Who Will... 

Get You Back
to the top of your game

Save Your Life 
when things go wrong

Keep You Healthy
for your children

2011 REPORT TO THE COMMUNITY
UNIVERSITY OF UTAH HOSPITALS AND CLINICS
The U's Sports Medicine Team got Brian Johnson back on the field after his shoulder and knee injuries, and he finished his career as the most winning quarterback in University of Utah history. Every day, they use those same skills to get regular folks back to the business of their own active lives. | Page 22

Surgeons Stephen Morris, M.D., Jeffrey Saffle, M.D., and Richard Barton, M.D., oversee University Hospital’s Burn, Trauma, and Critical Care services. They have dedicated their lives to making sure that when things go wrong, someone’s there to take care of you. | Page 18

When Heather Armstrong found herself suicidal with postpartum depression, she turned to the University Neuropsychiatric Institute as a last resort. The wildly popular mommy blogger doesn’t mince words about the experience: “They saved my life.” | Page 20
Every September, leaders from the country’s academic medical centers gather at a meeting hosted by the University HealthSystem Consortium (UHC), to share ideas and discuss common challenges. On the final evening, we also learn how our institutions stack up against each other in the rigorous UHC Quality and Accountability Study.

We admit it. We’re competitive. It may be fair to say that collegiate athletics has nothing on academic medicine when it comes to wanting to be the best.

In this regard, we’re pleased to report University of Utah Health Care is doing exceptionally well. In each 2010 and 2011, we’ve brought home a national top-10, five-star quality ranking from UHC. It’s a remarkable achievement and an honor that few of our peers have achieved. It’s also a tribute to the hard work, commitment, and yes—competitiveness—of our faculty and staff.

While we are proudly competitive, it’s not the only quality that defines us. Compassion, collaboration, and innovation also describe the characteristics of our faculty and staff profiled in this year’s annual report. Each represents why academic medical centers are well suited to lead by example as we work on solutions to the many challenges facing health care today.

This issue will also introduce you to Brian Johnson, Heather Armstrong, and the Bliss family. Their stories represent the breadth and depth of the services we provide. Their courage and zest for life serve as our inspiration and remind us that what we do is not about rankings. It’s about providing compassionate, healing care for our community.

The University is proud of its role as the only academic medical center in the Intermountain West, and we are committed to our responsibility to provide the backbone of critical health care services for the region.

Who will get you back to the top of your game, save your life, and keep you healthy? On behalf of everyone at University of Utah Health Care, we’re proud to answer: We will.

Sincerely,

David Entwistle
Vivian S. Lee

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We invite you to learn more about the Quality and Accountability Study and its data-driven methodology on our Web site at www.healthcare.utah.edu/quality.
I’ve received all of my health care through the U. I just trusted that I would receive the best care available here, and I’ve never been disappointed.

The past several years, however, I’ve had the privilege to go behind the scenes and experience this health care system not just as a patient, but also as a board member. It’s been remarkable to learn about the patient care University of Utah Health Care provides and the emerging technologies and research that support that care. Now I want to make sure the community knows about it, so they can take advantage of everything the U has to offer.

That’s really our role as Community Board Members: We serve as ambassadors and ombudsmen. We’re also an advisory board with a wide range of talent. We recommend ways to serve diverse populations, show leadership through health care reform, improve quality, and provide an exceptional patient experience.

Together, we’re working to make sure we serve our mission: to best meet the health care needs of our community.

Vicki Varela
Chair
President, Vicki Varela Strategic Communications, Inc.

To reach a member of the board, please contact Melissa Beck at 801-587-5572 or melissa.beck@hsc.utah.edu.

“What I’ve learned about the U’s commitment to patient care has made me want to go out into the community and help people understand what a remarkable resource this academic medical center is.”
Since University Hospital opened its doors in 1965, we’ve grown from a single hospital to an extensive health care system that includes four hospitals and 10 neighborhood health centers staffed by 1,000 board-certified physicians trained in 200 medical specialties.

We care for patients across the spectrum of health care, from routine screenings and outpatient visits to trauma emergencies. We know that many of our patients arrive at our front doors, having already been on long and difficult health care journeys. They’re seeking treatment, solutions and cures for some of the most complicated health issues. As an academic health care system, we’re able to collaborate with our research and academic partners to push the farthest limits of knowledge in science and medicine, so that we can discover the treatments and cures they need.

