Grateful Beyond Words

Chance Sommerer’s family kept the faith that his story would have a happy ending.
At University of Missouri Health Care, our mission is to save and improve lives. Saving lives is something we do every day at our five hospitals and more than 50 clinics. But what about improving lives? The services we provide at MU Health Care represent just a fraction of the needs of our neighbors. It takes a broad network of alliances and partnerships with complementary organizations to improve lives and create healthy communities. It means going above and beyond the walls of our hospitals.

To keep our communities thriving, we’re joining with likeminded groups focusing on engagement, access and opportunity. We strive to be active participants, partnering with local organizations to improve our communities through arts and culture, access to medical care and opportunities for individual growth.

That’s why we’re actively exploring new opportunities to serve our region. We recently signed a letter of intent with SSM Health to transfer ownership of St. Mary’s Hospital - Jefferson City and St. Mary’s Hospital - Audrain. We see the potential transfer of ownership of these two hospitals — as well as outpatient, home care, hospice and medical group locations throughout the region — as being consistent with MU Health Care’s mission to save and improve lives. This potential transaction would provide our region with greater access to care, a more reliable path for training and recruiting physicians, nurses and other health professionals, and a larger network that can provide more advanced levels of care, as needed.

In this issue of MU Health magazine, you’ll see how we’re changing lives not only through our medical care, but also through our engagement with and commitment to our communities. I invite you to visit muhealth.org/community to see more stories of how we’re partnering with communities to improve the places we call home.

Jonathan Curtright
CEO
University of Missouri Health Care
**LETTERS**

*Share your happiness.* Our patients inspire us, and sharing your story can inspire others. If you would like to share your story, we’d love to hear from you! Visit muhealth.org and click “Feedback” at the bottom of the page, email social@health.missouri.edu or send a letter to: MU Health Magazine, Office of Communications, 1 Hospital Drive, DC 401.00, Columbia, MO 65212.

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**Sonographer makes great catch**

I just wanted to give sonographer Tim Brown a kudo and a much-appreciated thanks!

I have had quite a few echocardiograms done since my heart became sick in 2011 due to chemo the previous two years. Most of my echoes have been done at the main hospital, but when they scheduled the first available, I received an appointment at the South Providence Medical Park.

My heart became sick mainly on the left side, and I began seeing Dr. Mary Dohrmann in cardiology. For this reason, the echoes are focused more on the sicker left side and not so much on the right. So when Tim took the time to get some clear pictures of the right, it probably saved my life. His echo showed a clot on the pacer wire on the right side.

Dr. Dohrmann called me that night after looking at the echo and got me on some medicine to deal with this new threat. I really appreciate the dedication that Tim Brown has for his job, and Dr. Dohrmann is one of the best cardiologists who really cares for her patients. Thank you both so very much. I can never repay what you have done for me.

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**Nurses provided compassionate care**

On behalf of the family of Philip Lee Gilmore, I would like to extend our most sincere appreciation to your staff for the amazing care you gave our father in May. Dad arrived at University Hospital on May 15 after suffering a massive brain hemorrhage. By 3:30 p.m. on May 16, he passed away.

We want to acknowledge your staff for making this tragedy as comfortable as possible for our family. We would especially like to thank two members of your nursing team: Danielle and Eliza. Although we didn’t have a lot of time with either, we will never forget them. Both treated Dad with such kindness and dignity.

Danielle never left our side during the day and patiently explained in detail what was happening to Dad. Although there were so many tears, and fear, she helped us understand what we were facing. Eliza treated Dad as though he were part of her family throughout the night. She was so kind and comforting. We know for certain these two women are doing exactly what they were called to do.

We are grateful for the level of care our father received at the University of Missouri Hospital. We all agree that he received the best of the best.

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Mark and Rachel Gilmore
PERRY, MISSOURI

Anne and Chris Merten
JONESBORO, ARKANSAS

Scott and Sara Gilmore
LEE’S SUMMIT, MISSOURI

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Warm Welcome

Diane Suthoff is a patient services representative at Ellis Fischel Cancer Center and the driver of the Mamm Van.

About Me
I am originally from Massachusetts. I think having a slight accent helps me put people at ease. They often come right out and ask, “Where are you from?” I reply, “Here.” They smile or chuckle immediately and say “No way.” So, it’s a good icebreaker.

About My Role
I work in cancer screening at Ellis Fischel Cancer Center, and I drive the MU Health Care Mammography Van. The Mamm Van, as it’s called, is a full-service mobile breast health clinic. It offers the same top-quality care you’ll find at any of our imaging centers. In addition to mammograms and breast exams, the nurses also check for suspicious moles, which helps a lot of patients detect problems they likely wouldn’t see on their own.

Favorite Part of My Job
The best parts of my job are meeting people and driving the Mamm Van. The mobile unit allows us to reach people who can’t make it to Columbia or take time off from their jobs throughout central and northern Missouri. This outreach enables us to serve those who otherwise might not get these recommended checkups.

Culture of Yes
When people come in to get screened for cancer, they usually feel nervous and anxious. I do what I can to put them at ease and make them feel comfortable. I enjoy it when I can get a smile or laugh from my patients.

The Mamm Van is a 38-foot vehicle that brings mammograms to women in 49 Missouri counties.

Read about a day in the life of the Mamm Van at muhealth.org/mamm-van
TMS Offers Alternative for Patients With Depression

Before joining MU Health Care over the summer, Matt Schmidt spent eight years at the Medical University of South Carolina and the Ralph H. Johnson VA Medical Center. While there, he used a variety of neuromodulation treatments, including transcranial magnetic stimulation (TMS), to treat psychiatric patients.

Schmidt often saw patients with low expectations that anything could make them feel better.

“In some people, TMS causes a dramatic shift, and they are very, very surprised about the way they feel,” Schmidt said. “They’re so used to being depressed. They come in and say, ‘I’m sleeping better, I feel better and I have more energy.’ ”

TMS is a nonsurgical procedure that is FDA-approved to treat depression in adults who have not had success with medication.

MU Health Care offers TMS at its new Neuromodulation Clinic at the South Providence Psychiatry facility, with Schmidt serving as the program director. Neuromodulation is one of three methods — along with traditional psychotherapy and medication — used to treat psychiatric patients.

A device that emits magnetic pulses to the brain’s left prefrontal cortex is placed on the patient’s head. The pulses stimulate nerve cells in the brain that control mood.

