PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

Spring 2018 | VOL 28 | NO. 2

Veteran's Health Care

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BSA Harrington Cancer Center is pleased to welcome **Dr. Javed Shinwari** to the comprehensive team of specialists. Dr. Shinwari is committed to providing patients with expert care in the diagnosis and treatment of cancer and blood disorders.

He completed his residency at St. Luke's Roosevelt Hospital in New York and his fellowship at the University of Miami in Florida. Dr. Shinwari has been in private practice for more than 20 years.

Dr. Shinwari joins the expert team of BSA Harrington Cancer Center oncologists:

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CONTENTS

Veteran's Health Care

On The Cover: "For the Birds", by Marsha Clements.

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President's Message:
New Year's Provocations

by Ryan Rush, M.D.

A new year always ushers in distinct challenges but also brings forth certain opportunities. As we plunge into 2018, we find our healthcare system in a state of confusion and disarray. Provocation #1: Bernie Sanders and many on the left side of the political spectrum stoke their base with the battle cry "Medicare for All." This sounds good as a catch phrase at political rallies and campaigns, but so long as only about 50% of the populace pays federal income tax and fewer than 30% remit payroll tax, this remains a pie in the sky. Organizationally, Medicare's 4,100 employees struggle to keep up with the current level of beneficiaries and would explode if another 200 million claimants were added to the rolls of the program. Politically, the advocates of "big" and "small" government are completely polarized and cannot find common ground to engage on any collaborative effort – welcome to the "Swamp" otherwise known as Washington, D.C. Furthermore, "Medicare for All" fails to address the economic conundrum of how society is to handle chronic disease in an ever-increasing aging population.

Provocation #2: Healthcare can be egalitarian or universal, but not both. In various healthcare systems throughout the world, there are methods for some patients to pay for newer, quicker and more technologies and higher levels of care than others. To some degree, a tiered system exists in our current system where the affluent pay for amenities in order for the impoverished to receive necessities. It is unresolved whether or not universal health insurance coverage actually results in better health of the population. But, Medicare coverage does seem to have a positive impact on the lifespan for seniors. The average American's life expectancy was 70 years in 1965, the year of Medicare's adoption. Today, on your 70th birthday, you can expect to live about 15 more years. However, the overall cost for this augmentation in lifespan has been astronomical to the current tax payer, and the program exists largely as an unfunded liability for future generations to shoulder.

Provocation #3: Texas does not actually have a physician shortage. Large cities such as Houston are loaded with every kind of physician and specialist imaginable. Rio Grande City in Starr County? Not so much. Rather than a true "doctor shortage," Texas has two challenges: 1) physicians, particularly s pecialists, tend to be distributed primarily into the metropolitan areas of the state, and 2) physicians are belabored by regulatory overload resulting in work flow inefficiencies and reduced productivity. Maldistribution could be addressed by permitting medical school graduates to barter service time as a part of their post-graduate training, for example, with the Veterans Health Administration for school debt amnesty. Technology could also be used to enhance geographic reach. Telemedicine allows identification and triage of disease remotely, potentially providing patients residing in sparsely populated counties in Texas an opportunity to receive a virtual consultation with a physician or even specialist without having to leave their own county. Presently, innovators labor to link telemedicine to artificial intelligence and machine learning in order to better identify pathology. As for the heavy regulatory burdens squashing physician productivity, a full repeal of the more than 20,000 pages of additional regulations issued as a result of the Affordable Care Act needs to occur, and occur quickly. I won't be holding my breath for this to transpire any time soon...

I hope that 2018 will be a prosperous and healthy year for you and your family, and I look forward to sharing more thoughts with you in the upcoming summer edition.

Our Next Issue Of

Panhandle Health

Features:

Special Populations

Alliance News

by Kristen Atkins, President

The Potter-Randall County Medical Alliance celebrated the end of 2017 with our Winter Wonder Gala fundraiser. This sold-out event raised funds for Our Children's Blessing, Heal the City and the Alliance. Guests entered the ballroom at Embassy Suites downtown wearing sparkling white, silver and gold to match our Winter Wonder decorated theme. The evening festivities included a plated dinner, casino games, photo booth, coffee bar, entertainment by 'The Fwoops" and a midnight countdown. The night was a success and raised nearly $18,000.

As we continue to grow our partnership with Heal the City, we were pleased to hear that Dr. Keister was awarded the John P. McGovern Champion of Health Award. This Texas Medical Association Alliance award is for individuals who do exceptional projects that address urgent threats to the public health. He was given this award at the Texas Medical Association Winter conference. Thank you to Audra Kirkendall and HTC for working together to make this award possible for Dr. Keister through TMAA.

The Alliance had our first quarterly meeting on February 1st. The meeting was held in the home of Dr. and Mrs. Cuatro Holland. After our meeting we assembled Valentine gift bags for the children at Northwest Texas hospital. There were a lot of familiar faces along with many new ones. We encourage members to come to the next meeting in April which will include a cooking component.

2018 Alliance Board
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Kristen Atkins
Past President:
Irene Jones
VP of Quarterly Meetings:
Ana Holland
Secretary:
Lacie Schniederjan
Treasurer:
Elisa Miller
Publicity:
Mackenzie Sigler

We are looking for more members to sign up to bring a meal to the Ronald McDonald House and bring toiletries to the ACTS Community Closet. If you are interested in this easy, but very impactful service, please contact Christi Rush at christirush1@yahoo.com.

The year is off to a great start, and we have a lot of fun and exciting plans ahead. Please visit our website at: *potterrandallalliance.com* for more information on upcoming events.

Save the Date:

March 30th- 6:30-9 Doctors Day Celebration @ Taste Dessert Bar

April 24th- 6:30 2nd Quarterly Meeting TBA

Shout outs:

A big thank you to Michele Agostini and Alice Hyde for stocking the ACTS closet and to Lindsay Brooks, Mackenzie Sigler, Audra Kirkendall and Jesareli Hernandez for bringing a meal to the Ronald McDonald House. We would not be able to provide this service without your help.

Keister, Price Receive Medical Society Honors

Amarillo Dr. Alan Keister, left, and state Rep. Four Price, center, receive recognition from the Potter-Randall County Medical Society and its president, Dr. Ryan Rush, at the medical society's offices in Amarillo. Keister, the founder of Heal the City Free Clinic, is the recipient of the Texas Medical Association Foundation's 2018 John P. McGovern Chamption of Health Award. Keister won the award last month at the TMA's winter conference. Price, of Amarillo, was honored with the TMA's Champion of Medicine Award. (Jeff Farris / Amarillo Globe-News)

Executive Director's Message

by Cindy Barnard, Executive Director

Our veterans have made huge sacrifices and are entitled to health benefits when they leave active duty.

The Veterans Administration provides world-class health care to eligible veterans and their eligible dependents and survivors. The VA is America's largest integrated health care system with more than 1200 sites of care. It is required by law to provide eligible veterans with hospital care and/or outpatient care services that are defined as "needed". A VA Healthcare Overview website defines "needed' as "care or service that will promote, preserve and restore health. This includes treatment, procedures, supplies, and/or services. This decision of 'need' is based on the judgment of the health care provider and is in accordance with generally accepted standards of clinical practice." The VA system care is personalized, proactive, and patient-driven. This Spring 2018 issue of *Panhandle Health* contains articles on some of the specific areas of care provided by our VA.

The 115^{5h} Annual Meeting of Potter Randall County Medical Society was held January 11th at Amarillo National Bank's Executive Dining Room. The gold-headed cane was passed from Dr. Rouzbeh Kordestani, 2017 President, to Dr. Ryan Rush, 2018 President. Officers for 2018 were installed by Dr. Carlos Cardenas, President of Texas Medical Association. New Officers include President, Dr. Rush, President-Elect, Dr. William Holland, and Secretary-Treasurer, Dr. Daniel Hendrick. I want to thank Amarillo National Bank for their continuing and unfailing generosity and hospitality. The dinner was exceptionally delicious and well-attended.

Presidential appointments to Boards and Committees of PRCMS are now ongoing. If you have an interest in serving on a committee, please call the Society office at 355-6854. The core of the Society is its volunteers—the physicians who volunteer for committees and board positions, working on behalf of their colleagues. We truly need you!

Get ready for "First Tuesday" at the Capitol. Pack your white coat and travel to Austin on March 6, April 3, or May 1 to participate in TMA's first Tuesdays. Please don't miss the chance to meet with legislators and their staffs to make sure the voice of medicine is heard. Remember, YOU, our physicians, are the best lobbyists for our patients. You will visit with your Senator, Representatives, and their aides about key issues facing your profession, attend committee hearings and house and Senate sessions, and learn about the obstacles medicine faces: taxes, Medicaid, CHIPS, physician ownership, and scope of practice. Physicians are asked to wear white coats while at the Capitol. Legislative talking points and other materials will be provided. A course on lobbying will be conducted early on each First Tuesday. A $25 charge for each First Tuesday covers your breakfast, lunch, and all materials. For more information, visit www.texpac.org.

On March 29, we will celebrate Doctors' Day, which was first observed in Winder, Georgia in 1930. According to Wikipedia, Eudora Brown Almond, a physician's wife, decided to declare a day in honor of doctors. The red carnation was chosen as the symbolic flower for National Doctors Day. In 1958, a resolution commemorating Doctors Day was adopted by the U.S. House of Representatives, and legislation was introduced both in the House and Senate to establish a National Doctors Day in 1990. President George Bush signed S.J. RES #336 (which became Public Law 101-473) in 1991, forever designating March 30 as National Doctors Day. President Bush wrote in the Proclamation, "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States, indeed, throughout the world. Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress, and sacrifice. All those who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life." President Bush urged that all Americans "observe this day with appropriate programs and activities."

Our cover is by Marsha Clements, an Amarillo artist, whose work we have featured many times. This cover is a bird nest, one of the first signs of spring. Happy Spring to all of you!

