, even conversationally, yet it is a permanent record.

Be strong when you read but smart and sensitive when you write.



Jennifer A. O'Brien, MSOD, has been in practice management consulting for 24 years and is currently the Executive Director of Arkansas Specialty Orthopaedics in Little Rock, Arkansas where fellowship trained orthopaedic subspecialists help Arkansas' physicians help their patients. Visit at arspecialty.com. You may contact Jennifer O'Brien at JOBrien@arspecialty.com.

Improving Asthma Outcomes, *continued from page 1*

Asthma Disparities in Arkansas (RADAR) research team that will examine a dozen school districts in rural east Arkansas counties. The team will place video-conferencing systems in six school districts so that recruited students with asthma may have regular education appointments with specialists in Little Rock. The remaining schools will serve as control sites. Researchers believe that schoolchildren participating in the school-based asthma education and monitoring will gain better control over their disease, with fewer episodes of acute breathing problems.

"Children with asthma often live with frequent symptoms, so it becomes the norm for them," said Perry, assistant professor of pediatrics at the University of Arkansas for Medical Sciences (UAMS) College of Medicine. "They don't understand that they shouldn't constantly struggle to breathe. We'll teach them that their asthma can and should be under control."

Beginning next fall, the RADAR study will initiate three consecutive years

of school-based intervention, with each site hosting video-conferencing sessions for a year. Schoolchildren ages 7 to 14 will learn how to recognize initial symptoms of an asthma attack, why it's important to take their medications as prescribed, and ways to reduce their risk of complications. They'll participate in video-conferencing education sessions during non-instruction periods, such as study hall or recess, and be able to speak directly with ACHRI asthma specialists to answer their questions, allowing physicians to track their progress.

The project also calls for parents' involvement by attending courses to learn similar concepts and effective ways to discuss their children's asthma with doctors.

Participating schools will receive video-conferencing technology for the year they are involved; the RADAR team will provide training for the districts' IT professionals and school nurses. Investigators will work collaboratively with students' primary care providers, with ACHRI asthma specialists providing

updates on the level of patients' asthma control and disease management recommendations, based on published national asthma guidelines.

Perry and her team hope the study will reduce the disparities faced by rural children at high risk for asthma. If successful, the RADAR project could become a model for future chronic care telemedicine initiatives in remote communities across the nation.

"We know that being far away from sub-specialty services can be detrimental for children with chronic health problems," Perry said. "It's up to us to find innovative ways to provide the care they desperately need."

The Arkansas Biosciences Institute and UAMS Arkansas Center for Health Disparities funded preliminary studies to support the project. The UAMS Center for Distance Health continues to provide support through training, technological resources and telemedicine session coordination.

3-D Retirement Planning

By RICK ADKINS, CFP®, ChFC, CLU

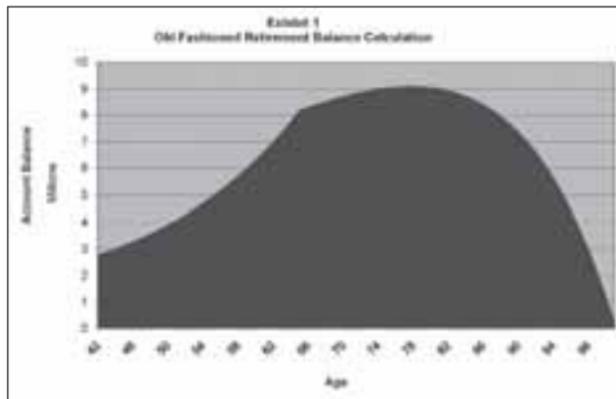
It's funny how time causes our perspective on "reality" to shift. Twenty-five years ago retirement planning was essentially a theoretical exercise. Our firm had few retired clients and most were concerned with accumulating assets. They, and we, were oblivious as to how to actually convert assets into an income stream.

Retirement models were deterministic; employing static savings, earnings, spending and inflation assumptions. The result was a neat, smooth chart like exhibit one. It was as good as we could do at the time. It brings to my mind the H. L. Mencken quote, "For every complex problem there is an answer that is clear, simple, and wrong."