“In research, about a third of patients go into remission, where your depressive symptoms completely go away,” Schmidt said. “And this is in people who often have tried not just one antidepressant but many.”

TMS has typically involved five 20-minute sessions per week for at least six weeks. However, the Neuromodulation Clinic is the region’s only provider that offers a new version of TMS recently approved by the FDA that cuts individual treatment times down to just three minutes.

TMS is an outpatient procedure that doesn’t require anesthesia, and patients can drive immediately after their session. During treatment, patients will hear a clicking sound and feel a tapping sensation on their head. A small percentage of patients complain of mild discomfort or headaches afterward. TMS patients do not suffer from antidepressant medication side effects such as weight gain, fatigue or insomnia.

“The goal is to put the patient in remission, which is defined as being free of symptoms for two months,” said MU Health Care psychiatrist Muaid Ithman, MD, the medical director of the Neuromodulation Clinic. “The people receiving the treatment are chronic in nature, because they have failed at least two antidepressants, so they will need maintenance after this. We hope to put them in remission and maintain them or at least give them a response to improve and maintain them on other medications.”

At the Neuromodulation Clinic, TMS is just one of the offerings. Light therapy boxes that mimic sunlight can treat seasonal affective disorder in the winter. Cranial electrotherapy stimulation, which involves sending a very low current to the brain through clips on the earlobes, is used to treat anxiety. Electroconvulsive therapy, in which electric currents are passed through the brain to trigger a brief seizure and change brain chemistry, is available to treat a variety of mental illnesses.

People interested in trying TMS or other treatments at the Neuromodulation Clinic should contact their primary care provider or psychiatrist, who can refer them to the MU Psychiatric Center. TMS is covered by most insurance providers.
A week after having a loop recorder implanted to monitor her heart rhythm, Mary Andersen was at home reading a magazine when the phone rang. The call was from University Hospital. Her recorder had alerted the cardiology clinic that Andersen's heart was racing.

“The person asked, 'What are you doing?’” Andersen recalled. “I said, 'I'm reading.' I hadn't done anything to trigger it. It really started going crazy.”

Andersen was suffering from a condition called atrial fibrillation — a rapid and irregular heartbeat originating in the upper chambers of the heart. Her racing heartbeat during a calm moment without any other known triggers such as alcohol or caffeine consumption was a sign that medication alone wasn't working to solve her problem.

A few days after that phone call, MU Health Care's Sandeep Gautam, MD, performed catheter-based ablation surgery.

Since that procedure in October 2015, Andersen has experienced only one AFib episode, and that was when she was ill after drinking sour milk.

“Atrial fibrillation is getting more common as our population is aging, especially because baby boomers are in their 70s now,” said Gautam, a cardiologist who specializes in arrhythmias. “A big influx of atrial fibrillation is coming up. You can imagine the degree of atrial fibrillation incidence by the fact that atrial fibrillation ablation is now the most common ablation procedure performed for any kind of rhythm problem. If you go back 20 years, atrial fibrillation ablation was 20 percent of the procedures we offered. Now it’s almost 75 percent.”

Andersen, who worked as a research specialist in the MU School of Medicine’s Division of Pulmonary, Critical Care and Environmental Medicine until her retirement in 2015, was diagnosed with AFib in 2011.

“It feels like a really sharp pain in your chest,” she said. “You can feel your heart is beating really fast. It’s just kind of throbbing. Then you start to feel generally bad, like when you’re getting really sick. You don’t want to do anything or exert yourself in any way.”

Patients who experience those symptoms should contact their primary care physician or cardiologist. AFib causes blood to pool in the heart, increasing the possibility of stroke. AFib risk factors include a family history of the disease, uncontrolled high blood pressure, uncontrolled diabetes, obesity and untreated sleep apnea.

After diagnosis, the first step is for a patient to receive an electrocardiogram and wear an outpatient heart monitor for one to 30 days. A shock to the heart called a cardioversion in conjunction with anti-arrhythmic medication can sometimes restore the heart to its normal rhythm.

Ablation procedures often can fix the problem and allow the patient to get off anti-arrhythmic medications.

“We use a technique called radio-frequency ablation, which uses radio-frequency energy to create what you can imagine as very low-power welding inside the heart,” Gautam said.

The procedure takes three to five hours. A catheter is inserted in the groin and run through the femoral vein to the heart. A puncture is made in the wall separating the right and left side of the heart. The source of AFib in most patients is the pulmonary veins in the left atrium of the heart, so a set of lesions is created to disconnect the electricity to those veins. The patient is usually monitored for a day and then released from the hospital.

Andersen has made some minor dietary adjustments and now uses a CPAP machine for her sleep apnea to guard against triggering her AFib. Otherwise, it’s business as usual for Andersen, an avid reader who enjoys volunteering in the library at Our Lady of Lourdes Catholic Church.

“She is off medicine for atrial fibrillation,” Gautam said. “She had an excellent response with great clinical improvement.”
Cardiologists nationwide are seeing more patients with atrial fibrillation (AFib), an irregular heartbeat originating in the upper chambers of the heart. If left untreated, the condition can cause blood to pool and coagulate in the heart and lead to strokes.

“Advanced age is one of the factors that can lead to AFib, but you can get AFib at any age,” said MU Health Care’s Hemant Godara, MD, a cardiologist specializing in the heart’s electrical system. “Just like prostate cancer in men, if you live long enough, you will probably have it. The reason is the fibrosis that goes on in the heart due to wear and tear through a natural aging process. It’s nothing you did or didn’t do. Fibrosis slowly accumulates, but it accumulates faster if you have other problems like hypertension, diabetes, heart failure, leaky valves or coronary artery disease.”

In response to the increased demand for advanced AFib treatment, MU Health Care has hired two new cardiologists who specialize in irregular heart rhythms — Godara and Sathish Kodali, MD — and will launch the Arrhythmia Clinic in October. The clinic will streamline the process from diagnosis to treatment to follow-up visits for patients with any heart rhythm disorder. A nurse coordinator will work with patients’ primary care doctor or cardiologist to coordinate tests, answer questions and schedule appointments.

“There are multiple levels of treatment we offer, depending on the patients’ symptoms and their condition,” Kodali said. “The first and most important thing is that most of them need anticoagulation — blood thinner medications — to prevent strokes. The second thing is that we control the heart rate, so the heart isn’t going too fast and cardiomyopathy — an enlarging of the heart — isn’t setting in.