POTTER RANDALL COUNTY MEDICAL SOCIETY (PRCMS) OFFERS HELP TO ADDICTED PHYSICIANS

If you, or a physician you know, are struggling with addiction and are unsure what to do or whom to contact, the Potter-Randall County Medical Society is here to help. We offer face-to-face confidential sessions with the PRCMS Physician Health and Wellness Committee, made up of your physician peers who know and understand recovery. Please don't struggle alone when help is a phone call or an email away. Whether you are calling for yourself, your practice partner, or as a family member of a physician, contact Cindy Barnard, PRCMS Executive Director, at 806-355-6854 or prcms@suddenlinkmail.com. Membership in PRCMS is not required.

Guest Editor's Message

by Richard L. Siemens, J.D., M.D., M.P.H.

Veterans' healthcare is both interesting and complex. It is also a national commitment dating from President Lincoln's day. It takes a well-integrated team of dedicated professionals to deliver that care, and that team, in the Texas Panhandle, extends well beyond our V.A. medical center. Part of what we hope to achieve in this edition of *Panhandle Health* is to identify, acknowledge and give overdue recognition to those members of the Amarillo medical community who do so much for our veterans. These partners include the Ussery-Roan State Veterans' Home, BSA and Northwest Texas Hospitals, and our ever-expanding cooperation with the Texas Tech University Health Sciences Center. One of our veterans, in a typical month, may well see a VA primary care provider, an Amarillo Heart Group cardiologist and a Texas Tech OB-Gyn resident.

The VA, naturally, recruits from the same pool of residents and other physicians as does the private sector. If the veteran is diagnosed with cancer, his or her case will then be presented to the VA's tumor board, wherein a multidisciplinary team of physicians and allied healthcare providers from both the VA and the wider medical community collaborate and make their joint recommendations. Deserving of special focus is our joint planning for the Texas Tech psychiatry residency in Amarillo. The Community Veterans Engagement Board, though not exclusively clinical, and despite not being VA-led, is another example of our community partnership to serve our veterans. Being a native New Englander, it is easy to note that the people of northwest Texas have respected and cared for our nation's veterans since long before it became trendy nationwide, and that deserves recognition as well.

We hope to inform those who care to read this issue about peculiarities of veterans' health and the V.A. itself, as well as rules for eligibility for care, our history and our future, in the hope of furthering our many alliances which benefit Panhandle veterans. We thank the Potter-Randall County Medical Society for this unique opportunity.

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

Purpose *Panhandle Health* strives to promote the health and welfare of the residents of Amarillo and the Texas Panhandle through the publication of practical informative papers on topics of general interest to most physicians while maintaining editorial integrity and newsworthiness.

Spectrum *The Journal* seeks a wide range of review articles and original observations addressing clinical and non-clinical, social and public health, aspects as they relate to the advancement of the state of health in the Texas Panhandle. Pertinent letters to the editor, news submissions, and obituaries listings are accepted pending editorial review. The Editorial Board accepts or rejects submissions based on merit, appropriateness, and space availability.

Submission process Material should be e-mailed to the editor at prcms@suddenlinkmail.com or mail a hard copy to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106. A recent photograph of the author (optional) and a curriculum vitae or a biographical summary are also to be submitted.

Conflict of Interest Authors must disclose any conflict of interest that may exist in relation to their submissions.

Journal Articles Manuscripts should be double-spaced with ample margins. Text should be narrative with complete sentences and logical subheadings. The word count accepted is generally 1200 to 1500 words. Review articles and original contributions should be accompanied by an abstract of no more than 150 words.

References References to scientific publications should be listed in numerical order at the end of the article with reference numbers placed in parentheses at appropriate points in text. The minimum acceptable data include:

Journals: Authors, article title, journal, year volume, issue number, inclusive pages.

Books: Author, title, place of publication, publisher, year.

Web sites: URL of the site and the date the information was accessed.

Other sources: Enough information must be included so that the source can be identified and retrieved. If not possible, the information for source should be included parenthetically in the text.

Illustrations Illustrations should be black and white only with complete-sentence legend.

Previously Published Material Short verbatim quotations in the text may be used without permission but should be quoted exactly with source credited. Otherwise, permission should be obtained in writing from the publishers and authors for publishing extensive textual material that was previously published.

Editing Accepted manuscripts are edited in accordance with the *American Medical Association Manual of Style*.

Letters Letters will be published at the discretion of the editor and editorial board. The length should be within 400 words. References should not exceed five. All letters are subject to editing and abridgment.

News News should be e-mailed prcms@suddenlinkmail.com or mailed to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106.

Obituaries Listings of deceased members of PRCMS with highlights of their contributions are published when adequate information is available.

Point of View Opinions published in any article, statement, or advertisement are the responsibility of the author and shall not be construed by any means to represent those of the editors or the medical society.

History and Accomplishments of the Veterans Affairs Healthcare System

by Lindsay Porter, MS, IV

The Department of Veterans Affairs (VA) has a long history of treating our nation's veterans. The VA's roots began in the seventeenth century before the United States was an independent nation. The Pilgrims settling colonial America established the standard for the government to take care of the soldiers fighting wars for the people. This was followed up by the Continental Congress providing benefits for those who enlisted to fight in the Revolutionary War. The first establishment of a medical facility at a national level for the treatment of veterans was in 1811. The US Congress established benefits for veterans with the US entry into World War I, but these benefits were under three different federal agencies. This gave no way to ensure the quality of care for our nation's veterans. Congress then established the Veterans Bureau in 1921 in order to consolidate veteran benefits. On 21 July 1930, the Bureau was reorganized as a separate administration in the federal government. The mission of the newly established VA was to fulfill President Lincoln's promise: "To care for him who shall have borne the battle, and for his widow, and for his orphan."(1) This mission has been fulfilled with the passage of legislation through the US Congress known most readily as the GI Bill. These laws ensure quality of care, ease of access and first-rate support for those who fought to preserve freedom in our own nation and across the world.

The VA hospital in Amarillo was built in 1939. The original site for the hospital was farm and ranchland. The facility was self sufficient with cattle and gardens to feed the veterans under care in the hospital. In 1960 a portion of the land was returned to Potter County in order to have other health related organizations built close to the VA hospital. This area now includes Northwest Texas Hospital, Baptist St. Anthony's, Harrington Cancer Center and Texas Tech University Health Sciences Center among other health related buildings. The current VA hospital sits on part of the original tract of land with parts of the initial buildings still important in the infrastructure of the hospital (2).

The Amarillo VA has undergone several changes since it was originally dedicated on May 12, 1940. The name of the hospital was officially changed to Thomas E. Creek Department of Veterans Affairs Medical Center in 2004. Lance Corporal Creek was a United States Marine fire team leader, I company, 3rd Battalion, 9th Marines, 3rd Marine division during the Vietnam Conflict. He was posthumously awarded the Medal of Honor for actions taken on February 13, 1969, near Cam Lo Resettlement Village. There have been other changes to the Amarillo VA Health Care System (AVAHCS) throughout the more than seventy five years it has provided service to our nation's veterans. The Thomas E. Creek VA Medical Center in Amarillo has grown to include a nursing home, hospitality house, the Center for Therapy and Recovery and a new specialty clinic. The latest addition to the AVAHCS will be a new facility for primary care. The system also includes clinics in Lubbock, Childress, Dalhart and Clovis, New Mexico (2).

This mission of the VA has led it to be on the front lines of innovation in healthcare across the nation, and here in Amarillo. The physicians, researchers and staff of VA hospitals around the nation have spearheaded breakthroughs in areas such as infectious disease, neurology, psychiatry, cardiovascular disease, laboratory techniques and imaging technology among many others. These innovations have led to two Nobel prizes in 1977 and another in 1998 for hormone peptide syntheses, laboratory techniques to measure particular substances in blood and the discovery of nitric oxide and its impact on blood vessels. There are two key areas that the VA has been a frontrunner in since it was established. These areas are prosthetics and women's health (1).

Prosthetic devices are an integral player in the care and treatment of our nation's veterans. In mid 1945 many veterans were returning from World War II. This war was a total mechanized war with new and unique healthcare hurdles for the veterans returning home, especially in the realm of prosthetics. The devices being used for the veterans were of substandard quality even compared to the devices used for civilian amputees. This sparked waves of protests from the nation's veterans and triggered the development of the VA's Prosthetic Appliance Service. This would evolve into the VA's Prosthetics and Sensory Aids Service under General Omar Bradley in 1948. This service has remained an integral part of the VA. Research into prosthetics, orthotics and sensory devices enjoyed a drastic increase in funding after General Bradley took over the helm of the VA. This funding allowed for research and development for better technology for prosthetics. Veterans were then able to upgrade their device with each advance per the requirements of General Bradley. This was significant for two reasons. The first was that veterans could maintain their independence, crucial for a returning soldier, marine, or sailor from World War II. The second was that the development of new and improved prosthetics allowed for a better transition to civilian life. A veteran with the scars of war had earned every possible chance to have a normal post-war life. Modern prosthetic devices were instrumental. World War II saw a revolutionary change in war machinery and technology. More veterans were making it back home alive, but more veterans were making it back home with fewer limbs. The deadly new technology of World War II made it a necessary to find better ways to help veterans return to quiet civilian life (3).

Prosthetic devices still play an integral role in the care of our nation's veterans. The process for these devices had become more sophisticated over time due to the nature of the war, enemy and technology of current wars. A multidisciplinary team has been required in order to allow for veterans to get the best possible prosthetic for their needs. The idea of prosthetics has changed over time. Prosthetics started out as a means to give a veteran a way to have an independent and productive life. It has evolved into a means to allow for a prosthetic to be individually tailored for the veteran. The multidisciplinary team plays a key role in this. This team includes the physician, prosthetist, physical therapist and biomedical representatives from prosthetic companies. The goal is to provide a prosthetic that meets the needs of the patient. These needs included work, recreational, general physical and home environment. This has led to new technologies and emerging ideas to allow each veteran to have their own individualized prosthetic to accomplish the rest of their life's mission. Prosthetics have been the physical aspect of allowing a veteran to do this. In these and other areas, the VA has been at the forefront in allowing veterans to reach their full potential and accomplish their mission (3).