Rarely were either client or investment market behaviors captured in our assumptions. We generally overstated portfolio earnings rates (greatly), inflation rates (modestly) and savings rates (ridiculously). We underestimated the increase in spending levels and unexpected, large withdrawals. We had no way to predict divorce or death of a spouse. Finally, in 1999 NO ONE predicted that major US equity indices would enjoy a decade of negative returns. That'll leave a mark!

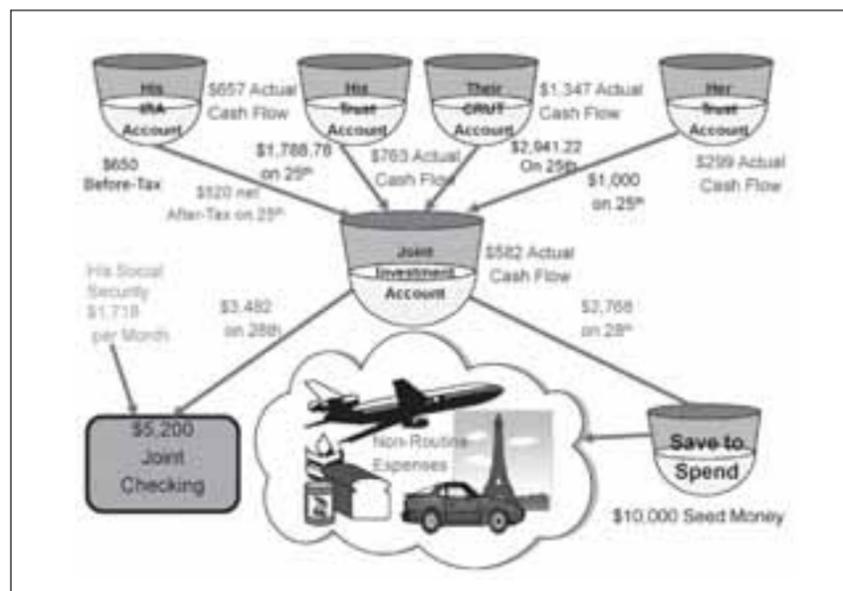
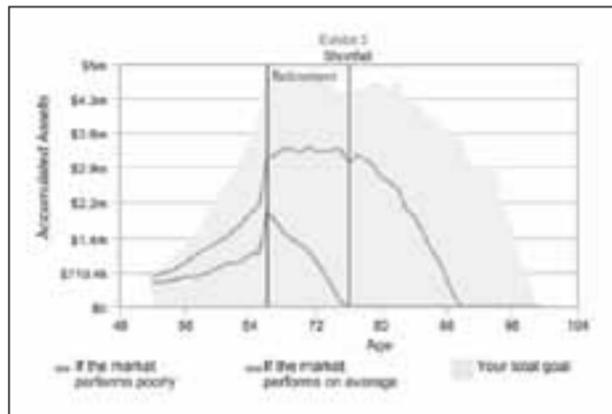
So, here are three of my beliefs about retirement planning along with the three dimensions from which retirement must be examined if you're going to successfully retire.

In the real world, there's no such thing as a straight line or a smooth curve (Portfolio Dimension) Compare the chart in exhibit two with exhibit one. Notice anything different? There are *no* straight lines or smooth curves. Some folks confuse this dimension with actual retirement planning. They naively assume that if investing is done well, retirement will work out fine. This chart shows the impact of: (1) portfolio performance and (2) your behavior. What it *doesn't* do is demonstrate how well you can meet your retirement expectations. You can do everything right investing, but if your saving or spending behaviors aren't adequate, retirement goals go unmet. People who stop at this dimension have no clue if their saving is sufficient to actually achieve their goals.