We’re also 8,000 committed staff members working together to treat all patients with the compassion, integrity, and respect they deserve.

Amit Patel, M.D., injects a patient’s own stem cells directly into the left ventricle of the heart. Patel, associate professor of cardiothoracic surgery and director of Clinical Regenerative Medicine and Tissue Engineering, is hopeful that this procedure will prove to be a lifesaving treatment for heart failure patients who have exhausted all other options.

Stem cells can be directed to become red blood cells, like the ones pictured here.
A lifeline. That’s what we are—for people who live down the street and those who live hundreds of miles away, across rugged mountainous and desert terrain, in every direction.

With a geographical catchment area that extends farther than any other academic medical center in the United States, we have a great responsibility—to make sure that millions of people from Utah and five surrounding states have access to the most comprehensive and specialized health care available.

From the moment our patients arrive, we want to assure them that they are in good hands. Whether it’s the friendly valets who meet patients at the front door of University Hospital or our new hospital rooms that have extra space and a sofa bed for family members, the overwhelming message to patients is that they are welcome here.

More than 20 percent of our patients live at least 200 miles from Salt Lake City. Some of those patients are transported by AirMed’s highly trained flight crew—a team of 90 nurses, paramedics and pilots who go on nearly 2,000 missions per year.
Each year, we strategically expand with a singular goal in mind: To best meet the health care needs of a growing community. Here are three new projects completed in fiscal year 2012.

University Neuropsychiatric Institute | August, 2011

It’s one thing to be put on a waiting list at a popular restaurant. It’s an entirely different thing if you’re an acutely ill mental health patient seeking help. Yet that is exactly the situation at psychiatric treatment centers across America. We set out to change the situation in our community. In August, University Neuropsychiatric Institute completed a beautiful LEED certified building that greatly increased capacity for intensive inpatient and outpatient care and substance abuse services. The building also houses a new MRI used for brain imaging research and the Department of Psychiatry faculty, creating exciting new opportunities for collaboration.

Huntsman Cancer Hospital | November, 2011

The ambitious goal of Huntsman Cancer Institute is to conquer the disease. While world-class researchers diligently work toward that goal, Huntsman Cancer Hospital staff provides the finest and most compassionate care to cancer patients and their families from across the Intermountain West. Almost from the day the hospital opened in 2004, it was filled to capacity. This expansion project doubles the hospital’s capacity and provides much-needed space for programs in cancer research, education, and treatment.

South Jordan Health Center | January, 2012

We’re constantly striving to be on the frontier of medical and scientific breakthroughs. With the new South Jordan Health Center we are celebrating the arrival at a different frontier: a geographical one. Our new South Jordan multispecialty center is about providing access to one of the fastest-growing communities in Utah. Located at the foot of the Oquirrh Mountains in the southwest corner of the Salt Lake Valley, the South Jordan Health Center is the University’s largest off-campus facility, providing primary, specialty, and emergency care—and bringing all of the U’s expertise into the neighborhoods of the people who need it.
Inside Our Academic Medical Center

“The learning never stops here.” That’s how one nurse manager describes the dynamic environment at University of Utah Health Care. On the next few pages, we highlight just a few of the bright minds who’ve chosen to work at our academic medical center. They represent thousands of dedicated researchers, providers, and educators who every day conspire to re-envision the treatments and care we offer our patients.

Years before Mario Capecchi, Ph.D., won the Nobel Prize for his pioneering work creating “knockout mice,” R. Lor Randall, M.D., was already knocking on his door, determined to collaborate with the geneticist to investigate the origins of deadly sarcoma tumors.

“I knew that if I could get one of my human sarcoma genes into one of Dr. Capecchi’s mice, we’d have a robust model with a great deal of fidelity that would enable us to go after better treatments.” Randall, one of the country’s most respected orthopedic surgeons specializing in sarcoma treatment, came to Utah early in his career because of the University’s formidable reputation in genetics. It was 1998, and he knew “the soil was rich and the potential was tremendous” to begin to find the answers he needed about sarcomas—highly aggressive cancers that attack newborns to octogenarians, but have a predilection for the young. “It’s an incredibly challenging disease that knows no anatomic boundaries,” says Randall.