A critical area in which the VA has been pushing forward is women's health. The number of female veterans has continued to grow at a swift pace. Recent

| continued on page 12

changes in the Department of Defense have allowed for an ever growing number of women veterans in the future as well, including allowing women in combat roles in the US military. An ever growing number of women have served in Operation Enduring Freedom and Operation Iraqi Freedom. There was an essential need to change the role of the VA from an entity that treats mostly male patients to now being a mix of men and women. The development of these initiatives began as early as 2004, coinciding with the first wave of female veterans from Operation Enduring Freedom. The national initiatives put in place have allowed for better care, ease of access, and treatment that is necessarily different from males for our nation's female veterans. This has included research into sex based differences in prevention, onset and progression of diseases in women. Areas such as mental health, occupational hazards such as vaccine development and chemical/biological exposures, oncology, reproductive health, and most notably chronic diseases have been addressed as well. The VA has moved into the front lines of research in how chronic diseases differ based on biological sex. In the private and academic sectors, most research into chronic diseases has primarily included male populations. The VA has been moving forward in the development, diagnosis and treatment of chronic diseases focusing on female veterans and how these things differ from their male counterparts (4, 5).

Reforms at the Congressional level have made more services specifically for women available. These include prenatal and obstetric care, infertility services, and extensive gynecological care. The VA has been on the forefront of how female physiology differs from male physiology in response to standard treatments as well. The AVAHCS has revolutionized how care is delivered to female veterans. One step was the establishment of a women's health clinic within ambulatory care with physicians, nurse practitioners and physician assistants being specifically trained in women's health and how best to deliver care to the female veterans. Ambulatory care has also partnered with mental health for primary care-mental health initiative in order to deliver mental health services without stigma. This allows for veterans to seek care from a provider they have seen before that they trust. Another step forward in women's health at the VA here in Amarillo was a partnership with the Texas Tech University Health Sciences Center obstetrics and gynecology faculty and resident program. This partnership allows for faculty and residents to be involved with health care of female veterans at the VA. This enables the patient to meet the provider who will be taking care of her and to develop a trusting relationship with them to enhance improved patient care.

The AVAHCS has been on the cutting edge of medical care for the area's veterans. The medical staff works hard to ensure that veteran care meets and exceeds standard of care in the community. The rich history of the VA in West Texas has continued to grow for more than seventy five years and will continue to grow as more innovative ideas and affiliations are developed. All the work and effort of the staff of the entire hospital, from medical to administrative to maintenance to engineering, is a concerted effort to ensure that care of the veterans is second to none. The goal that President Lincoln set forth as the foundation of the VA is on clear display every time a veteran steps foot into Thomas E. Creek VA Hospital.

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Veterans Affairs Eligibility

by T.J. Bowerman

The Veterans Affairs Health System (VA), is America's largest integrated health care system, serving more than 8 million Veterans each year. A variety of health care services is offered, from basic primary care to nursing home care for eligible Veterans. Enrollment in the VA health care system provides Veterans with the promise that comprehensive health care services will be available when and where they are needed. In addition to the assurance that services will be available, enrolled Veterans welcome not having to repeat the application process — regardless of where they seek their care or how often.

VA is committed to providing the high quality, effective health care Veterans have earned and deserve. We have established a record of safe, exceptional care that is consistently recognized by independent reviews, organizations and experts. VA is recognized as a leader in improving the quality of health by leveraging new technologies, research and relationships with other health care organizations.

Veterans Eligibility

For the purposes of VA health benefits and services, a person who served in the active military service and who was discharged or released under conditions other than dishonorable is a Veteran.

Basic Eligibility

If a Veteran served in the active military service and was separated under any condition other than dishonorable, they may qualify for VA health care benefits. Current and former members of the Reserves or National Guard who were called to active duty by a federal order and completed the full period for which they were called or ordered to active duty may be eligible for VA health benefits as well.

NOTE: Reserves or National Guard members with active duty for training purposes *only* do not meet the basic eligibility requirement.

Minimum Duty Requirements

Most Veterans who enlisted after September 7, 1980, or entered active duty after October 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty in order to be eligible. This minimum duty requirement may not apply to Veterans who were discharged for a disability incurred or aggravated in the line of duty, for a hardship or "early out," or those who served prior to September 7, 1980. Since there are a number of other exceptions to the minimum duty requirements, VA encourages all Veterans to apply so that we may determine their enrollment eligibility.

Enhanced Eligibility

Certain Veterans may be afforded enhanced eligibility status when applying and enrolling in the VA health care system, including veterans who:

- Are a former Prisoner of War (POW).
- Received the Purple Heart Medal.
- Received the Medal of Honor.
- Have a compensable VA awarded service-connected disability of 10% or more.
- Are in receipt of a VA Pension.
- Were discharged from the military because of a disability (not preexisting), early out, or hardship.
- Served in a Theater of Operations for 5 years post discharge.
- Served in the Republic of Vietnam from January 9, 1962 to May 7, 1975, including U.S. Navy and Coast Guard ships associated with military service in Vietnam.
- Served in the Persian Gulf from August 2, 1990 to November 11, 1998.
- Were stationed or resided at Camp Lejeune for 30 days or more between August 1, 1953 and December 31, 1987.
- Are found by VA to be Catastrophically Disabled.
- Had a previous years' household income below VA's National Income or Geographical-Adjusted Thresholds.
- Are experiencing a mental health emergency.

Enrollment

VA operates an annual enrollment system that helps to manage the provision of health care. VA applies a variety of factors during the application/verification process when determining a Veterans' eligibility for enrollment, but once a Veteran is enrolled, that Veteran remains enrolled in the VA health care system and maintains access to certain VA health benefits.

Once an application is successfully processed, the Veteran will be assigned an enrollment Priority Group. Certain Veterans may be eligible for more than one enrollment Priority Group. In that case, VA will always place them in the highest Priority Group they are eligible for. Under the VA Health Benefits Package, the same services are generally available to all enrolled Veterans. Once enrolled, the Veteran will receive a personalized Veterans Handbook, which will detail their VA health benefits and provide important information concerning access to VA health care.

Easy Ways to Apply for Enrollment

By Phone

Veterans can complete applications for enrollment in VA health care by telephone without the need for a signed paper application. VA staff members will collect the needed information and process the enrollment application for an enrollment determination. To apply, call 1-877-222-VETS (8387) Monday - Friday between 8 a.m. and 8 p.m. ET.

Online

When applying online at Vets.gov, Veterans simply fill out the application and electronically submit it to VA for

processing. VA will search for your supporting information through its electronic information systems and will contact you if it is unable to verify your military service. For help filling out the application, call 1-877-222-VETS (8387) Monday - Friday between 8 a.m. and 8 p.m. ET.

By Mail

The application form can be downloaded from www.vets.gov/healthcare/apply/. Mail the completed form to:

Health Eligibility Center Enrollment Eligibility Division 2957 Clairmont Road Suite 200 Atlanta, GA 30329-1647

In Person

Veterans may also apply in person at any VA health care facility.

Additional Information

Detailed information on available benefits and other VA programs can be found on the U.S. Department of Veterans Affairs Health Benefits website at https://www.va.gov/healthbenefits/apply/veterans.asp.

NATIONAL DOCTORS' DAY
MARCH 30

Potter-Randall County Medical Society celebrates National Doctors' Day to recognize the service and dedication of its members in promoting a healthy community.

On March 30, we will celebrate Doctors' Day, which was first observed in Winder, Georgia in 1930. According to Wikipedia, Eudora Brown Almond, a physician's wife, decided to declare a day in honor of doctors. The red carnation was chosen as the symbolic flower for National Doctors' Day.

In 1958, a resolution commemorating Doctors' Day was adopted by the U.S. House of Representatives, and legislation was introduced both in the House and Senate to establish a national Doctors' Day in 1990. President George Bush signed S.J. RES #336 (which became Public Law 101-473) in 1991, forever designating March 30 as National Doctors' Day.

President Bush wrote in the Proclamation, "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States indeed, throughout the world. Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress, and sacrifice. All those who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life." President Bush urged that all Americans "observe this day with appropriate programs and activities."

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Be a part of the circle. In 2006, Potter Randall County Medical Society introduced the Circle of Friends, a program designed with the business of medicine in mind. Members of the Circle of Friends are companies that pay an annual fee to participate in Medical Society events. Their financial commitment allows PRCMS to provide quality programs throughout the year, such as the Annual Meeting, Doctors Day, Resident Reception, Family Fall Festival, Retired Physicians Lunch and Women in Medicine. In return, these companies are invited to attend these events and discuss with the physicians the benefits that their companies offer a physicians practice.

We are grateful for the support of these organizations and anticipate another great year of serving the needs of our members. The purpose for Circle of Friends is to provide a valuable base of resources to assist the physician in the business of medicine so their practice of medicine can improve.

This program has proven to be a valuable resource of services such as liability insurance, accounting, banking and much more. This year, we hope to expand the Circle to include services the physician may use in his or her personal life. Through this program, we can invite businesses serving physicians to support the Society and increase their visibility among its members. Corporate support contributes to the Society's ability to advocate and care for physicians and patients in Potter and Randall Counties.

The Medical Society thanks all of its supporters as it offers new opportunities to its membership.If your business is interested in being a part of our Circle of Friends, please contact Cindy Barnard at 355-6854 or e-mail prcms@suddenlinkmail.com.

Combat Related Posttraumatic Stress Disorder (PTSD):

Recovering from the War Within

by Kennan G. Carley, LCSW and Michael T. Lambert, M.D.