There's no such thing as a "safe" investment (Risk Dimension) Years ago, most believed that small-cap stocks were risky, but large-cap stocks were "safe." People recited the old saying "As goes GM (...GE or Merrill Lynch), so goes the country." We now know that's not so. We also believed that quality bonds were safe; until we watched AA-rated bonds default in 2008. The biggest trap caused by the bull market of the '90s was that we focused on return, with little regard for risk. We got sucked into thinking, "If the retirement numbers don't work, just bump up return assumptions, ignoring the increased risk level!" Even today, risk lurks in unlikely places. Ten-year treasuries currently yield around 4 percent. I just heard a noted economist suggest that the 10-year treasury could be at 10 percent by mid-2013. That will have a substantial negative impact on bond values. Retirement planning demands obsessive scrutiny of risk. Failure here can ruin lives. You must understand the known and possible risks you face in your retirement portfolio. Exhibit three doesn't just show when you're likely to run out of money if average returns are achieved; it also shows the impact of persistently "poor" markets. This gives you time to take actions to improve the outcome. Performance alone won't achieve retirement success.

The "answer" doesn't (and will never) rely on one simple solution or product (Cash Flow Dimension) For decades, insurance and investment product manufacturers have been touting various "silver bullet products" that will solve all problems associated with retirement planning (remember the Mencken



quote). One word explains why this is unlikely to happen – *complexity*. Exhibit four shows the cash flow between accounts for one of our retired clients. Failure here means you don't eat! So, what are the limitations of a one product-fits-all approach in the real world? First, few clients have just one account; most have five or more. Second, the source of distributions may need tax flexibility; particularly before 50½ and after 70½. Flexibility of distributions is necessary to accommodate changes as they arise. Third, I'm concerned about likely tax law changes over the next decade. The last thing I'd want is to have all distributions taxed at ordinary rates if there are less onerous options (as we have today). The importance of flexibility to affect the character of taxable income may grow, not decline, as Congress continues to wrestle with deficits.

Even if you master all three of the dimensions, the remaining wild card is changing your behavior to deal with retirement realities. Here's a powerful quote in therapist circles: "Change happens when the pain of staying the same is greater than the pain of the change." Retirement math is brutal; simply trying to deal with it by wishing, hoping and living in denial is a formula for disaster. It is imperative that you're armed with accurate information to make needed changes before it's too late.



Rick Adkins, CFP® is President/CEO of The Arkansas Financial Group, Inc., a Registered Investment Advisory Firm. Since 1998 he has been recognized as one of the top financial advisors in America, including Medical Economics magazine's list of "120 Best Financial Advisors for Doctors," Worth magazine's list of "The Best 250 Financial Advisors in America" and Mutual Fund magazine's list of "100 Great Financial Planners." Rick can be reached at RickA@ARfinancial.com.

Focus on Efficiency, continued from page 8

his practice group signed on with BHN in 2004. Since then, BHN technicians "have been completely invisible," he said. "The nurse sees the patient, so we doctors can see other patients. It makes us much more efficient."

Wood can now scan BHN's UroAnalysis™ Report quickly, and view bullet points highlighting concise comments, and surgical and non-surgical suggestions.

"The brief summary of patient problems includes open-ended recommendations by physicians," he explained. "I've never felt boxed in by the plan. I've never been afraid to put the report in the patient chart. It's nothing for me to pick up the phone and call one of the network physicians to review a report. I didn't expect such support."

There's only one drawback, cautioned Wood.

"You're set on their schedule," he said. "Let's say a pre-op hysterectomy patient comes in three days before surgery and says, 'oh, by the way, I have a leaky bladder,' so unless you hold on to the testing equipment, which we haven't

done, we either do the hysterectomy or postpone surgery until we can get a BHN testing appointment. Other than scheduling issues, it's been a wonderful addition to our office."

Joe Washburne, MD, whose practice group—Women's Pavilion of South Mississippi—joined BHN in 2004, recalled initial concern among the 10 partners about not having enough testing to justify the service.

"That was only at first, and BHN has been very flexible with the scheduling," he said. "They went from once a month to twice a month and back to once a month until we established flow. I'm blessed to have patients come to me with bladder problems when I know many are hesitant to broach the subject. If you're looking to drum up business, stick a questionnaire in your waiting room."

As word spreads about the service, BHN anticipates another growth surge.

"The BHN UroAnalysis™ Report," said Washburne, "gives me the extra level of confidence that I'm doing the right thing for patients."