For the first five years, Randall burned the midnight oil to build the fledgling sarcoma program. By day, he’d work on building his clinical practice; by night (when he wasn’t taking call) and on weekends he’d work in his lab, isolating sarcoma genes from humans, building up a bank of genes, applying for grants, and acting as his own medical oncologist. He affectionately referred to his efforts as “Project Tumbleweed.”

In 2003, however, the door to Capecchi’s lab opened, and Randall began collaborating with one of his post-docs. Four years later, the first mouse model of a synovial sarcoma was built, creating a powerful new tool to make and test drugs, but more fundamentally to understand the biology of the disease and to manipulate specific genes. Today, the Sarcoma Array Research Consortium (SARC) Lab is one of the most recognized sarcoma programs in the world, with about a dozen M.D.s and Ph.D.s investigating the molecular genetic mechanisms behind it.

One of those researchers is another orthopedic surgeon, Kevin Jones, M.D. He didn’t go into medicine planning to be a scientist. But when Jones found himself doing “horrific, function-changing operations” on teenage sarcoma patients, half of whom would die within a few years, he needed to figure out exactly what he was dealing with. Utah seemed to be the ideal place to find the answer.

“Something very funky is going on with sarcomas,” says Jones. “When you look at sarcoma cells under a microscope, it looks like a bomb went off in the genome. It’s a complete fiasco.” With the help of an NIH K08 grant that supports the development of outstanding clinician research scientists, Jones now spends 75 percent of his time on research. Whenever he presents lab results at a weekly sarcoma research-in-progress meeting, however, he always tells a patient story both to humanize the research and inspire the researchers. Jones and Randall work hard to bridge this connection and are anxious to get new therapeutic agents to the bedside.

Capecchi, who also attends the meetings, approaches the problem from a different perspective. “Dr. Jones and Dr. Randall have a lot of impetus and drive to translate what we learn,” says Capecchi. “I’m the opposite. I think, let’s concentrate on how it works, let’s understand the mechanism, and then the translation will be obvious.” It is that collaboration between scientists and clinicians that creates a dynamic tension between understanding the mechanism and finding a solution. They are essentially different roles, Capecchi says, and they both are important.

There’s still a long way to go, Randall acknowledges, but there’s also been great progress. “We have the passion and the drive, and now the model is there,” Jones agrees. “We win more often than we lose with sarcomas, but that’s not good enough,” says Jones. “We have to double down our efforts. We’ve got to be smarter.”
Nasir Marrouche, M.D., considers himself an impatient sort. Early in his career as a cardiologist he became irritated with what he felt was an imperfect and generic approach to detecting arrhythmias—heart rhythm disorders that affect 4 to 5 percent of the world’s population. “That’s millions of people who are at a three-fold increased risk for stroke,” says Marrouche. “We needed to do much better.”

After training and working at Harvard, the University of California, San Francisco, and the Cleveland Clinic, he chose the University of Utah to build a Comprehensive Arrhythmia Research & Management Center, known as CARMA. It was the interdisciplinary research environment, in particular, that lured Marrouche to Utah. “Walking through Research Park was unbelievable. I had never seen so much advanced technology and the best research scientists all available in one location. I knew I had to work here.”

As the director of CARMA, Marrouche brings together an interdisciplinary team of cardiologists, lab technologists, and medical researchers to conduct the world’s most innovative research using MRIs to treat arrhythmias. Their current focus is on atrial fibrillation (afib), the most common type of arrhythmia. “I knew there was much research to be done,” he says. “But I wanted to pursue research that I know would make a difference in the patient’s life.”

At CARMA, that’s already happening, thanks to its ground-breaking work to enhance early detection of afib and improve patient outcomes. For patients worldwide, Marrouche’s impatience has proven to be a virtue. Imagine you’re a cancer patient who finds out the chemotherapy drug you depend on to survive suddenly isn’t available, or a busy trauma surgeon who learns that an important anesthesia drug is out of stock.

Those are common scenarios playing out across the country because of an increasing number of drug shortages. In 2010, there were 211 reported national drug shortages—the most in recorded history. “This has become a national health crisis,” says Erin Fox, Pharm. D., manager of the University of Utah Drug Information Service.

The U’s Drug Information Service is the nation’s authority on the subject, providing hospitals around the country with the latest advisories about pending drug shortages and the best alternatives. Fortunately for University of Utah Health Care patients, that means many drug shortages never happen here.