Introduction and Case Study

Jim, a 38 year-old Veteran, served two combat tours in Iraq. During service no one noticed anything different about him. However, within 6 months of leaving active duty, family and friends noticed Jim acting uncharacteristically. Jim avoided his family and rarely went out except to work. He was moody and easily startled or irritated, blowing up over minor problems. He seemed detached emotionally. Jim started drinking each night saying it helped him sleep and dulled the nightmares. When he tried spending time with his family, he became angry and on guard for danger. Jim was diagnosed with combat related posttraumatic stress disorder (PTSD), and entered a Department of Veterans Affairs (VA) dual diagnosis treatment program that focused on PTSD and problem drinking. After several months of abstinence, psychotherapy, and medications, Jim improved significantly and could enjoy life with his family again. Jim is one of the over 442,000 active PTSD cases identified by VA (3).

This article provides a basic understanding of combat related PTSD. The symptoms of PTSD and associated issues frequently seen in PTSD will be outlined first, followed by a description of the most relevant treatments for PTSD.

Signs and Symptoms of Posttraumatic Stress Disorder (PTSD)

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM 5) (1) is the defining authority in diagnosing mental health disorders. Symptoms fall within broad groupings of re-experiencing, avoidance, hyperarousal, and emotional numbing outlined in the DSM 5 criteria, which also define trauma exposure and requires significant distress or dysfunction for the diagnosis (table 1).

When assessing response to treatment

Table 1: DSM 5 Diagnostic Criteria for PTSD (1)

A.	*Exposure to a trauma as defined as experiencing an actual or threatened death, serious injury, or sexual violation.*
B.	*Criteria for trauma exposure:* • Directly experiencing the traumatic event; • Witnessing the traumatic event in person; • Learning about a traumatic event that occurred to a close family member or close friend; or • Experiencing first-hand repeated or extreme exposure to aversive details of a traumatic event (not through media, pictures, television, or movies unless work related)
C.	*The veteran's reaction to the trauma causes clinically significant distress or impairment in the person's social life, ability to work, or other important areas of functioning.*
D.	*The veteran exhibits behavioral symptoms generally classified under the **following four clusters of symptoms:*** 1) Re-experiencing of the trauma through one or more of the following: intrusive thoughts, recurrent dreams, or flashbacks (a sense of reexperiencing the trauma in subtle or extreme ways). 2) Avoidance behavior indicative of going to extremes to avoid distressing memories, thoughts, feelings, or external reminders of the event. 3) Heightened arousal symptomatic of one or more of the following: aggressiveness, reckless or self-destructive behavior, sleep disturbance, or hypervigilance. 4) Disturbance of mood and persistent negative cognitions including a distorted sense of blame of self or others, isolating from loved ones and society, or loss of interest in normally pleasurable activities, or emotional numbing.
E.	*The criteria must continue for more than a month to distinguish between acute and chronic phases of PTSD.*

of PTSD, measurement-based care tools such as the PTSD Checklist (PCL), a self-rated checklist, or the PTSD Checklist-5 (a clinician-scored checklist of symptom severity) allow objective assessment of response to treatment. (4)

Special Features of Combat-Induced PTSD

Combat PTSD can be complex and severe due to unique factors associated with the trauma exposure, duration and repetitiveness of the exposure, and trauma associated with inflicting harm on or killing enemy combatants.

Unlike some civilian traumas, combat trauma typically has many episodes of reinforcing trauma. Combat tours in modern times are typically one year, but veterans of the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) era often served extended 18 month tours and multiple tours. Symptoms go unrecognized initially as they enable the veteran to cope under constant combat duress (hyperarousal, hypervigilance, emotional numbing create a state called "combat mindset"). Exposure to alcohol is ubiquitous in military culture, and a high percentage of cases initially involve addressing problem drinking. PTSD symptoms are often not recognized until returning home and attempting to reintegrate into civilian society.

Comorbidity and Suicide Risk in Combat PTSD

Comorbid psychiatric disorders are extremely common in PTSD and must be addressed. Substance use disorders, especially alcohol abuse, are commonly seen as a form of self-management of the disorder. Depression, anxiety, and behavioral disturbances can accompany PTSD. Suicide risk is especially high in combat Veterans, who kill themselves at a rate six times the general population. Clinical care for PTSD must include careful screening for co-morbid disorders and suicide risk, and appropriate interventions to manage these issues (5).

Evidence-Based Treatment for PTSD

Currently no *cure* exists for PTSD. However, the recovery model used by VA promotes a hopeful prognosis and indeed many Veterans experience significant relief and return of function from PTSD through evidence-based psychotherapy and pharmacotherapy. Therapy models focus on avoidance behavior. Avoidance behavior appears to be key in maintaining heightened levels of PTSD overall. Though it seems natural to avoid trauma related triggers, avoidance only provides short-term relief. Avoidance behavior feeds the intensity of PTSD in the long term.

Avoidance manifests in intrapsychic and externally driven ways. Intrapsychic avoidance includes any attempts mentally to control trauma related memories, thoughts, and feelings, normally through distraction and suppression. External avoidance is behavior designed to not be near or experience trauma-related triggers such as crowds or certain people, places, or situations remindful of the trauma. Therapy models, in different ways, confront intrapsychic and externally driven avoidance so the victim is able to experience trauma related thoughts and reminders comfortably. Current evidence based psychotherapies (EBP) for recovery from PTSD include cognitive processing therapy (CPT), and prolonged exposure therapy (PE) (2).

Cognitive processing therapy (CPT) focuses on perceptions adopted that become automatic thoughts following exposure to a traumatic event. CPT focuses on extreme or exaggerated beliefs generated in reaction to a trauma. CPT argues that five base areas of cognition are disrupted from trauma exposure including self-esteem, safety, trust, intimacy, and power and control (the ability to manage one's own life). CPT trains the person with PTSD to identify the associated thoughts in each domain, challenge the thoughts in rational discourse, and then develop a more reasonable core belief based on the evidence. The result is better emotional modulation (2).

Prolonged exposure (PE) therapy challenges core dysfunctional beliefs in two ways. First, the PTSD survivor identifies various people, places, and situations in daily life that trigger PTSD related anxiety. The therapist exposes the patient to the triggers in a systematic way until anxiety dissipates. The second part of PE identifies the most disturbing trauma experiences and discusses the trauma account in detail during sessions. The survivor listens back to the account of the trauma memory daily in between sessions. This controlled re-experiencing of trauma material desensitizes reactions to the memory, just as watching a horror movie repeatedly removes the intense feelings experienced when first viewed. The survivor can then discuss and process the trauma experience, which allows cognitive re-tooling the trauma similar to what is accomplished in CPT (2).

Other promising therapies are being studied. However, there is not enough evidence now to support any of these approaches as being effective treatments for PTSD. The efficacy of psychotherapy for PTSD appears to be related to some level of exposure in one form or another.

Pharmacotherapy

Medications are also helpful, especially in conjunction with psychotherapy, based on the latest treatment guidelines published by the VA and Department of Defense (5). Recent guidelines emphasize the efficacy of psychotherapy above that of medications. However, pharmacotherapy for PTSD is important for many Veterans and is thought to augment the response to therapy. Additionally, some Veterans with PTSD cannot tolerate the rigors of exposure therapy without some relief from excessive hyperarousal and irritability. It is important for the therapist and the prescriber to work together well, to share insights and concerns, and to communicate with the Veteran in a manner that shows good coordination of effort.

Selective Serotonin Reuptake Inhibitors (SSRI's) are the backbone of PTSD medication management. Fluoxetine and sertraline are perhaps the most researched effective therapies; in addition to reducing hyperarousal, irritability and hyperalertness, they often help with mood. Other SSRI medications used in PTSD include paroxetine, citalopram, and escitalopram. A good rule of thumb in selecting an SSRI medication is to explore prior history of response and first degree relative response to a particular SSRI. In general, fluoxetine is more activating than other SSRIs and may be

| continued on page 20

useful for a Veteran with low levels of activation.

Second line antidepressant strategies include the venlafaxine, mirtazapine and trazodone. When used as monotherapy, trazodone often requires higher doses than the doses used to treat insomnia. Tricyclic antidepressants, due to side effects and overdose risk, are usually reserved for cases failing other medication trials.

Current research and guidelines advise against benzodiazepines in treating PTSD, because they inhibit recovery and response to exposure-based psychotherapies. Buspirone for anxiety is often helpful. For sleep disturbance, a second low-dose antidepressant such as mirtazapine or trazodone is sometimes helpful. Prazosin, an antihypertensive agent, shows promise as augmentation treatment for decreasing intrusive nightmares.

Mental Health Services for PTSD Offered by the VA

Mental Health staffing and resources for PTSD have increased significantly in the last 10 years. Most local VA Medical Centers offer evidence-based psychotherapy and medication management for PTSD, and many offer specialized care programs for dual diagnoses cases. Special residential care programs throughout the country focus on intense treatment of PTSD. VA has also expanded same-day mental health access and suicide prevention resources, including the national 24 hour Veterans Crisis Line (1-800-273-8255), answered by a mental health clinician, and on-line chat and text messaging support at https://www.veteranscrisisline.net/. Veterans Crisis Line, online chat, and text-messaging services are free to all Veterans, even those not registered with VA.

Conclusion

Though the fact that PTSD is not curable seems daunting for many veterans, recovery is attainable through evidence-based treatment. Recovery essentially means learning to accept the disorder and managing it better by confronting the thoughts and feelings rather than avoiding them. Through active confrontation, it is very possible for a veteran to return to having a rich, full and productive life.

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Housing Homeless Veterans:

Why Community Relationships are Essential

by Michael Boyd, LCSW, BCD

HOW IT STARTED

Much has been publicized about veteran homelessness since 2009 when then Secretary of Veterans Affairs Eric K. Shinseki unveiled a plan to end homelessness among Veterans by "marshalling the resources of government, business and the private sector… Those who have served this nation as Veterans should never find themselves on the streets, living without care and without hope." (U.S. Department of Veterans Affairs, 2009). The partnership between the Department of Housing and Urban Development and the Department of Veterans Affairs created an opportunity to do something that had never been accomplished.