PUBLISHED BY:
SouthComm, Inc.

CHIEF EXECUTIVE OFFICER
Chris Ferrell

PUBLISHER
Jackson Vahaly
jvahaly@southcomm.com

ASSOCIATE PUBLISHER
Rebekah Hardin
rhardin@medicalnewsfarkansas.com
Ad Sales: 501.580.8903

NATIONAL EDITOR
Pepper Jeter
editor@medicalnewsinc.com

LOCAL EDITOR
Lynne Jeter
lynne@medicalnewsinc.com

CREATIVE DIRECTOR
Susan Graham
susan@medicalnewsinc.com
931.438.8771

CONTRIBUTING WRITERS
Steve Brawner, Sharon Fitzgerald,
Becky Gillette, Lynne Jeter,

ACCOUNTANTS
Allison Hearing
ahearing@southcomm.com

Paige Hamilton
phamilton@southcomm.com

CIRCULATION
Julie Rutter
jrutter@southcomm.com

All editorial submissions and press releases should be emailed to:
editor@medicalnewsinc.com

Subscription requests or address changes should be mailed to:

Medical News, Inc.
210 12th Ave S. • Suite 100
Nashville, TN 37203
615.244.7989 • (FAX) 615.244.8578

or e-mailed to:
jrutter@southcomm.com

Subscriptions:
One year \$48 • Two years \$78

Medical News of Arkansas is published monthly by Medical News, Inc., a wholly-owned subsidiary of SouthComm, Inc. ©2010 Medical News Communications. All rights reserved. Reproduction in whole or in part without written permission is prohibited. Medical News will assume no responsibilities for unsolicited materials.

All letters sent to Medical News will be considered Medical News property and therefore unconditionally assigned to Medical News for publication and copyright purposes.

medicalnewsfarkansas.com

UAMS Names Raney Chair of Biochemistry and Molecular Biology

LITTLE ROCK – Kevin Raney, Ph.D., a scientist who has studied enzymes that help build and maintain the body's DNA, has been named chairman of the Department of Biochemistry and Molecular Biology in the University of Arkansas for Medical Sciences (UAMS) College of Medicine.



Dr. Kevin Raney

Raney, a native Arkansan, joined the UAMS faculty in 1995, becoming a full professor in 2007. From 2002-2007, he led the UAMS Proteomics Core Facility, which hosted research into the changes of proteins in the body's cells. His appointment is effective June 1. He succeeds the late Alan Elbein, Ph.D., who died in November 2009 after serving as chairman for nearly two decades.

He has authored 47 peer-reviewed manuscripts and eight review articles and is principal investigator on three National Institutes of Health research grants. His research interests include nucleic acid metabolism, viral genome replication, single molecule enzymology, proteomics and the use of nanoparticles for biological applications.

Raney earned his doctorate in organic chemistry in 1992 at Vanderbilt University. Prior to that, he received a bachelor's degree with distinction in chemistry from Hendrix College in Conway.

He is a member of the American Chemical Society, American Society for Biochemistry and Molecular Biology and the American Association for the Advancement of Science.

Baker Named Director of the Division of Diagnostic Medical Sonography in UAMS Allied Health College

LITTLE ROCK – Anthony Baker has been named director of the Division of Diagnostic Medical Sonography in the Department of Imaging and Radiation Sciences in the College of Health Related Professions at the University of Arkansas for Medical Sciences (UAMS).



Anthony Baker

Baker has served as an instructor and clinical coordinator in the Division of Diagnostic Medical Sonography since 2000, coordinating clinical rotations for the program's students and teaching numerous courses. An Air Force veteran, he received his master's degree in education in 2004 from the University of Arkansas at Little Rock.

Baker was class president for the first diagnostic medical sonography class at

UAMS, graduating in 1997. Prior to his UAMS faculty appointment, Baker worked as a clinical instructor at Baptist Health Medical Center in Little Rock.

He is a member of the Society of Diagnostic Medical Sonography and a member of the American Registry for Diagnostic Medical Sonographers Examination Development Task Force for Sonographic Principles and Instrumentation.