“We reinvent everything we learn about drug shortage management on a national basis back into our own system for our patients,” says Fox. “That allows us to stay ahead of the curve, saves our system millions of dollars each year, and ensures that our patients have the drugs they need.”

The Drug Information Service began as a partnership between the hospital and the health sciences, as a resource for U scientists or clinicians who had questions about specific drugs. “At the time, no one else in the country was doing that, so we filled an important void,” says Fox. “And it’s one of the most complex cases in his field. Using this flexible fiberoptic nephroscope, he can remove a large kidney stone through a small incision.

One centimeter is about the length of a grain of rice. It’s also the size of the incision Blake Hamilton makes when he’s removing a very large kidney stone or taking out a diseased kidney through the belly button.

As one of the Intermountain West’s pioneering surgeons in minimally invasive techniques for urology, Hamilton treats the most complex cases in his field. Yet, through his use of robotic, endoscopic, and laparoscopic surgical techniques, it’s often hard to tell he’s operated.

Hamilton is part of a team of subspecialists in urology at the University, each highly trained in a specific area of their field and researching new ways to improve treatments of diseases. “We’re frequently referred patients who can’t be treated elsewhere, because we can bring all of our individual experience together and work as a team,” says Hamilton.

Hamilton thrives on working in an environment that constantly challenges him intellectually. Part of that challenge comes from teaching and mentoring aspiring surgeons who serve their residencies at the University. “You watch young medical graduates come in with eagerness and enthusiasm and over the course of five years become remarkable practitioners of the surgical art. I’ve watched this cycle for 14 years, and it still thrills me to see this progression.”

Blake D. Hamilton, M.D., associate professor of surgery, Division of Urology, uses robotic, endoscopic, and laparoscopic surgical techniques to treat some of the most complex cases in his field. Using this flexible fiberoptic nephroscope, he can remove a large kidney stone through a small incision.

The information and data gathered is also used for teaching and research. “Working in the U’s academic setting really allows for creative and innovative problem solving,” says Fox. “Our collaboration and research now improves the care of patients all over the country. I’m really proud of that.”

Nassir Marrouche, M.D. assistant professor of internal medicine and director of CARMA—the U’s premier Comprehensive Arrhythmia Research & Management Center: “When I meet with everyone involved in the process of treating a patient, I know that 78 percent of the people in the room are smarter than I am. I learn from them. They learn from me. That’s why we can make such a difference in our patients’ lives.”

Erin Fox, Pharm. D., manager of the University of Utah Drug Information Service, provides hospitals around the country with the latest advisories about pending drug shortages and the best alternatives.
“Every morning, I pull out of my driveway excited to do what I do,” says Caroline Milne, M.D.

What Milne does—when she’s not caring for her own patients—is mentor and guide hundreds of new physicians through their internal medicine residencies at the University of Utah School of Medicine.

During this intense training period, Milne gets to know each of the resident’s clinical and academic strengths, but she also makes an effort to get to know them personally. “This is pivotal time in their lives,” she says. “And I have an opportunity to help them choose what I hope will be immensely satisfying careers.”

That’s because after training for three years in internal medicine, most residents continue their training in a subspecialty. Milne helps them secure prestigious fellowships, but she also wants to ensure it’s a good fit. Fortunately, Milne says, her department chair, John Hoidal, M.D., shares that vision. “We have a fantastic department, but John really

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In appreciation of her efforts, residents have honored Milne with a number of teaching awards. “The most important thing to me,” she says, “is that 10 years down the road, everyone loves what they’re doing.”

Eventually, everyone here has an educational role,” says Ramin Eskandari, M.D., a sixth-year neurosurgery resident. “I’ve grown up in this program, and now I’m honored to be able to train others. I take that responsibility very seriously.”

Even as a young child growing up in Iran, Ramin Eskandari, M.D., knew he wanted to become a surgeon.

Now at age 34, with 16 years of higher education under his belt, Eskandari is in his sixth year of a seven-year neurosurgery residency at the University of Utah, excited about another intense and grueling year ahead of him. He’s grateful for the high expectations that his mentors have set for him—not just clinically, but also scientifically and academically. “This is a culture of total patient care—and I appreciate that the faculty here emphasize the importance of learning to take care of the whole patient not just as a technician but as a clinician.”