First, housing vouchers were awarded to VA sites. "The HUD-Veterans Affairs Supportive Housing (HUD-VASH) program combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics." (U.S. Department of Housing and Urban Development, n.d.).

A change in the way we viewed homelessness was also required. The innovative Housing First model was adopted, which used a forward-thinking approach of placing the homeless in housing first, then using wrap-around services and support to help keep them housed. "The Housing First model prioritizes housing and then assists the Veteran with access to healthcare and other supports that promote stable housing and improved quality of life. The model does not try to determine who is 'housing ready' or demand treatment prior to housing." (U.S. Department of Veterans Affairs, n.d.). The success of this model has nationwide data to back it up.

The Supportive Services for Veteran Families (SSVF) program was established in 2011. "Under the SSVF program, VA awards grants to private non-profit organizations and consumer cooperatives that can provide a range of supportive services to eligible very low-income Veteran families. Services include outreach, case management, assistance in obtaining VA benefits, and help in accessing and coordinating other public benefits. SSVF grantees can also make time-limited temporary payments on behalf of Veterans to cover rent, utilities, security deposits and moving costs." (U.S. Department of Veterans Affairs, 2012).

As support and resources were allocated, and programs were established nationwide, success followed. "The national picture is also improving. Homelessness among Veterans is down by nearly 50 percent since 2010. The data also revealed a 17 percent decrease in Veteran homelessness since 2015—quadruple the previous year's rate of decline." (U.S. Department of Veterans Affairs, 2016). However, there is much more to building a successful homeless program than just resources. It takes a bottom up approach of creating networks and relationships. It takes a community.

LUBBOCK'S STORY

Lubbock, Texas first started building its VA homeless program in 2012 with one staff person and 25 vouchers. Lubbock has a VA Community Based Outpatient Clinic, and is part of the Amarillo VA Healthcare System. Amarillo VA already had an established housing program. Despite having support and oversight from Amarillo, it was still a 2-hour drive away. This created challenges and opportunities.

The 2017 estimated population of Lubbock is 254,565 (City of Lubbock, 2017) which is similar to the size of Amarillo. Knowing this, and the large population of veterans in both cities, it was expected that the number of homeless veterans would be similar. However, without referral sources and organizations willing to bridge gaps in services, many homeless veterans would get lost in the shuffle. And they did.

When the Lubbock program first started, there were many barriers to housing homeless veterans. There were not enough landlords willing to work with a new program that waived past legal issues that would usually disqualify them from public housing. There were very few funding sources to assist with expenses like deposits and application fees. Many veterans could not get utilities turned on due to having outstanding balances. Transportation to help find housing was an issue. There was also an overall community need for education.

HOW WE BUILT COMMUNITY RELATIONSHIPS

Lubbock was fortunate for many reasons. The VA provided the resources, and most importantly, the flexibility for staff to go out into the community. Amarillo served as the model, which helped identify what worked, and just as importantly, what did not. The biggest factor may have been being in the right city at the right time. The Lubbock community was new to addressing its own homeless issues, and was very open to finding solutions and welcoming anyone willing to help. We avoided or minimized many coalition building problems, such as:

1) Turf issues. Sensitivity about sharing work between individuals and organizations can encountered.
2) Domination by one organization or group. Coalitions are diverse by definition, and this diversity is part of what makes them strong.
3) Losing focus. Coalitions must always keep in mind the community they are working to improve, and keep community concerns and needs at the forefront of their work.
4) Leadership issues. "Coalitions demand a very special kind of collaborative leadership which can harness the strength of everyone involved. Cultivation of this leadership is important to success." (American Library Association, n.d.).

The framework that worked in Amarillo was used in Lubbock, which included citywide outreach with all stakeholders, and developing partnerships with the Lubbock Housing Authority and the South Plains Homeless Consortium.

The relationship with the Lubbock Housing Authority became so beneficial to both sides that our VA Housing First Program is now located inside the LHA. At the time this happened, it was a rare occur-

rence. Now many cities consider it a best practice.

The SPHC was the most efficient way to meet community agencies working with the homeless. The SPHC is "a group of service organizations and agencies committed to serving people who are homeless and improving their quality of life. South Plains Homeless Consortium reflects the true scope of service in the 15 county South Plains Region." (South Plains Homeless Consortium, 2018).

Lubbock staff also began attending everything possible related to networking with agencies, including health fairs, agency events, and the annual Point-in-Time count. "The Point-in-Time (PIT) count is a count of sheltered and unsheltered homeless persons on a single night in January." (Texas Homeless Network, 2018). The flexibility to work evenings and weekends helped with outreach.

Willingness to speak, serve on committees, hold VA Stand Downs, and mostly just being available to the community was invaluable. Because of this, educating the community was successful and well received.

As veterans were housed, regular meetings with the Housing Authority kept everyone on the same page. We are now able to reconcile our data and to identify issues before they turn into an eviction. Negative exits for Lubbock have consistently been low.

Connections made with local agencies helped to bridge the gaps that previously prevented housing, such as the local Supportive Services for Veterans Families (SSVF) grant provider, VetStar that could house a veteran while they were waiting on the HUD/VASH process as well as provide one-time financial assistance. Other local agencies were also willing to cover certain expenses to help a veteran get into housing. The faster a veteran was housed, the less likely they were to give up during the process.

Meeting and recruiting landlords was also a vital piece. Lubbock is very veteran friendly, and some landlords who would not work with regular public housing were willing to house veterans in the HUD/VASH program. Sometimes a letter written to a property owner from out of town would make the difference.

The most important thing to remember when working with community stakeholders is to understand what they do, why they do what they do, and be accepting.

PLANS FOR CONTINUED SUCCESS

Currently, the Lubbock VA Housing First Program has almost 100 vouchers and 4 full time staff. So where do we go from here?

Our mission has always been ending veteran homelessness. "The goal is to achieve and sustain 'functional zero' – a well-coordinated and efficient community system that assures homelessness is rare, brief and non-recurring and no Veteran is forced to live on the street. This means that every Veteran has access to the supports they need and want to avoid staying on the street and move quickly to permanent housing." (U.S. Department of Veterans Affairs, n.d.). Declaring functional zero would be a major accomplishment in Lubbock, and it is currently within reach.

The Lubbock Housing First Program continues to be active in the SPHC, which has been working with the Texas Balance of State on Coordinated Entry. "Coordinated Entry simplifies the process for obtaining assistance, which has traditionally been difficult to decipher. Households experiencing literal homelessness present at designated entry points are assessed using a common assessment tool, and referred to appropriate agencies using a standardized and coordinated referral process. The primary goals for coordinated entry processes are that assistance be allocated as effectively as possible and that it be easily accessible no matter where or how people present. Coordinated entry processes help communities prioritize assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Coordinated entry processes also provide information about service needs and gaps to help communities plan their assistance and identify needed resources." (Texas Homeless Network, n.d.).

After declaring functional zero, and establishing coordinated entry, we will continue to improve existing services such as Case management, Peer Support, Supported Employment, Justice Involved, and Homeless Court. We also hope to bring programs to Lubbock like Transitional Housing, Grant and Per Diem, and Mental Health Intensive Case Management Program (MHICM). Effectively ending veteran homeless is dependent on keeping the previously homeless veterans housed.

The VA Homeless Veterans programs have been one of the more successful VA initiatives, with evidence based data and national success. Veterans and their families in the Panhandle and South Plains have benefitted, and the Amarillo VA Healthcare System remains a best practice model.

For more information go to www.va.gov/homeless/

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Veteran Suicide Rates and Prevention Initiatives

by Kristell Brinkmann, LCSW

Suicide is a stark reality for many Americans, especially for our nations' Veterans and their loved ones. According to the National Office of Mental Health and Suicide Prevention, 20 Veterans a day commit suicide according to most recent statistics reported in 2014. The report also included an alarming fact that only 6 of these 20 Veterans had been recently involved in VA services, meaning they had been seen in either 2013 or 2014. According to state data released by The Department of Veteran's Affairs, there were 554 Veteran suicides in Texas in 2014. The numbers show a downward trend according to statistics reported previously; however, there is still work to be done.

By looking at statistics, it is apparent that some Veterans choose to receive their care outside of the VA. This has been the case all along, but it begs the question of how these Veterans can be reached and adequately evaluated for suicide risk. Secretary of the VA, David Shulkin, has made suicide prevention the VA's top clinical priority. Accordingly, the Amarillo VA has taken an increased initiative to reach out to all Veterans regardless of whether they receive care at the VA or not. The largest of these tasks is getting information out into the community and into the hands of people who may interact with Veterans and their families, especially those who have not walked through the doors of the VA in quite some time or ever. During 2017, the Amarillo VA Suicide Prevention Team dramatically increased outreach activities within the community. The Suicide Prevention Team is expanding these outreach efforts in 2018 by targeting community agencies, religious organizations, educational institutions, and Veteran's organizations, which are all vitally important in identifying those who may be at increased risk for self-directed violence. The focus of these outreach activities is to educate the community about the risk factors of suicide and how to help in a time of crisis.

Risk factors for suicide are utilized by clinicians to gauge a Veteran's propensity to take his or her own life. Some of these risk factors include: being over the age of 65, male gender, history of suicide attempts, substance use, low support system, chronic pain, serious health conditions, mental health diagnosis and comorbidity, recent discharge from a psychiatric facility, psychosocial stressors or personal loss, and traumatic brain injury. Suicidal ideation in combination with a plan of how it would be carried out along with access to the means to do so are key indicators that the Veteran may be seriously considering suicide. It is vital that clinicians, community partners, and loved ones know the risk factors and are comfortable asking about suicidal thoughts.

The major hurdle in becoming familiar and comfortable with addressing suicide is overcoming the stigma associated with suicide and the myth that asking about suicide will plant suicidal thoughts in a person's mind. According to the Department of Veteran's Affairs Operation S.A.V.E training, "asking about suicide does not create suicidal thoughts any more than asking about chest pain causes angina." The reality is that asking about suicide may create a space of openness and comfort for the Veteran to talk about thoughts that they would have otherwise kept to themselves if not asked. Typically, with serious or uncomfortable topics, it is genuine concern in addressing the topic that helps reduce stigma and increase community action.