“After that, we try to convert them to a normal heart rhythm with a nonsurgical procedure called electrical cardioversion, which gives the heart a shock. If they fail this conversion to normal rhythm, we’ll use some medication called anti-arrhythmic drugs. If they fail that, as well, and if they have significant symptoms, then they’re a candidate for ablation.”

Ablation is not open-heart surgery. It’s a procedure done in the cath lab where patients will stay overnight in the hospital and be discharged the next day.

“Between 60 to 70 percent of the people who have an ablation are able to get off the anti-arrhythmics and anti-coagulants,” said electrophysiologist Sandeep Gautam, MD. “But we stress to patients when they come in for a consultation that we cannot promise that they will be able to stop the anti-coagulants. We do not want them to go through an ablation procedure solely to get off the anti-coagulants.”

MU Health Care offers the latest technology that makes ablations safer. With the help of 3-D heart mapping, the catheter can be guided to the heart using little or no fluoroscopy, which limits or eliminates a patient’s exposure to radiation.

MU Health Care electrophysiologists soon will have the option of performing cryotherapy ablations, in which the malfunctioning heart tissue is frozen rather than heated. Another treatment option soon to be available is a procedure designed for AFib patients who cannot tolerate blood-thinning medication. Many advanced treatment options beyond medication exist for patients, and the MU Health Care electrophysiologists work with each patient to identify the best treatment plan for their type of AFib.

See how an ablation procedure works at muhealth.org/afib

MU Health Care Increases Commitment to Arrhythmia Treatment

SATHISH KODALI, MD
Dr. Kodali has more than two decades of experience as a cardiologist and recently completed an advanced fellowship in electrophysiology with Aurora St. Luke’s Medical Center in Milwaukee. He is originally from India. With two children under the age of 10, Dr. Kodali doesn’t have much free time, but when he does, he enjoys reading non-medical books and playing chess.

HEMANT GODARA, MD
Dr. Godara recently completed an advanced fellowship in electrophysiology at The Ohio State University Medical Center, where his attending physician was Zhengou Liu, MD, who is now the director of the MU School of Medicine’s Division of Cardiovascular Medicine. Dr. Godara is originally from India. In his leisure time, he likes to spend time with his family and furbabies, watch Netflix and fix things around the house.
A Powerful New Tool to Fight Cancer

Immunotherapy helps Columbia man see the world with fresh eyes

In April 2016, Jack Stiefvater arrived at a visit with MU Health Care cancer surgeon Eric Kimchi, MD, assuming the small lump near his hip was just an “angry lymph node” and not a sign of something more sinister in his body.

“Dr. Kimchi was looking at the form from the biopsy, and I sensed that he changed,” Stiefvater said. “He said, ‘Just a second,’ and came back in with two or three other people. I knew something was up.”

A lump in the lymph node region of his hip had tested positive for melanoma, an aggressive form of skin cancer that often spreads to other parts of the body. He had lesions on his lungs and kidneys. If the disease wasn’t successfully treated, he could expect to live about 18 more months.

Stiefvater doesn’t remember much else that was said in the meeting. Afterward, he was in such a fog he couldn’t find his car in the parking garage.

Stiefvater thought back to his childhood on a farm in northern Wisconsin, his teenage years working construction and his time in the U.S. Army as a cadre at Fort Sill in Oklahoma — in each case, if it was summertime, he probably wasn’t wearing a shirt. He always loved going to the beach. All that exposure to the sun, he thought, had finally caught up to him.

“The worst part was from diagnosis until I got treatment,” he said. “You sit there and think, ‘This is growing inside me.’ ”

At his lowest moments, Stiefvater drew strength from his wife, Judy, whom he described as his “rock.” She accompanied him to medical appointments and asked all the right questions. She kept him positive at home.

Even Stiefvater’s Old English sheepdog, Maggie, sensed something was wrong and gave him comfort.

A month after his diagnosis, Stiefvater was placed in a clinical trial that used targeted therapy — so named because it targets a mutation called BRAF, a protein deficiency that fuels tumor growth in about half of melanoma patients. He took a combination of two pills each day for a month.

At his next appointment, the doctor again did a double take, this time when his scans showed no signs of tumors. A call was placed to the radiology lab to make sure this was indeed Stiefvater’s chart.
The next big thing

Kevin Staveley-O’Carroll, MD, PhD, MBA, chair of surgery and director of MU Health Care’s Ellis Fischel Cancer Center, was an early convert to the idea of fighting cancer with the body’s natural defense system. He began his research on immunotherapy 25 years ago, when it was not widely accepted as a potential cancer treatment.

Our body’s T cells are constantly attacking foreign invaders. They sometimes meet their match with a mutated cell that not only escapes detection, it also turns off the checkpoint switch that should sound the alarm for an immune system response. The immune system is tricked into allowing the cell to reproduce and cancerous tumors to grow and spread. Immunotherapy aims to alert the immune system to the cancer so it can fight back.

Two T cell checkpoints, PD-1 and CTLA-4, have been identified as culprits in cancer growth. Immunotherapy drugs inhibit the checkpoints, releasing the brakes on the immune system to attack the cancer cells.

“Sometimes things that never responded at all to other therapies will have dramatic responses to immunotherapy,” Staveley-O’Carroll said. “In some ways, it is a little miraculous. But it doesn’t work on everyone. We’ve got to learn a few things. We’ve got to learn how to integrate it with all the other therapies. We’ve got to learn when is it going to work. And with immunotherapy, sometimes we get great responses, but then sometimes it will work for a while and then stop, like many of our other therapies.

“The most important thing is getting a memory immune response. If you get certain viral infections, you develop an immune response, and you’re immune to them forever. If you can get that kind of immune response, you’re cured of cancer.”

Huang said MU Health Care currently uses immunotherapy to treat advanced-stage melanoma, lung cancer, kidney cancer and some gastrointestinal cancers in cases in which surgery is not an effective option. The list of cancers with FDA-approved immunotherapies is expanding every year. Staveley-O’Carroll said cancers with multiple mutations or a dominant antigen — a foreign protein recognizable to the immune system — have responded best.

Immunotherapy is still young as a widely accepted treatment — Keytruda, one of the most frequently used brand-name immunotherapy drugs, was FDA-approved to treat melanoma in 2014 — but much of the brain power in cancer research is now focused on activating the immune system.

“If there is a way to really cure all cancers, the immune system is the key,” Staveley-O’Carroll said. “It’s likely to be enormously important in all cancers. You can study little pathways in your cancer of choice, but this is a global pathway that is critical in all cancers.”