This year, he will participate in some of the most complex surgical cases, continue his research in the U’s well regarded hydrocephalus lab, and oversee junior residents.

It’s the training environment, Eskandari believes, that enables academic medical centers to provide the very best patient care. “The number of eyes on each patient at any time is incredible,” he says while taking a break from rounding on patients in the Neuro ICU. “And the combined amount of expertise taking care of each of these patients is tremendous.”

“I love to see people happy,” says nurse manager Adjei-Poku, R.N. “So when I see patients who are uncertain or anxious, I let them know they have a whole team of people behind them, not just me.

I reassure them that each of these team members—from neurologist to cardiologist and the nursing staff—is going to give them the best, most up-to-date care available.”

Energetic and charismatic, Adjei-Poku is beloved by staff and patients alike. Since she began working at University Hospital in 1995, she has been one of its most enthusiastic supporters and one of the greatest advocates for providing every patient with exceptional and compassionate care.

“When I was a patient, I remember I had many questions,” says Adjei-Poku. “The attendings, the residents, and the nursing staff, all gave me a lot of input on the decisions I needed to make for my own care. To me, that was invaluable.”

Adjei-Poku encourages her patients to take advantage of the U’s breadth of expertise: to ask questions about their condition, so that they can make educated decisions about their care.

“I’m learning and teaching at the same time. Everyone here is,” she says. “We give and take knowledge: we share experiences. The learning never stops, and it makes patient care here very vibrant.”
When things go wrong
These Men Will Save Your Life

It was a day or two before Christmas nearly two decades ago, but trauma surgeon Richard Barton, M.D., remembers it vividly. A 50-year-old man involved in an ultralight plane crash was rushed into University Hospital’s Emergency Department with multiple injuries, bleeding profusely.

Barton knew he needed to stop the blood gushing from his patient’s iliac artery and spleen, but during surgery the patient suffered cardiac arrest due to blood loss. While the OR team tried to resuscitate him, Barton continued operating, until he heard the anesthesiologist say, “Rich, it’s time to stop. He’s dead.”

Barton still gets choked up when he recounts the story. At the time, he didn’t know the man had eight children; he hadn’t met his wife, distraught with worry, in the waiting room. But he knew that like all of his patients, this man had a story. “It’s Christmas,” Barton said, not looking up from the operating table. “Let’s keep going.” Despite the odds, the patient was resuscitated and made a full recovery. He even became friends with Barton, who has attended several of his children’s weddings. “It’s moments like those that make our jobs worth the effort,” says Barton.

Barton, Stephen Morris, M.D., and Jeffrey Saffle, M.D. are part of a team of dedicated trauma and burn surgeons and critical care doctors at University Hospital. The clock ticks loudly and tension runs high for these doctors, who’ve spent the past twenty years working in the trenches of some of the most intense situations in medicine. These are men who have never punched a clock or gone home at the end of a workday. They vigilantly care for some of the sickest patients in the hospital, routinely have their lives interrupted to respond to a trauma; and are occasionally awakened in the middle of the night to turn on their telemedicine computers and evaluate a burn patient in Boise, Idaho, or Helena, Mont. “It’s a sacrifice not to be at home or with family,” acknowledges Barton, who spent nearly one-third of his nights in the hospital last year. But the upside is that “we’re highly tuned into our patients’ needs, making judgment calls—and there are many—not as tough.”

While it’s immensely satisfying to perform acute interventions on patients 30 seconds from dying, it’s also a weighty responsibility. “My wife can tell you how many nights I’ve laid awake worried about whether or not a graft will take, or if I did the right things with fluids,” says Saffle. Their greatest thanks come in the form of graduation announcements, wedding invitations, and birth announcements from former patients.

They’re quick to acknowledge that they are only one member of an entire patient care team that includes “terrific” physicians, nurses, residents and staff. “We hold each other up and get each other through the day,” says Saffle, who considers the Burn Center his home, the staff his friends. They’re also grateful to be part of a health care system that supports the highest level of care—from the ICUs, operating rooms, and blood banks, to the surgeons and critical care doctors in house. “We have such a valuable resource for the community,” says Barton. “We need to make sure we maintain this level of excellence.”