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Population Health Quality Improvement Project:

Opioid Reduction Efforts in the Veteran Population of the Texas Panhandle, 2015-2017

by Richard L. Siemens, J.D., M.D., M.P.H.

Introduction and purpose

Opioid overprescribing, diversion and misuse constitute a well-known health crisis, an epidemic. https://www.cdc.gov/drugoverdose/epidemic/index.html. The veteran population in the United States is not immune to this problem. Two factors led to this being chosen as our number one priority as I began my service as Chief of Staff at the VA in Amarillo. First, the fact that we are the largest integrated healthcare system in the United States (and one of the largest in the world) places an onus on the VA to lead, if possible, national efforts in opioid use reduction. Second, the Amarillo VA Healthcare System (AVAHCS) was a high outlier in terms of opioid use. At special risk are veterans who are prescribed over 200 mg morphine equivalents of opioids daily, as well as those concurrently on benzodiazepines.

In the recent past, pain had been referred to as the fifth vital sign. The origins of this reference are obscure. Many would point to The Joint Commission and its focus on adequate pain control in relieving the stress involved inherently in chronic pain, but the Joint Commission's position is that that was never a considered the fifth vital sign from their standpoint. Regardless, the "patient-centered" high-dose prescribing approach rose throughout the 1970s and 1980s and continued well into the nineties and even until today, with the patient in many cases determining the pain level that he or she will accept and the clinician then being obligated to treat that pain. Before the advent of many interventional pain treatment options, narcotics were one of the few tools available to the primary care provider for moderate to severe pain. Naturally this option is far from ideal. The cultural norm at the time across the United States, including here in the Panhandle of Texas, was to prescribe opioids for myofascial pain.

The VA is not immune to this culture, as it is the largest integrated healthcare system in America, and one of the largest in the world. Managing patient and provider expectations is therefore paramount in controlling and addressing in the opioid epidemic. The number of opioid overdoses has continued to rise over the past five years, and the President has declared this a national emergency. Several years ago, the Veterans Health Administration began to seriously address not only the overprescription of opioids, but other risk factors, including concurrent benzodiazepine use and opioid doses in excess of 90 morphine equivalents daily. Urine drug screens are used not only to ensure the patient is adherent but also to address diversion when that is suspected. Pain contracts and informed consents are also used. Since primary care providers within the VHA are normally not anxious to prescribe long-term opioids, positive urine drug screens often lead to frank and helpful discussions with the patient in order to optimize treatment. In addition, interventional pain management became more readily available, including Radio Frequency Lesioning (RFL) and cognitive behavioral therapy to help patients cope with the long-term pain. All of this amounts to a cultural shift which has borne and will continue to bear dividends in population health among the 16% of Panhandle veterans who are still taking chronic opioids. In 2012, that that number was 25%. Multidisciplinary teams are now reviewing the highest risk patients' cases and are rendering advice. VAMC Amarillo has also just hired a new physiatrist who is strong in interventional pain management. We hope therefore to sustain the reduction trends shown in the charts on the following pages.

Design

It was critical at the outset, in dealing with a project of this import and magnitude, to get our clinicians, and in particular our primary care providers, the information they needed to improve patient safety in this area, specifically in the areas of training and urine drug screens. The percentage of chronic opioid users who have submitted urine drug screens within the past year is an established metric within the Veterans Health Administration (VHA). Care has to be taken, of course, to deal with each patient individually, and too rapid a decrease in opioid prescribing as a healthcare system could be indicative of clinically overenthusiastic efforts.

Second, suboxone certification was added as an incentive for psychiatrists, obviously to provide a treatment pathway for veterans appropriately in need of suboxone treatment.

Third, alternative therapies (detailed in the next section) were offered to the primary care providers looking for assistance for patients who were candidates to be tapered off opioids.

Fourth, and perhaps most importantly, providers were assured of leadership's support of their efforts to taper veterans whenever appropriate off opioids, especially in terms of patient complaints against the provider.

In addition to the efforts just described above, VAMC Amarillo has a Pain Management Committee, which tracks chronic opioid use and advises providers and leadership on issues affecting pain management. We currently have available the following modalities:

| continued on page 28

Interventional Pain Management (Anesthesia Pain Management) services both in-house and in the community, to include: trigger point injections, epidural spinal injections, rhizotomies, and spinal cord stimulator placement.

Pharmacological Pain Management: In-house (Pharmacy clinics) & in the community in combination with anesthesia pain management specialists.

Chiropractic Care: Available in the community.

Acupuncture Therapy: Available in the community.

Aquatherapy: Available in the community on a limited basis.

Suboxone therapy: Available in house.

These alternative therapies were of course announced as available to all providers and were made accessible through the electronic health record.

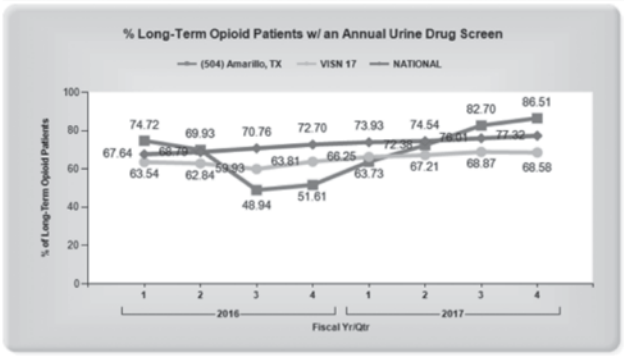
Results and Discussion

The results of these combined efforts were immediate and sustained, as the following charts illustrate:

Urine Drug Screening (All Opioids)

Numerator: # of Long-Term Opioid Patients (received a VA-issued opioid prescription during the specified fiscal quarter and a ≥ 90 days supply of opioids over the indicated quarter and the quarter prior) that had a urine drug screen completed within 365 days of the end of the fiscal quarter.

Denominator: # of Long-Term Opioid Patients (received a VA-issued opioid prescription during the specified fiscal quarter and a ≥ 90 days supply of opioids over the indicated quarter and the quarter prior).



Location	Value	Q1 FY16	Q2	Q3	Q4	Q1 FY17	Q2	Q3	Q4
NATIONAL	# LT Opioid Pats w/ Annual UDS	303,631	301,214	300,781	297,964	290,777	281,905	283,273	275,853
	# Long-Term Opioid Pats	448,906	437,865	425,048	409,856	393,332	378,181	372,682	356,784
	% LT Opioid Pats w/ UDS	67.64	68.79	70.76	72.70	73.93	74.54	76.01	77.32
(504) Amarillo, TX	# LT Opioid Pats w/ Annual UDS	2,155	2,016	1,406	1,441	1,713	1,850	2,061	2,129
	# Long-Term Opioid Pats	2,884	2,883	2,873	2,792	2,688	2,556	2,492	2,461
	% LT Opioid Pats w/ UDS	74.72	69.93	48.94	51.61	63.73	72.38	82.70	86.51
VISN 17	# LT Opioid Pats w/ Annual UDS	19,980	19,378	18,065	18,525	18,338	17,913	18,000	17,182
	# Long-Term Opioid Pats	31,447	30,839	30,144	29,033	27,678	26,652	26,138	25,055
	% LT Opioid Pats w/ UDS	63.54	62.84	59.93	63.81	66.25	67.21	68.87	68.58

These initial efforts (Amarillo HCS being the blue line, as per the legend) gave critical information to the opioid prescribers as to what the patients were taking, such as street drugs, and reliable clues as to whether they were adherent to the prescribed opioid regimen.

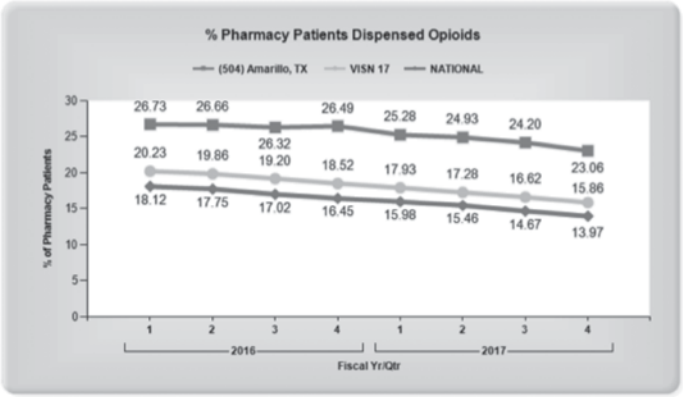
As to the trends of overall opioid use, please note the following:

Last Salesforce Update: 8/28/2017

All Opioid Patients

Numerator: # of Patients who received a VA-issued opioid prescription (**excluding buprenorphine sublingual** products) during the specified fiscal quarter.

Denominator: # of Patients who received a VA-issued prescription during the specified fiscal quarter.