The journey continues

Since December, Stiefvater, 71, has received an intravenous infusion of Keytruda once every three weeks. He said he still feels anxious that his cancer will return and is especially nervous when he goes in for scans. But so far, so good.

Stiefvater is one of the lucky ones. “We’ve seen cases where the immunotherapy completely shrinks the tumor to the level it cannot be detected by a regular CT scan. That’s what we call complete remission,” Huang said. “But the majority of the time, we see what we call partial response. The immunotherapy is able to shrink the tumor down but not completely get rid of it. In this case, it most likely prolongs the patient’s life but does not cure a patient. We also see what we call stable disease, where the tumor is not growing, not shrinking, just staying the same.”

Although usually better tolerated by patients than chemotherapy, immunotherapy can have unpleasant side effects such as fatigue, diarrhea and skin rash. Stiefvater said the only side effect he’s experienced is mild fatigue. His heart is back to normal.

“I look at things differently now,” he said. “I appreciate looking up at the stars, the kinds of things I never thought of before.”

Before he retired, Stiefvater worked as a science teacher, corporate trainer and tutor. He still works part-time as a tutor for the MU athletic department. He and Judy love to travel, particularly enjoying European river cruises. They have plans to visit the Christmas markets along the Danube River from Germany to Hungary this year.

Since his melanoma scare, Stiefvater sees the world through new eyes. “I’ve lived a full life,” he said, “but I don’t want to miss anything.”
For women who need help conceiving, a reproductive endocrinologist such as MU Health Care’s Albert Hsu, MD, can help make the dream of having a baby become reality.

Reproductive Endocrinologist Helps Patients Overcome Fertility Challenges

Not every pregnancy comes easily. Some couples spend months or even years unsuccessfully trying to conceive. Others pursue parenthood through the use of donor eggs or sperm.

Regardless of the scenario, a reproductive endocrinologist can help make the dream of having a child come true.

Albert Hsu, MD, is a reproductive endocrinologist with MU Health Care. In this Q&A, he describes his role and the options available to people who need a little help starting a family.
**Q: What is a reproductive endocrinologist?**

Reproductive endocrinology is a subspecialty of obstetrics and gynecology. It requires four years of medical school, four years of residency training in obstetrics and gynecology and three years of fellowship in reproductive endocrinology and infertility. A reproductive endocrinologist is trained to evaluate problems that can interfere with conception, and he or she can carry out various treatments to address these problems.

Reproductive endocrinologists are experts in many fields, including polycystic ovarian syndrome (PCOS), endometriosis, infertility, recurrent pregnancy loss, diminished ovarian reserve, hypothalamic pituitary dysfunction, hyperprolactinemia and disorders of the female reproductive tract. They have in-depth knowledge of sperm, eggs, male and female reproductive anatomy, the mechanics of conception and the complex interactions between pituitary and reproductive hormones.

**Q: What are the reasons people might consider making an appointment with you?**

The most common reason is to address infertility, which is broadly defined as the inability to conceive after one year of frequent unprotected intercourse. For women older than 35 years of age, we encourage evaluation after six months. And for women who are 40 years of age or older, we recommend expediting an infertility evaluation at their earliest convenience.

Another common reason to visit a reproductive endocrinologist is to pursue conception with donor sperm or donor eggs. Recurrent pregnancy loss is another area where a reproductive endocrinologist can assist patients. If you have experienced more than one miscarriage, we can run tests to help uncover why this is happening and work toward preventing future complications.

Reproductive endocrinologists also are equipped to help patients explore fertility preservation when faced with medical treatments that could cause damage to their oocytes or sperm, such as radiation or chemotherapy for cancer treatments or immunosuppressants for organ transplantation.

Finally, reproductive endocrinologists commonly see patients who have PCOS, hypothalamic amenorrhea, abnormal uterine bleeding or endometriosis.

**Q: What can your patients expect during their first visit and what are some of the treatment options you might offer?**

A patient should expect for us to conduct an extensive history of both herself and her partner. We will discuss the patient’s personal situation and goals and answer any questions she may have. Then, we will usually order bloodwork, a tubal patency test and a semen analysis if a male partner is involved.

Depending on the results of this fertility workup, we will discuss treatment options such as medications for ovulation induction, intrauterine inseminations and/or in vitro fertilization.

**Q: What is your ultimate goal for your patients?**

My ultimate goal is to provide effective treatment that helps my patients achieve the families that they seek. I am also passionate about cost-consciousness, as the most expensive treatments are not necessarily the right treatments for every patient.

Patients frequently have questions about cost, insurance coverage and success rates. The answers to those questions are different for every individual, so we encourage you to make an appointment for a consult.

**Q: What do you love most about being a reproductive endocrinologist?**

I experience many gratifying moments each and every day. I particularly enjoy making sure my patients feel heard by answering concerns that no other provider has previously addressed. But of course, all told, there’s nothing better than seeing a patient who thought she’d never have a baby come into our office and show off her beautiful, healthy child after fertility treatment from our program.

I also greatly enjoy teaching medical students, residents and fellows, and I especially delight in participating in important research studies that seek to answer complex questions within the realm of reproductive endocrinology and infertility.
Two years after having both hips replaced, Jon Pierce shows his primary care nurse, Alicia House, LPN, that he still has the moves that helped him win a disco contest in the 1970s. Pierce, who was confined to a wheelchair before his hip replacements, has regained his independence and can dance again.
Pierce Doesn’t Miss a Beat After Double Hip Replacement

On a magical Hawaiian night in 1974, Jon Pierce stepped onto a dance floor packed with people in polyester and platform shoes. When the music finally stopped in this disco contest, Pierce and his partner were the last dancers standing. It is a victory he jokingly refers to as “the highlight of my lifetime.”

Disco’s mass appeal faded in the 1980s, but Pierce, 73, never stopped loving the music and the way dancing made him feel.

“Any time disco comes on the radio, I don’t care if I’m cooking dinner, I’ll do a few fancy moves as I’m moving around the kitchen and take the spatula and toss things up in the air,” he said.

Pierce attended his first dance — sponsored by his Boy Scout troop — as a 12-year-old in his home state of Iowa. He was hooked. Despite a bout with polio as a 4-year-old, he was able to swim, golf, wrestle and play football through his teenage years, but dancing has been his favorite lifelong activity.