Jones Eye Institute Receives \$3 Million for Genetics Center

LITTLE ROCK – A Rogers couple has pledged \$3 million to the Harvey & Bernice Jones Eye Institute at the University of Arkansas for Medical Sciences (UAMS) to establish the Leland and Betty Tollett Center for Retinal and Ophthalmic Genetics Disorders.

The Tolletts' gift will provide the resources to finish out the eighth floor of the Jones Eye Institute to house the center, which will include diagnostic and treatment space, low vision and rehabilitation space, clinical research and database facilities. Basic research will continue on the third floor and will be expanded to include basic genetic research.

John P. Shock, M.D., distinguished professor and founding director of the Jones Eye Institute, said there have been major discoveries in the knowledge of retinal disorders and ocular genetics in the past decade, prompting the need for the new center.

The new discoveries along with new diagnostic and therapeutic strategies have provided exciting opportunities for the prevention of vision loss said Shock and when taking into account that in the next decade or so the number of patients with serious ocular conditions will double due to our growing aging population, the timing for developing a Retinal and Ophthalmic Genetic Disorders Center is ideal.

Leland Tollett, a former two-time chief executive officer and chairman of the board of Tyson Foods Inc. of Springdale, decided to make this gift because of his lifelong interest in eye care.

Jones Eye Institute leaders agree that the new center has the potential to be a magnet for attracting patients and families from across the region.

The gift will go a long way in helping to make the Jones Eye Institute a premiere comprehensive eye center for cutting-edge genetics research and treatment according to Christopher Westfall, M.D., chairman of the Department of Ophthalmology and director of the Jones Eye Institute.

Shock said the eighth floor renovation project will take up to 18 months, and that the Jones Eye Institute already has the team in place to help the new center grow.

Dr. David Hall Joins The Arkansas Hospice Staff

Arkansas Hospice is excited to announce that Dr. David Hall has joined its team as a staff hospice physician. Dr. Hall will be making pre-hospice visits to patients and families in the Little Rock and North Little Rock areas.

Dr. Hall comes to Arkansas Hospice from St. Vincent Health System, where he was the Chief medical Medical Officer and Senior Vice President for Medical Affairs for more than 10 years. Dr. Hall has been a huge supporter of hospice and palliative care since attending a conference sponsored by the Center to Advance Palliative Care. During his time at St. Vincent, Dr. Hall helped start the palliative care program, which was one of the first in Arkansas.

Dr. Hall hopes to add support and comfort to patients and their families during the end-of-life stages, an area in medicine that is little understood by many physicians and the public.

Sparks Announces New Hires/Appointments

Sparks Health System is pleased to announce that Dr. Katherine Irish-Clardy will be Sparks Health System's Chief Medical Officer. Dr. Clardy is certified by the American Board of Family Practice, and has been affiliated with Sparks since 2001. She has served on various Sparks' committees, and received numerous awards including a Certificate of Congressional Recognition from the U.S. House of Representatives for Service to Victims of Hurricane Katrina.

Also, Sharon McMillan has been appointed as Spark Health System's Director of Laboratory effective June 14. McMillan brings a proven record of success as a Director of Laboratories with 30 years of experience. She graduated from the University of Texas Medical Branch with a Bachelor of Science in Technology, American College of Pathologist Registry, and University of Arkansas Fort Smith, Lean Six Sigma Certification.

Patti Kirby has accepted the position of Assistant Director of Laboratory effective June 14. Patti has been with Sparks for 30 years.

Dr. Cygnet Schroeder has been appointed as Medical Director of Case/Resource Management. Dr. Schroeder's duties will include rounding to identify utilization issues while interacting with medical staff, managed care providers, assisting Risk Management with observation issues, reviewing and evaluating various reports and costs.

Time Out!



Like your patients,
you need to know your options.

We specialize in providing professional liability insurance for physicians, and have been selected as the exclusive independent agents appointed in Arkansas for MAG Mutual Insurance Company.



**Call Andrew Meadors at Meadors Adams Lee (501) 372-5200 or
Judy Englehart at Regions Insurance at 1-800-273-6631**

www.magmutual.com