Location	Value	Q1 FY16	Q2	Q3	Q4	Q1 FY17	Q2	Q3	Q4
NATIONAL	# Opioid Pats	736,592	726,943	696,839	673,693	651,761	637,853	606,091	575,012
	# Rx Pats	4,065,936	4,095,835	4,094,085	4,096,224	4,078,545	4,126,113	4,130,875	4,117,096
	% Opioid Pats	18.12	17.75	17.02	16.45	15.98	15.46	14.67	13.97
(504) Amarillo, TX	# Opioid Pats	4,330	4,370	4,268	4,226	4,015	3,960	3,829	3,662
	# Rx Pats	16,200	16,391	16,214	15,952	15,883	15,885	15,820	15,882
	% Opioid Pats	26.73	26.66	26.32	26.49	25.28	24.93	24.20	23.06
VISN 17	# Opioid Pats	52,252	51,838	50,049	48,363	46,790	46,001	44,206	42,222
	# Rx Pats	258,226	261,002	260,720	261,139	261,031	266,143	266,002	266,225
	% Opioid Pats	20.23	19.86	19.20	18.52	17.93	17.28	16.62	15.86

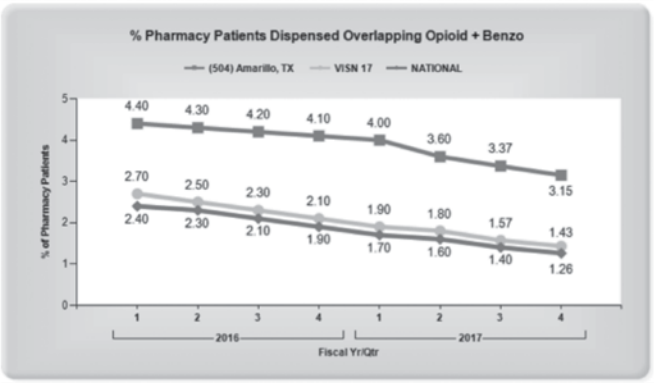
This shows a sustained and steady trend in a favorable direction. Amarillo HCS, as an outlier on the high side in opioid prescribing, is undergoing a cultural shift in terms of pain management.

On this particularly difficult measure as well, we have made steady progress, especially through multidisciplinary efforts.

Opioid + Benzodiazepine

Numerator: # of Patients who received a VA-issued opioid prescription that had 1+ day of overlap (Release Date + Days Supply) with a benzodiazepine prescription during the specified fiscal quarter.

Denominator: # of Patients who received a VA-issued prescription during the specified fiscal quarter.



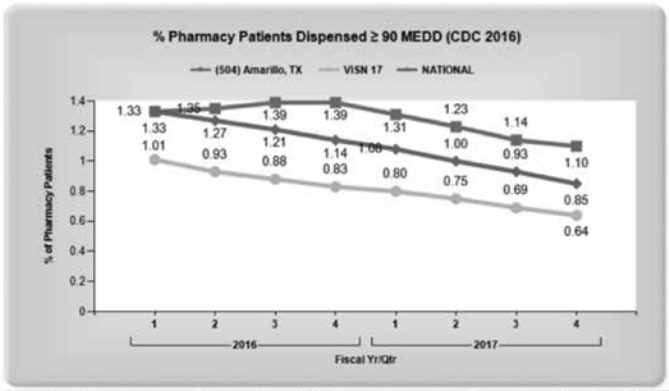
Location	Value	Q1 FY16	Q2	Q3	Q4	Q1 FY17	Q2	Q3	Q4
NATIONAL	# Opioid + BZD Pats	99,282	93,437	85,450	77,895	70,394	64,213	57,718	51,712
	# Rx Pats	4,065,936	4,095,835	4,094,085	4,096,224	4,078,545	4,126,113	4,130,875	4,117,096
	% Opioid + BZD Pats	2.40	2.30	2.10	1.90	1.70	1.60	1.40	1.26
(504) Amarillo, TX	# Opioid + BZD Pats	714	709	682	648	641	577	533	501
	# Rx Pats	16,200	16,391	16,214	15,952	15,883	15,885	15,820	15,882
	% Opioid + BZD Pats	4.40	4.30	4.20	4.10	4.00	3.60	3.37	3.15
VISN 17	# Opioid + BZD Pats	6,959	6,517	6,040	5,427	5,028	4,672	4,163	3,810
	# Rx Pats	258,226	261,002	260,720	261,139	261,031	266,143	266,002	266,225
	% Opioid + BZD Pats	2.70	2.50	2.30	2.10	1.90	1.80	1.57	1.43

This effort trended well initially, but the rate of decrease stalled somewhat, so we have made additional interventions here in the form of pain reviews and interdisciplinary pain teams, and will follow it further.

MEDD ≥ 90 (CDC 2016) (Morphine Equialent Daily Dose)

Numerator: # of Patients who received a VA-issued opioid prescription were taking a high daily dose [≥ 90 MEDD (CDC 2016) or ≥ 100 MEDD (PBM OSI)] during the specified fiscal quarter.

Denominator: # of Patients who received a VA-issued prescription during the specified fiscal quarter.



Location	Value	Q1 FY16	Q2	Q3	Q4	Q1 FY17	Q2	Q3	Q4
NATIONAL	# High Dose Pats	54,060	52,066	49,384	46,503	43,926	41,082	38,277	35,147
	# Rx Pats	4,065,936	4,095,835	4,094,085	4,096,224	4,078,545	4,126,113	4,130,875	4,117,096
	% High Dose Pats	1.33	1.27	1.21	1.14	1.08	1.00	0.93	0.85
(504) Amarillo, TX	# High Dose Pats	215	221	226	221	208	195	180	174
	# Rx Pats	16,200	16,391	16,214	15,952	15,883	15,885	15,820	15,882
	% High Dose Pats	1.33	1.35	1.39	1.39	1.31	1.23	1.14	1.10
VISN 17	# High Dose Pats	2,608	2,418	2,282	2,169	2,099	1,988	1,835	1,691
	# Rx Pats	258,226	261,002	260,720	261,139	261,031	266,143	266,002	266,225
	% High Dose Pats	1.01	0.93	0.88	0.83	0.80	0.75	0.69	0.64

Conclusion

Efforts at all levels of healthcare administration can be combined successfully to address the opioid crisis. These efforts will be continued and supplemented by new efforts until Amarillo HCS approaches the national mean for these opioid measures.

Staphylococcus scuiri late peri-prosthetic osteomyelitis of the tibia from the Amarillo Veterans Affairs Medical Center

by Tarek Naguib, M.D., Robert S. Urban, M.D., Teji Dhami, M.D.

ABSTRACT

Staphylococcus sciuri is an emerging gram-positive bacterial pathogen that is occasionally isolated from cases of human disease (1). Most reported cases are in animals. We present a case of *Staphylococcus scuiri* osteomyelitis of the tibia and highlight epidemiiological and therapeutic implications of this unusual pathogen.

KEYWORDS

Osteomyelitis –surgical site infection--tibia--*Staphylococcus scuiri*

INTRODUCTION

Infection of metallic devices used in fixation/replacement orthopedic surgery is a commonly encountered problem in infectious diseases (2). Much of the bacteriological data comes from periprosthetic joint infections (PJIs). About 70% of cases of PJI are caused by staphylococci (*S. aureus* and coagulase-negative staphylococci), 10% by streptococci, 10% by gram-negative bacilli, and the rest by various other microorganisms (3). Metallic device infection is traditionally classified as early (<3 months after implantation), delayed (3–24 months after surgery), or late (>2 years after implantation) (3). Late infections are generally felt to be related to seeding of the appliance from transient bacteremia.

Infections following plate fixation of proximal tibial fractures have been extensively studied and occur in 5-25% of patients in published series (4). A recent retrospective case review showed that risk factors for infection included alcoholism (relative risk 6.7), obesity (relative risk 6.5), age >50 years (RR 3.6) and several factors related to severity of the injury and complexity of the repair (e.g. requirement for a spanning external fixator); only 17% of infections were delayed or late infections (4). In this case from the Amarillo Veterans Affairs Medical Center, we report a late metallic device associated infection in one patient due to a rarely isolated organism, *Staphylococcus sciuri*.

CASE HISTORY

77-year-old Latin-American male veteran, with past medical history of poorly controlled diabetes mellitus (hemoglobin A1c 9.7) and hypertension, had been treated 5 years previously for right tibial pilon fracture. Initial management was with an external fixation device, followed by interfragmentary fixation of the major fragments. He subsequently presented with worsening pain, redness & swelling of the medial aspect of the right ankle, noted for the preceding 2 to 3 days, ascribed by the patient to mowing his lawn. The patient did not remember any insect bites, contact with animals, or substantial trauma to the area.

Social history revealed that he was an ex-smoker, who had smoked ½ pack per day for almost 40 years. He denied use of injectable or illicit drugs and did not consume alcoholic beverages. The patient was unmarried and was retired. His functional status had been excellent until 2 to 3 days prior to admission.

His vital signs on admission were: temperature 98.4, pulse 79, respiratory rate 18, blood pressure 149/84, oxygen saturation 94%, BMI 30.41. Physical exam revealed a well-developed Hispanic male with mild complaints of pain. General physical exam was unremarkable; no cardiac murmurs were appreciated. Examination of the right lower extremity revealed multiple surgical scars over the distal tibia and diffuse swelling with erythema and fluctuation on the anteromedial aspect of the right ankle. Sensation to light touch was reduced bilaterally, consistent with diabetic polyneuropathy.

Initial laboratory studies were remarkable for WBC 12,100 with 64.5% polys, sedimentation rate 76 (normal <15), C-reactive protein elevated at 7.37, and normal procalcitonin at < 0.05.

Pre-op superficial culture from the foot grew *Serratia marcescens* resistant to ampicillin/sulbactam and cefazolin but sensitive to cefotetan, ceftriaxone, ciprofloxacin, gentamicin, meropenem, piperacillin/tazobactam, ticarcillin/clavulanate, and trimethoprim/sulfamethoxazole. Radiographs of the distal tibia showed healed tibial pilon fracture with advanced traumatic arthritis of the tibiotalar joint and retained surgical hardware consisting of 2 anterior to posterior cannulated lag screws through the distal tibia. No subcutaneous gas was identified.

The patient was taken to surgery for incision and drainage of the abscess and intramedullary canal, irrigation of the right distal tibia wound and removal of necrotic material and retained surgical hardware. Operative findings suggested osteomyelitis. Gram stain was negative, but intra-operative cultures revealed moderate growth of *Stapylococcus scuiri*. The organism was resistant to clindamycin, erythromycin, oxacillin, penicillin, and vancomycin but was sensitive to fluoroquinolones, tetracycline, and trimethoprim/sulfamethoxazole. No anaerobes were isolated.