After college, Pierce taught high school math and science and coached wrestling before switching to a career in medical sales that overlapped the disco era. He and a group of dietitian friends danced the nights away.

“I liked other music, but disco brought life,” he said. “I just felt completely alive, energetic. It was better than a good golf game.”

A female companion convinced him to switch careers and locations in the 1980s, and he settled in the small Missouri Bootheel town of Blodgett and worked as a nursing home administrator. In recent years, his health deteriorated on several fronts, and he relocated to mid-Missouri to be closer to two of his daughters and his specialists at MU Health Care.

The most painful of his problems was arthritis in both hips that left him confined to a wheelchair at The Neighborhoods by Tiger Place, a skilled nursing facility in Columbia. That is where he met his new primary care physician, MU Health Care’s Amitava Dasgupta, MD.

“The first thing you do with a new patient is get a weight and a height if you can,” said Alicia House, LPN, the nurse who works with Dasgupta. “His hips popped so loudly when he tried to stand up, you could hear them all the way back to our work area. He was very frail. He looked so much older than he really was.”

Pierce was referred to MU Health Care’s Missouri Orthopaedic Institute, where he was introduced to surgeon Benjamin Hansen, MD.

“He had severe arthritis in the hip, which is inflammation of the hip joint, leading to loss of cartilage or damage to the cartilage that covers the ball and the socket where the two bones come together,” Hansen said. “He also had a collapse of the femoral heads. Balls that are normally round, because of the degeneration of the hips, you can get insufficiency fractures or weakness in the bone leading to the collapse of the femoral heads.”

The only solution was a double hip replacement. Hansen performed surgeries on the left and right hips six months apart in 2016.

In each case, Pierce spent a few nights in the hospital recovering. After each surgery, he needed to use a cane or walker for about six weeks.

Pierce bonded with Dasgupta and House as he recovered. They provided emotional support as he became more independent and got off the pain pills he needed before his surgeries.

“I liked other music, but disco brought life. I just felt completely alive, energetic. It was better than a good golf game.”

— Jon Pierce

The color returned to his face. His gregarious personality re-emerged.

“He has really made an about-face to a degree I’ve rarely seen,” Dasgupta said.

Pierce rehabbed by walking, riding a stationary bike and lifting weights. Still, he wondered if his new hips could swivel like the old ones.

“Disco dancing struck my mind right away,” he said. “I wanted to see if I could dance. So, I started practicing.”

In June 2018, with House as his partner, Pierce returned to the dance floor. Sure enough, when the music started, he was right back in the groove. Pierce hopes to continue dancing as a way to stay young and meet new people.

“Dancing is one of those things that’s great to do for hip-replacement patients,” Hansen said. “He should absolutely be able to dance after a successful hip replacement. It brings him a lot of joy in his life.”

See Jon’s dance moves in action at muhealth.org/disco
By chance, James Stannard, MD, and Suthorn Bavonratanavech were seated at the same dinner table during an international orthopaedic conference in December 2015 in Switzerland. Suthorn, a prominent surgeon in Thailand, made some small talk with his American counterpart.

“I said, ‘Jim, at my hospital we’re going to build a building that will be focused on orthopaedic surgery for all the specialties. Do you know of any place like this in the U.S.? ’ ” Suthorn recalled.

Stannard not only knew of one, he ran one: the Missouri Orthopaedic Institute. What Stannard didn’t realize was that Suthorn wasn’t just representing a Bangkok hospital, but rather Bangkok Dusit Medical Services (BDMS).

“It turned out his company was the fourth-largest hospital chain in the world with 46 hospitals,” Stannard said. “I had no idea it was more than a single hospital.”

If neither man knew quite who he was dealing with initially, they began a fruitful partnership built on an open exchange of information and ideas. MOI became the model for the new BDMS orthopaedic center, which is slated to open in early 2019.

After Suthorn accepted Stannard’s invitation to visit Columbia, he was immediately impressed by the itinerary — a three-day program filled from morning to night.

“I showed it to my boss, and he read it and said, ‘Do you have time to rest?’ ” Suthorn said with a laugh. “It was fully packed. But that was fine with me because I wanted to learn everything I could in these three days.”

After his busy tour, Suthorn was sold.

“I sent an email to my CEO and the chief of the medical staff and told them, ‘This is the place. I can learn almost everything here — the management system, the leadership system, the organization of the departments divided into different specialties, the nursing system. It’s all in one place. I don’t need to go to different places to get different things,’ ” he said.

Chaiyapruk Pundee, left, and Pat Laupattarakasem are orthopaedic surgeons from Thailand serving one-year fellowships with the MU Department of Orthopaedic Surgery. Chaiyapruk and Pat are conducting research and observing surgeries at the Missouri Orthopaedic Institute, which has developed an open partnership with the leading hospital system in Thailand.
“Everyone at MOI was very generous. Whoever I talked to, they said, ‘If you need more information, let us know. If you need some documents, we can give them to you.’”

In the last 2½ years, delegations from MOI including Stannard, executive director Bob Schaal, director of nursing Angela Story and manager of support services Wes Sconce have traveled to Bangkok to train and advise BDMS employees as they prepare to launch the new orthopaedic center. Stannard has become a frequently invited guest speaker at orthopaedic conferences in Thailand, and he and his wife have fallen in love with the country, its culture and its food.

Meanwhile, Thai orthopaedic surgeons Pat Laupattarakasem and Chaiyapruk Pundee are in Columbia serving one-year fellowships. They have quickly assimilated. Chaiyapruk, who is better known around the Missouri Orthopaedic Institute as Bert, has joined a group that runs on the wooded trails around Columbia. He is an eager student of American football and sat alongside new friend Ted Choma, MD — both are spine specialists and former military flight surgeons — in the stands at the Tigers’ 2018 season opener. Pat, who specializes in sports medicine, has become a regular in a weekly Sunday soccer game at Cosmo Park.

They spend their work hours observing surgeries and assisting MU doctors with research. Pat is using a motion-capture device to record the range of motion of college athletes in an attempt to predict and prevent injuries. Chaiyapruk is studying biomarkers for clues to spine degeneration. Both are grateful to have more time and resources to devote to research than they normally do as practicing surgeons. Both plan to continue their collaborative research with MU doctors after returning to Thailand.

“Sharing our experience, there’s really no downside. In some ways, it helps to enhance our big-picture reputation.”