When Barton, Morris, and Saffle finally do go home, it’s because they know their patients are in good hands. “That peace of mind is only possible when you know that others are as committed and competent,” says Morris. “That you don’t need to worry about the decisions they make or the procedures they do. You know that they’re the best and they’ll stop at nothing. Only then, can you sleep well at night.”

The three surgeons believe they carry a torch in the work they do, and feel it’s both a privilege and a responsibility to do so. “I’ll do it as long as I’m capable of giving something back and doing it well,” says Barton. But as they get a little “longer in the tooth and their hair gets gray,” as he puts it, they are concerned that there will not be a new generation to pass this torch on to, as fewer physicians are being trained in their specialties. “Burn care is dying. It’s like a lost language we’re trying to keep alive,” says Saffle. Trauma is the No. 1 cause of death under the age of 44, yet three-quarters of U.S. emergency departments report they don’t have enough on-call trauma surgeons.

For now, they love what they do and feel an intense responsibility to do it. To take care of their patients. To train physicians of tomorrow. To be there for the community. “We do what we do,” says Morris. “So that people can go about their lives—working, playing, being with their families—with a peace of mind that someone will be there to take care of them.”
Mommy blogger and outspoken advocate Challenges the World to Rethink Crazy

She couldn’t unclench her hands. Nor could she imagine getting through the next hour. That’s what Heather Armstrong remembers most vividly about the August morning she woke up and turned to her husband and said, matter-of-factly, “If you leave today, I won’t be here when you get back. I will have killed myself.”

Since the moment her daughter Leta was born nearly seven months earlier, Armstrong had battled paralyzing feelings of despair and anxiety from postpartum depression. She was desperately lonely, but the thought of the effort it would take to leave the house—to get her daughter dressed or put her in a stroller or car seat—was paralyzing. Even feeding Leta seemed like an insurmountable task. To make matters worse, she was exhausted. “Everyday at about 5 or 6, the anxiety would really start to build up because I’d think ‘I’m not going to sleep again tonight.’ I’d just lie in bed, rocking back and forth like a very insane person.”

Armstrong was adamant, however, about not going to a hospital. “Don’t you dare try to put me into the hospital,” she threatened her husband. “I don’t want to be the woman who went crazy.” But that morning was different. “There was no other option at that point,” she said. “It was absolutely terrifying to admit to myself that I was at the end.” She remembers how frightened she felt on the short drive from her Salt Lake home to University of Utah Neuropsychiatric Institute (UNI), and how bleak her future seemed. But her outlook changed when a “warm and charismatic” doctor calmly walked into the room, sat across from her, and asked her to tell him her story. She did.

Afterwards, she remembers, the first thing he did was set his pen down, look at her and said, “I am so sorry. I am so sorry that you’ve been put through all of this.” And then he said the words that she was so desperate to hear. “I know exactly what will help. You are going to be feeling fine really, really soon.”

Lowry Bushnell, M.D., adjunct professor psychiatry, is known for prescribing a combination of medications that can have an immediate effect, critical for patients who are suicidal. “He told me he’d been doing this for many years, and had treated so many women going through this. I trusted him,” said Armstrong, and she started the medications. “Within two hours,” she says, still incredulous, “I felt completely differently.” When her husband, Jon, came to see her at lunchtime, he noticed the change right away. “Welcome back,” he said, smiling. “I haven’t seen you for seven months.”

Armstrong will forever be grateful to Bushnell. “He saved my life,” she says. She’s also eternally grateful to readers of her blog, dooce.com, who “safety-netted” her decision to go to the hospital. Even when she couldn’t muster the energy to get out of the house, she had her on-line mom friends . . . in San Francisco, New York, and Florida. When she’d post how she couldn’t make it through the next 10 minutes without crying, her readers urged her to get help. One reader reassured her, “If you have to go away and get help, we’ll be here for you when you get back.” And they were. Throughout her four-day hospital stay at UNI, Armstrong would write her blogs in a notebook and Jon would post them on her blog at night. Traffic on her site spiked. By the time she returned home, her readership had tripled.

She continues to receive thousands of heartfelt e-mails from people thanking her for sharing her journey. And she feels a deep responsibility to answer as many as she can. “It’s my job,” she says simply. She feels a profound responsibility to speak up and to try to destigmatize mental illness. “It’s probably the most important thing I do.” Armstrong exercises, eats well, and goes to talk therapy, but she is adamant that she will never be without medication again. “It allowed me to be myself. And if it takes me standing up and saying ‘I am weak enough to take medication’ to make others find their own solution, then I’m happy to do that.”