Pathological findings showed acute and chronic panniculitis and synovitis with fibrosis & bony remodeling, plus areas consistent with acute and chronic osteomyelitis. The patient was initially

| continued on page 32

treated with IV vancomycin & piperacillin/tazobactam but was then switched to oral levofloxacin 750 mg daily and IV vancomycin (for the possibility of uncultured resistant *Staphylococci*), with plans to continue this regimen for 6 weeks. He was treated at a long-term acute care facility with these antibiotics, as well as wound vac & wound care. The redness, warmth & tenderness over the wound improved, and discharge from the wound became clear. An infectious disease specialist recommended colonoscopy, which revealed benign polyps without evidence of malignancy.

DISCUSSION

Most surgical site infections are caused by the most virulent and invasive Staph organism, *Staphylococcus aureus*, but prosthetic and intravascular devices are susceptible to infection with coagulase-negative Staphylococci. The most troublesome of the coagulase-negative organisms is *Staph epidermidis*, but infections with *Staph lugudensis* and *Staph scheiferi* are reported with increasing frequency, especially in prosthetic valve endocarditis (5).

Staphylococcus sciuri group includes five species, most often described as commensal animal-associated bacteria (1). Species of this group are *Staphylococcus sciuri* (with three subspecies), *Staphylococcus lentus*, *Staphylococcus vitulinus*, *Staphylococcus fleurettii* and *Staphylococcus stepanovicii* (6). Members of the group have been reported as pathogens in chickens, cockroaches, cows, horses, and cats (7). The clinical importance of *S. sciuri* in human disease results from the fact that it has been associated with infections such as endocarditis, urinary tract infection, and wound infections (8). This organism is capable of rapid conversion from a state of methicillin sensitivity to a state of methicillin resistance and has been shown to express a set of highly effective virulence factors (6). Several observations support the proposition that the mecA homologue ubiquitous in the antibiotic-susceptible animal species *S. sciuri* may be an evolutionary precursor of the methicillin resistance gene mecA of the pathogenic strains of methicillin-resistant *Staph aureus* (MRSA) in humans (9,10). There is also concern for potential spread of multidrug-resistant coagulase-negative staphylococci through healthcare waste (11).

CONCLUSION

S. sciuri species have also been found to carry multiple virulence and resistance genes (6). The isolate from our patient, for instance, was resistant to beta-lactams as well as vancomycin, although fortunately sensitive to fluoroquinolones and trimethoprim/sulfamethoxazole. More investigation into the role of the *S. sciuri* species group as commensal and pathogenic bacteria is required to fully assess its medical and veterinary importance (1). In addition, with the increased incidence of diabetes, and with the aging of the Veteran population, infection with this and other minimally pathogenic species may become increasingly common and increasingly challenging to treat.

CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

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Cataracts: What You Need To Know

by Taru Bharadwaj and Tarek Naguib, M.D., M.B.A., F.A.C.P.

What is a cataract?
Cataract is a clouding of the lens of the eye causing blurry vision and blindness, if untreated. The lens lies just behind the pupil to focus the light and project it onto the back of the eye on the retina. If the exact protein arrangement of the lens becomes damaged and starts to clump together, the lens will cloud.[1]

What are the symptoms of cataracts?
Cloudy or blurry vision, faded colors, poor night vision, glare from lights, and frequent prescription changes in a short amount of time can seem mild, but require a check with an eye care professional to get the eyes tested.[1]

What factors affect the development or prevention of cataracts?
Old age and ultraviolet light for long exposure, smoking, family history, and certain diseases such as diabetes are risk factors.[2,3] Regular exercise, normal blood pressure and cholesterol levels, diet, sunglasses and a hat with a brim can all protect eyes and lower the risk of developing a cataract.[4]

What are the types of cataracts?
Diabetes, trauma after eye injury (including very excessive rubbing of the eye), and radiation exposure such as UV radiation can cause cataracts.[5]

How are cataracts treated or removed?
If early and mild, eyeglasses, brighter lighting, and sunglasses are used to manage cataracts."[6] If surgery is planned, the cloudy lens is removed and replaced with a clear artificial lens. Cataract surgery is the safest, most effective, and most common surgery in the U.S. due to the development of more sophisticated tools and methods of lens replacement.[7]

If you are considering cataract surgery:
If you are planning on getting your cataracts removed, make sure you have discussed cataract surgery with your eye doctor; ask questions and follow any directions or procedures that you need to undergo before or after the surgery to maximize results and reduce risk.

The need for cataract awareness
Everyone knows about heart disease and cancer and reads articles on how to prevent such diseases; this is wonderful and vital. However, it is also important to be aware of seemingly smaller health issues, such as cataracts. Potentially blinding eye issues affect around 81 million Americans; partial or total vision loss can lead to other severe issues such as depression, loss of mobility, and severe falls.[8] By raising awareness, more people can take measures to prevent cataracts as early as possible, rather than staying under the notion that cataracts are only related to age; awareness can also promote more research towards cataracts to help provide more definitive knowledge about cataracts and more absolute measures to help prevent them.

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by Tarek Naguib, M.D., M.B.A., F.A.C.P.

Urine Test for TB in Development. JAMA (2/13) – An international team of researchers is developing a nanotechnology-based urine test to detect active tuberculosis that will make for a cheap and quick diagnosis.

Global Burden of TB. JAMA (2/13) – World Health Organization reports that, in 2016, 10.4 million people fell ill with TB, and 1.7 million died from the disease (including 0.4 million among people with HIV). Over 95% of TB deaths occur in low- and middle-income countries. TB is one of the 10 top causes of death in the world.

Indoor Smoking Restriction. JAMA (2/13) – Texas and Oklahoma remain among 22 states that lack comprehensive smoke-free laws and do not prohibit indoor e-cigarette smoking.

CVS to Acquire Aetna. Med Econ (01/25) – CVS Health (the drug store giant) announced plans to acquire Aetna insurance company in a $69 billion deal. CVS could now offer primary care to patients in a one stop shopping, which could alter the landscape of primary care in the US. The deal is still to be approved by Federal regulators.

Aetna Under Investigation. CNN (2/11) – California's insurance commissioner has launched an investigation into Aetna after learning a former medical director for the insurer admitted under oath that he never looked at patients' records when deciding whether to approve or deny care.

Increase in Diabetes Cases among the Young. JAMA (5/2017) – The CDC has announced an increase of type-1 diabetes in youths 0 to 19 years old from 15,900 cases in 2003 to 17,900 cases in the year 2012. In the same time frame, type-2 diabetes also increased in youths aged 10 – 19 years old from 3800 to 5300 cases.

Death Less under Teaching Hospitals Care. JAMA (5/2017) – Research showed that major teaching hospitals had lower mortality for common conditions when compared with non-teaching hospitals. The study evaluated 21 million total hospitalizations.

Red Meat Allergy & Tick Bites. JAMA (1/30) – Rare cases of allergic reactions to red meat have been linked to Lone Star tick bites as outlined by National Institute of Allergy and Infectious Disease.

Bariatric Surgery Decreases Blood Pressure. JAMA (1/23) – A study of 100 patients with hypertension undergoing weight loss surgery showed that the overwhelming majority were able to maintain their blood pressures on 30% fewer medications.

Posttraumatic Stress Disorder Better with Prolonged Therapy. JAMA (1/30 – PTSD was better with massed prolonged therapy over 10 weeks than more intensive massed therapy over 2 weeks. Both were better than minimal contact control. The improvement was modest, however, indicating need for more breakthroughs.

Total Live Births in Texas. Tex Med (01/2018) – The total number of live births in Texas in 2013 was 387,110 out of which (42%) were attributed to unmarried mothers.

Medications do not Prevent Dementia. Ann Intern Med (1/2) – Evidence does not support use of any current pharmacologic treatments for cognitive protection in persons with normal cognition or mild cognitive impairment.

Cognitive Training Prevents Cognitive Decline. Ann Intern Med (1/2) – Training improved cognitive performance in the domains in which training was conducted but researchers cannot say it prevents dementia.

Over-the-Counter Supplements Do Not Prevent Dementia. Ann Intern Med (1/2) – Over the counter supplements failed to show evidence that they may prevent dementia in normal or mildly demented individuals. Vitamin E, folic acid plus vitamin B12, gingko biloba, Omega 3 fatty acid, beta carotene, vitamin C, vitamin D, calcium, and multi vitamins have all been included in the study.

Exercise May Help in Preventing Cognitive Decline. Ann Intern Med (1/2) – Physical activity interventions in one component were not proven to delay cognitive decline in normal of mildly demented individuals. However, there was a trend to prevention in multicomponent intervention that included flexibility, strength, balance, endurance, and aerobic training.

Vitamin B-3 May Prevent Dementia in Mice. MD Linx Neurology (2/17) - New research finds a compound that prevents brain damage in mice. The substance is a form of vitamin B-3, nicotinamide riboside, and the findings suggest a potential new therapy for Alzheimer's disease in humans.

PROFESSIONAL CARDS

Cardiology

AMARILLO HEART GROUP
Joaquin Martinez-Arraras, M.D.
Marc Moreau, M.D.
Prakash K. Desai, M.D.
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D. Gary Soya, M.D.
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Dr. Constantine Saadeh Introduces

DR. NICOLE DAVEY

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We are so pleased to have Dr. Nicole Davey-Ranasinghe (ΑΩΑ, University of Nevada School of Medicine) aboard Allergy A.R.T.S.

Dr. Davey did her internal medicine residency at the University of Nevada School of Medicine where she served as chief resident. Following residency, Dr. Davey completed her clinical training with a **fellowship in rheumatology** at Oregon Health and Science University. She has spent the last three years with Centura Health Physician Group in Durango, Colorado.

Board Certified in rheumatology and internal medicine, she brings experience and passion for the management of both common and complex rheumatologic conditions, such as **rheumatoid arthritis, lupus, osteoarthritis, spondyloarthritis and osteoporosis**.

I know Dr. Davey will be a great asset to the patients of Allergy A.R.T.S. and to the Amarillo medical community. **Welcome!**

To make an appointment with Dr. Davey, please call (806) 353-7000

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