— James Stannard, MD

and there are some fundamental differences in the American and Thai health systems that prevent completely replicated business models. Schaal said a far greater proportion of an American hospital’s budget is devoted to labor compared to Thailand, where the wages are lower. Thai hospitals require more beds than American hospitals because outpatient surgeries are rare. But there are lessons MU Health Care can learn from BDMS, which attracts patients from across Asia and the Middle East.

“The whole medical tourism thing, we’ve always thought we could learn from them and apply it to a program like BioJoint,” Schaal said, referring to the biological joint transplant procedure that has drawn patients from other countries to Columbia.

A random conversation in Switzerland led to a partnership that could benefit both health systems.

“We feel like this facility has really worked well,” Stannard said. “Sharing our experience, there’s really no downside. In some ways, it helps to enhance our big-picture reputation. There are a lot of people in the Asia-Pacific region that know about MOI right now. Suthorn has such a broad reach over there, we’re pretty well-known. And that wouldn’t have happened without our relationship.”

James Stannard, MD, fourth from right, helped develop a partnership between the Missouri Orthopaedic Institute and Thailand’s Bangkok Dusit Medical Services. Stannard’s relationship with Suthorn Bavonratanavech, third from right, led to the Missouri Orthopaedic Institute becoming the model for BDMS’ new orthopaedic center.
A Recovery Worth Writing Home About

Expert treatment, family support helps Chance Sommerer get back on his feet

“I got the call about 5:25 p.m. on my way home. A lady called from your phone saying you had been in an accident.”

— EMILY SOMMERER, SEPT. 27, 2017

The story of a traumatic injury is often best told through the words of others. The injured person might not remember the incident. As in the case of Chance Sommerer, the injured person might not even remember a month in the hospital.

The future of that person is in the hands of EMTs, doctors, nurses and therapists but also in the hands of family and friends who put their own lives on hold to care for a loved one.

“Unfortunately, because of the acute life-stressors and the acute life change that happens when suffering from trauma, depression, anxiety and post-traumatic stress disorder are very common,” said Brett Crist, MD, an orthopaedic trauma surgeon at MU Health Care. “Usually people have a hard time getting back to work quickly, so people lose income and can become destitute. It also puts a lot of strain on family relationships, so divorce is also not uncommon.

“However, Chance has been able to persevere and has always had an awesome attitude. A lot of it is because he has such great social support from his family. When I went to talk to his family after I did his first surgery, the room was full. It stinks to have to go through what he went through, but he’s going to be much more likely to be successful because he has such great support.”

This is Chance’s story of injury and recovery, and it is best told in the words of his wife — the woman who had been married to him less than a year when she got that fateful phone call.

Emily kept a journal in a red spiral notebook for 48 days, noting the emotional swings, the major and mundane milestones and the parade of guests who stopped by every day.

Chance Sommerer is able to enjoy time at home with his wife, Emily, and dog, Moose, after being involved in a serious car accident and enduring a life-threatening complication.
“I came back at 5 a.m. You had your dressing changed. That's when you started to act different.”

SEPT. 28, 2017

Chance was driving to his Jefferson City home from his job as an engineer at Quaker Windows in Freeburg when, according to a Missouri State Highway Patrol report, he failed to negotiate a curve on Highway 63, overcorrected and struck an oncoming truck head-on. The driver of the other vehicle suffered minor injuries. Chance had broken femurs in both legs, a broken arm, bruised lungs, a broken nose and a concussion.

Still, he was able to tell a woman at the scene who she needed to call from his cell phone. He was taken via Staff for Life helicopter to University Hospital. At 11:30 that night, when his parents and wife were able to see him, Chance was alert and remembered that he and Emily, a fifth-grade teacher at South Elementary in Jefferson City, had planned to come home to a slow-cooked meal.

His first question was, “Em, did you put the ribs in the fridge?”

As sometimes happens in trauma accidents in which long bones are broken, fat embolisms from his femurs leaked out into his blood stream. Usually, those fat globules are filtered through the lungs and heart. But Chance, then 24 years old, had an undiagnosed condition called patent foramen ovale — a hole between the left and right upper chambers of the heart — so nothing stopped the embolisms from travelling to his brain and causing strokes, which led to a frightening change in his behavior.

“You had a look in your eye,” Emily wrote. “You tried to pull out your IVs. You kept pushing down your blankets and saying, ‘Come on,’ or pressing your head, saying, ‘Dammit.’ ”

For the next week, Chance rarely opened his eyes and could not speak. This was the most difficult point for his family, including Emily, his father, Danny, and his mother, Denise. University Hospital was their new home, but they had plenty of company.

“We had probably at least five people there at all times,” Emily said. “The first Saturday he was in the Surgical Intensive Care Unit, we had the whole entire waiting room filled and the whole hallway. I guarantee you there were 40 to 50 people there, if not more, for a good three to four hours.”

“You have a procedure today to try to find the hole in your heart. I’m absolutely terrified. I need a big hug from you to reassure me.”

OCT. 5, 2017

Chance was in no position to reassure Emily. Sensing her anxiety, anesthesiology resident Joanna Gould, MD, went out of her way to soothe her.

“She just sat with me, and we talked about our wedding days,” Emily said. “I felt as though she was sitting next to me as a friend, not just a doctor. She knew exactly what to talk about to make me feel better and treated me as family. It meant more than she will ever know.”

Richard Webel, MD, fixed the hole in Chance’s heart. The next day, Crist repaired his legs, which were broken in several places, by making multiple small incisions and setting the bone with plates and screws. Then Crist addressed the broken right arm.

There was no surgery to get Chance’s brain back to normal. That would take time and therapy.

Emily’s journal entries reflected the incremental progress. On Oct. 9, he wiggled his toes on command. The next day, he spoke. The day after, he breathed on his own without a ventilator.

His memory, though, was slow to return.

“Yesterday you said you didn’t remember me,” Emily wrote on Oct. 11. “Then today said the same thing. I told you that I was your wife, and you said, ‘Good.’ ”

On Oct. 18, the day before Chance was released from the hospital and sent to Rusk Rehabilitation Center, he asked about the accident.

“Your dad explained what happened and how prayer got us all through,” Emily wrote. “You and I then discussed it and looked at pictures. Tears were shed, but I believe it is a step forward.”

“We had pork steaks, ranch potatoes and green bean casserole. It was delicious. Topped off with some sparkling grape juice and wedding cake.”