Five and a half years later, Armstrong went on to do something she never thought she could, have another baby—Marlo. This time, with the help of Bushnell, her experience was happily “normal.” But she will always be grateful to Leta. “Leta was my greatest teacher,” says Armstrong. “At the time, I was all alone, thinking that I was the only person who didn’t know how to be a mother. And even though the experience was sad, I thank her for letting me tell my story so that all these other women will feel less alone.”

Heather Armstrong went from being suicidal after the birth of her first daughter to being named to the Forbes list of the 10: ‘Most Influential Women in Media.’ “It’s crazy,” laughs the irreverent Salt Lake City-based mommy blogger, shown here with her younger daughter, Marlo. Armstrong, a bestselling author, has 1.5 million followers on Twitter, and every month, her dooce.com blog has 4 million page views. “I am absolutely proud. I think I show that a person with a mental illness can succeed and be powerful and confident and call her own shots,” says Armstrong. “I went from wanting to hang myself with a dog leash to living a really fulfilling life, and that’s what I want to tell people who need help. It gets so much better!”
Brian Johnson didn’t always want to play football. In fact, he laughs about the first reason he came up with for not playing the game. “They’re gonna paralyze me!” cried a tearful 9-year-old Johnson to his mother, as he tore off his gear and threw it on the floor after being hit hard on the first day of practice.

Fortunately, his mother persuaded him to keep playing, and Johnson went on to become the University of Utah’s most winning quarterback, and the 2009 Sugar Bowl Most Valuable Player.

While his childhood fear never materialized, Johnson certainly had his fair share of injuries. It was another hard hit during the 10th game of the 2005 season that presented him with perhaps the biggest challenge of his career. “I remember it was fourth down and I ran back, and right when I tried to cut back in, I was tackled and went down.” He first heard the “pop” from his knee. When he realized what had happened, he felt overwhelming disappointment and guilt for letting down his teammates.

Johnson’s season-ending knee injury required surgery, and he knew his college football career depended on the outcome. “I remember talking to Coach Whittingham before surgery, and he had the utmost confidence in the doctors and surgeons. And Dr. Greis did a great job,” says Johnson, about Patrick Greis, M.D., associate professor of orthopedics and team physician for the U’s football program, who performed the surgery at the University Orthopaedic Center (UOC). After redshirting the following year, Johnson went on to play for the Utes for two more years, and finished his career with an undefeated season and a Bowl Championship Series win. He credits much of his success to the doctors, nurses, and physical therapists at the UOC.

“Taking care of the U’s athletes puts us to the test,” says Charles Saltzman, M.D., chair of the Department of Orthopaedics at the U’s School of Medicine. “It matters that we get it perfectly for these athletes, because dropping off 1 or 2 percent from our very best work makes a difference. These are some of the top athletes in the country with a lot at stake—scholarships, potential pro deals—so our physicians and therapists have to be at the top of their game.”

Saltzman emphasizes, however, that it isn’t just elite PAC-12 athletes who benefit from UOC’s expertise. Most patients are regular folks wanting to get back to the business of their lives. “We use the same advanced, innovative techniques for repair and rehab that we do for these athletes, for everyone we care for,” says Saltzman. “Whether it’s getting back on the golf course, hiking or skiing again, we want everyone to achieve their very best.”

In Brian Johnson’s case, mission accomplished. He’s now the quarterback coach for the Utes, and at age 24, he’s the youngest college football coach in the nation. Currently, the U’s starting quarterback, Jordan Wynn, is out for the season with another shoulder injury. Johnson says he’s disappointed for Wynn and the team, but is confident about his recovery. “Our medical staff and trainers are hands down the best in the business at what they do,” he says. “I think he’ll be fine.”
Nevada mom hands over the reins to the AirMed High Risk Obstetrics Flight Team

Just off of Highway 50, known as the loneliest road in America, lies the old mining community of Eureka, Nevada. While the stoplight-free town cheerfully welcomes visitors to “The Happiest Place on the Loneliest Highway,” AAA takes a more cautious approach, warning motorists not to drive through Nevada’s desolate high desert “unless they’re confident of their survival skills.”