OCT. 22, 2017

Nobody plans to spend their first anniversary at a rehab center, but the Sommerers made the best of it. Visitors continued to stop by, and that meant Chance and Emily sometimes entertained guests in the activity room instead of his patient room.

Chance made great progress in physical and occupational therapy, but he was frustrated by the cognitive tests.

“He scared us because he’s a mechanical engineer, and when we got to Rusk, he was having a hard time counting to three,” his father said.

With the help of the Rusk therapists and time for his brain to heal, he came around.

On Nov. 3, he returned home to a support team that had grown by one member — a Labrador retriever puppy named Moose.

“We somehow got a dog in the middle of all this,” Emily said with a laugh. “I couldn’t tell him no. He said, ‘I need a buddy.’ ”

Life slowly got back to normal. Emily returned to work. Chance got out of his wheelchair and went back to his job in mid-December.

Chance shows some effects of his accident. He walks with a slight limp, and his right arm is still recovering from an April surgery to repair his radial nerve. He said he occasionally gets tongue-tied. But his outcome could have been so much worse.

“He very well could have died with what happened to him,” Crist said. “There’s about a 50 percent chance of dying when someone has both femurs broken. It just indicates you had a lot of energy going through your body, so you likely have other things going on, like chest or abdomen or head injuries.

“He did have some chest injuries, but he was lucky he didn’t have a real bad head injury before he had the fat embolisms. Now when I see him in clinic, it’s hard to tell he had any problem with his head. His personality seems the same as before he got hurt, according to his family.”

His family is grateful. Accompanying his son on a follow-up visit to University Hospital in February, Chance’s father expressed thanks.

“The people here cared for him, and they also cared for us,” Danny said. “Every time they walked in and every time they walked out of the room, they said, ‘Can I get you all something? Is there something I can do for you?’ We got more than one lecture that we needed to take care of ourselves so we could take care of him. God gave these people an amazing gift to be able to heal people the way they do.”
A Gift to Help the Band Play On

MU Health Care will contribute $100,000 annually for the next four academic years to the College of Arts & Science. The scholarships are designed to help improve the retention of upperclassmen in Marching Mizzou, with a priority on students majoring in health care-related fields.

“We’re proud to support our campus community with the Marching Mizzou Scholarship Fund,” said Jonathan Curtright, chief executive officer of MU Health Care. “We hope that as the official sponsor of Marching Mizzou, even more exceptional students will receive the opportunities and support they need to pursue careers in health care and other vitally important fields.”

Marching Mizzou is in its 133rd season. Its more than 250 members represent nearly every college on the MU campus. Marching Mizzou features the Golden Girls, three twirlers, a color guard and more than 200 instrumentalists.

“We cannot thank MU Health Care enough for their generosity, and we look forward to our continued partnership for the next four years and beyond,” said Amy Knopps, associate director of bands and director of athletic bands at MU. “Our partnership with MU Health Care will be a critical asset to our program, as the scholarships will not only reward our students for their service to MU but create a financial pathway so more students have the ability to remain in Marching Mizzou throughout the entirety of their degree programs on campus.”

For more information or to donate to the Marching Mizzou Scholarship Fund, visit music.missouri.edu/marching-mizzou-scholarship-fund

By the Numbers in 2018

Missouri’s premier academic health center began when University Hospital opened in Columbia in 1956. Today, MU Health Care includes five hospitals and more than 50 clinics. Here are some highlights from Fiscal Year 2018.

<table>
<thead>
<tr>
<th>226,465 TOTAL PATIENTS</th>
<th>602 BEDS</th>
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<tbody>
<tr>
<td></td>
<td>INTENSIVE CARE: 159</td>
</tr>
<tr>
<td></td>
<td>ACUTE CARE: 443</td>
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HOSPITALS
- Ellis Fischel Cancer Center
- Missouri Orthopaedic Institute
- Missouri Psychiatric Center
- University Hospital
- Women’s and Children’s Hospital

<table>
<thead>
<tr>
<th>221,363 MISSOURIANS</th>
</tr>
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<tbody>
<tr>
<td>5,102 OUT-OF-STATE</td>
</tr>
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</table>

6,936 TOTAL STAFF
MEDICAL STAFF: 720
OTHER STAFF: 6,216

<table>
<thead>
<tr>
<th>26,847 PATIENT DISCHARGES</th>
<th>7,422,083 PHARMACY DOSES</th>
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<tbody>
<tr>
<td>2,732 CARDIAC CATHETERIZATION PROCEDURES</td>
<td>79,464 Emergency and trauma center visits</td>
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<table>
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<tr>
<th>594 PATIENTS TRANSPORTED BY HELICOPTER</th>
<th>680,624 CLINIC VISITS (all sites)</th>
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</thead>
<tbody>
<tr>
<td>2,417 BIRTHS</td>
<td>313,954 RADIOLOGIC EXAMS AND TREATMENTS</td>
</tr>
<tr>
<td></td>
<td>25,800 MAJOR SURGICAL OPERATIONS</td>
</tr>
<tr>
<td></td>
<td>1,645,121 LABORATORY TESTS</td>
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Statistics are reported for Fiscal Year 2018, from July 1, 2017, to June 30, 2018.
Caregiving is Her Calling
Washington devotes herself to palliative care research

Karla Washington was an undergraduate student majoring in biology when her father was diagnosed with lung cancer. Her family embraced the goal of helping him beat the disease, and the initial results were positive.

Then the cancer returned aggressively, and all that could be done was manage the symptoms rather than cure the disease. With a short amount of time left with their dad, Washington and her family were adrift. How were they supposed to process all these feelings, ranging from existential questions about why bad things happen to good people to practical concerns about family finances?

“We were pretty much a mess and needed help in a way we hadn’t needed it before,” Washington said. “We also had to get comfortable with needing help, which was new for us. An oncology social worker was instrumental in helping our family go through these experiences, even in terms of the paperwork and the bureaucratic, pragmatic pieces of logistically coping with a serious illness.”

That experience changed Washington’s career plans, prompting her to earn a master’s and PhD in social work from the University of Missouri. While in graduate school, she found a valuable mentor in Debra Parker Oliver, PhD, who helped focus her research on family caregivers of patients in palliative care.

Washington’s goal was to give family members the tools to control the stress that can lead to anxiety and depression. That would allow them to make the best use of the time left with their loved ones.

“The really important work of serious illness and end-of-life is reminiscing and strengthening relationships and saying things like, ‘Thank you. I love you. Forgive me. Goodbye,’” she said.

After earning her PhD, Washington spent four years at the University of Louisville before joining the MU School of Medicine as an assistant professor in Family and Community Medicine in 2013.

She recently completed a pilot study funded by the National Cancer Institute that focused on problem-solving therapy for the family caregivers of patients at Ellis Fischel Cancer Center. Nurses met individually with family members to identify their most pressing problem — for example, trouble communicating with the health care team, sleep deprivation or declining work performance — and then the nurse and caregiver brainstormed solutions and created an action plan.

“The caregivers who did the problem-solving therapy reported lower anxiety than a control group.

“She’s got a lot of creative ideas around interventions for caregivers and has really started focusing her own line of research on patients that are in the outpatient palliative care service,” Parker Oliver said. “Most of my work has been in hospice, so she is doing what we call ‘going upstream’ before they get to hospice, looking at interventions that can be helpful to specific populations.”

Parker Oliver called Washington her “most prized student.” The women have collaborated on several research projects and continue to do so. Most medical research focuses on curing diseases, while comparatively little has been devoted to the wellbeing of caregivers.

“Our job as researchers is to usher these ideas along and work to get support so we can test them more broadly.” — Karla Washington, PhD

Karla Washington, PhD, developed an interest in palliative care in college after she and her family dealt with her father’s serious illness. Washington’s research is devoted to improving the caregiver experience.
“I wondered what more I could have done,” Brandes said.

Brandes, a native of Prairie Home, Missouri, enlisted in the Army in February 2009. Ten months later, he deployed to Iraq with the Third Infantry Division. He returned to the U.S. in December 2010 and in the summer of 2011 was promoted to rank of sergeant.

“I was due to get out in 2012, but we had a call to go to Afghanistan,” Brandes said. “I extended for a year to go to Afghanistan with my squad.”

It was during his second tour that Reigoux was killed six weeks before they were scheduled to come home.

“There were lots of emotions during the remaining time there,” Brandes said. “I served my country, and now I was ready to go home and serve my community.”

Brandes considered the options available through the GI Bill, and with encouragement from his friends, applied and was accepted into MU’s Sinclair School of Nursing. He graduated with a Bachelor of Science in Nursing degree in 2017. After graduation, he had multiple job offers in mid-Missouri emergency rooms.

“I chose University Hospital for its Level 1 trauma center. I knew I would be getting the most experience here.”

— Adam Brandes, RN

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In the Army, he supervised soldiers and had to make decisions quickly. In the ER, life-and-death decisions also have to be made fast.

“Being overseas, stuff changes rapidly,” Brandes said. “It was something I enjoyed about it. You never know what the next day will bring.”

Brandes isn’t left wondering any more if there is something he can do to help during medical emergencies. The skills he acquired on the front lines with the Army and in the simulation lab during nursing school allow him to help any patient who comes through the doors of the emergency room.

On June 1, 2013, Adam Brandes’ Army unit had just left a graduation ceremony for new Afghanistan police officers it had trained and was headed back to its base in Ghazni Province.

“It was a nice summer day when, out of nowhere, there was a loud explosion and a cloud of dirt,” Brandes said.

Staff Sgt. Job Reigoux was in the lead vehicle with other soldiers and their interpreter when it was struck by a rocket-propelled grenade.

“It went through the side of the truck, through Job’s right leg and left hand,” Brandes said. “When we got to the outpost … we couldn’t tell if he was alive or dead.”

Reigoux was sent to a bigger base with a field hospital. Less than an hour later, Brandes and his unit learned their buddy died on the operating table.

Army veteran finds new purpose in emergency room

Adam Brandes, RN, served in the Army, including tours in Afghanistan and Iraq, before deciding to attend MU’s Sinclair School of Nursing. He is now a nurse in University Hospital’s emergency room.
In her part-time job as a rehabilitation technician at MU Health Care’s Children’s Therapy Clinic, Rachel Hughes describes her duties as “fixing things, building things, organizing things.” Using those three skills, she created Project SWITCHED: Adapted Toys, a program that helps children with disabilities.

One day at work, Hughes, a third-year student in the School of Health Professions’ physical therapy program was asked to adapt a battery-operated toy so it could be used by a patient who lacked fine motor function. After a tutorial from supervisor Katheryn Maddox, Hughes soldered a wire onto the toy and connected it to a large switch the child could operate.

It was a quick and inexpensive fix.

Yet, Hughes noticed the cost of new adapted toys, which are needed for children with conditions such as cerebral palsy, is often more than quadruple the price of the originals.

“A lot of the kids don’t even have toys, because they’re too expensive, or they’ll have baby toys because that’s their motor level, but that’s not their cognitive level,” Hughes said. “They’re playing with rattles when they could be playing with more fun toys.”

To address this problem, Hughes started adapting used toys in her basement and providing them to the Delmar Cobble School for the Severely Disabled and the special-needs ministries at The Crossing and Alive in Christ Lutheran.

To help even more children, she needed to take her project out of the basement and recruit more workers. Hughes contacted Pascale’s Pals, the local volunteer organization that works with Children’s Hospital. With its backing, she began Project SWITCHED, which is modeled on a similar organization in Ohio called RePlay for Kids.

On July 28, Hughes held a toy drive at the Target store in the Columbia Mall, which netted about 50 new toys. Two September “build” sessions were scheduled at the School of Health Professions for faculty and students to gather and adapt all the toys so they can be given away through Pascale’s Pals in December.

Bill Janes, OTD, an assistant research professor in the Department of Occupational Therapy, said he was amazed at Hughes’ ambition and organizational skills. The only trait she lacks is self-promotion.

“She is humble almost to a fault,” Janes said. “We have tried to compliment her on her skill set and the value of what she’s doing, and she shrugs it off. I don’t think she knows how special it is.”
Skylar Russell was too ill to attend her high school prom. The staff at Children’s Hospital created a special celebration just for her.
ABOVE: Before speaking at the 2018 Best of Prep high school sports awards show on July 19, Alex Smith, the former Kansas City Chiefs quarterback who now plays for the Washington Redskins, stopped by Children’s Hospital and lifted the spirits of young patients.

LEFT: Spiderman and his superhero friends washed windows and greeted patients at Children’s Hospital.

ABOVE: University Hospital was lit up in red, white and blue for Independence Day.
MU Health Care’s orthopaedics and nephrology departments have been named as 2018-2019 high performing specialties by U.S. News and World Report.

MUHEALTH.ORG/US-NEWS