Survival skills are an afterthought for Rosie Bliss, who grew up in Eureka rodeoing and doing ranch work in the wide-open spaces quilted with sagebrush. Home for her family is down a long dirt road on their 240-acre Two Bit Ranch, where she and her husband, Chad, have 70 head of cattle and a handful of horses. The closest neighbors are three miles away. “In Nevada, our acreage would be considered a chunk of land, not a ranch,” contends Rosie.

But when Bliss found herself in a high-risk pregnancy with twins, she was “absolutely concerned.” She’d already lost a baby during a previous pregnancy with twins. Unlike some families who move closer to a hospital for greater peace of mind, however, the Bliss family decided to stay put. They had the ranch and cattle to look after as well as their day jobs—she’s a librarian and reading specialist at the Eureka County High School and Chad’s a lineman for a local power company. The pregnancy was going smoothly, but at 32 weeks, Rosie’s water broke. She was worried as she drove the 114 miles to Elko, Nevada, to see her obstetrician, who confirmed that it was way too early to have the babies there. It was time, he said, to call AirMed.

Within the first eight hours at the hospital, four maternal-fetal medicine specialists conferred and oversaw her care. “Every nurse who walked in knew exactly what was going on. And a social worker and a nurse supervisor checked to make sure I had everything I needed,” says Bliss, who was put on strict bed rest. Even the flight nurses visited her. A week later, one of the doctors became concerned that one of the twins’ feet was wedged in Rosie’s cervix. “Instantly five people were getting me ready for a C-section,” recalls Rosie. On June 26—their father’s birthday—she delivered Natalie (2 lbs. 14 ozs.) and Nicholas (3 lbs. 9 ozs.).

A month later, the twins were discharged and the family packed up the car and headed west on Highway 50 towards home. Natalie and Nicholas, toddlers now, are slowly taking ownership of the Two Bit Ranch along with their older sister, Hannah. In a place where cows outnumber people, some might consider it lonely. For the Bliss family, however, it’s a slice of paradise for raising their three children. Rosie says simply, “They’re safe here.”
As a state-owned, but self-funded, institution, University of Utah Hospitals and Clinics is continually striving to provide the best value and highest quality health care.

Fortunately, value and quality go hand in hand. From year to year, we carefully balance our need to grow and to invest in new technology and capital improvements with our annual revenue. We also ensure that we’re able to fund the care of our patients not covered by commercial or government insurance programs. Our goal is to operate as strategically and efficiently as possible so as the community grows, we can grow too. We know that if our system remains financially healthy, we can continue to keep the community healthy.

**Sources of Funds**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care provided to patients, for example, surgeries, therapies, pharmaceuticals and laboratory tests</td>
<td>$1,687,000,000</td>
</tr>
<tr>
<td>We did not receive full payment for services provided to patients covered by Medicare, Medicaid, and other payors because these agencies have limited their level of payment</td>
<td>$(726,000,000)</td>
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<tr>
<td>As part of our ongoing community commitment, we provided charity services to qualifying patients unable to pay</td>
<td>$(29,000,000)</td>
</tr>
<tr>
<td>We incurred bad debts for services provided to patients who were unwilling to pay</td>
<td>$(46,000,000)</td>
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<tr>
<td>Other revenue sources</td>
<td>$40,000,000</td>
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<td><strong>Total Sources</strong></td>
<td><strong>$926,000,000</strong></td>
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**Uses of Funds**

<table>
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<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Operating expenses, including salaries and supplies</td>
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<tr>
<td>Capital investments to improve and replace facilities, technology and services</td>
<td>$(41,000,000)</td>
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<tr>
<td>Payments on debt obligations</td>
<td>$(25,000,000)</td>
</tr>
<tr>
<td>Support payment to the University of Utah for research and education</td>
<td>$(26,000,000)</td>
</tr>
<tr>
<td><strong>Total Uses</strong></td>
<td><strong>$926,000,000</strong></td>
</tr>
</tbody>
</table>
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Leah Ann Lamb, a volunteer with the Hospital Elder Life Program (HELP), visits with a patient at University Hospital. The HELP program—designed to prevent delirium in patients—offers a low-tech, high-touch approach that helps relax and orient the patient, improves the quality and safety of care, and saves the hospital money.

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