Meet Doug Weeks, AHA’s New Chairman

Arkansas Health Insurance Marketplace News
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Having Arkansas’ uninsured population access newly available healthcare insurance will be a big plus, not only for patients, but also for hospitals throughout Arkansas. It won’t be easy; change rarely is. And this change, brought about by the Affordable Care Act, marks the biggest healthcare reform since Medicare was implemented in 1965.

Covering the uninsured has been a focus of America’s hospitals for the past 20 years, long before the earliest discussions of the Affordable Care Act began. We’re now on the verge of seeing it happen, but success depends on everyone pitching in to do their part.

Our hospitals can perform their role best by being able to answer questions, point the uninsured to those who can help them enroll, and keep lines of dialogue going.

Open enrollment began October 1, and runs through March 31. Coverage by the new health plans will start January 1, 2014. We know everything won’t move along smoothly in these early months. In fact, things may seem to be a bit bumpy and unorganized. But, we’ll adjust as we go. While many may not recall, Medicare wasn’t perfect when it was launched, either, but today’s senior citizens have grown to rely on the program, which operates smoothly for them.

The success of the healthcare legislation will depend on the uptake, how quickly the people who need insurance enroll through the insurance marketplaces in each state. For hospitals, the quicker, the better.

The Arkansas Hospital Association and its member hospitals are working diligently to ensure that the state’s unique Private Option plan and the broader health insurance expansion efforts translate seamlessly from a well thought out theory to reality, and that as many uninsured Arkansans as possible receive the coverage they need.

Because dramatic Medicare reimbursement cuts are already in effect, hospitals have good reason to help in the enrollment of uninsured Arkansans. Caring for more patients with insurance coverage will help to offset those losses, lower the rates of uncompensated care and improve hospitals’ ability to remain open to serve their communities.

So how can hospitals help? Make certain all staff from the C-Suite down through the organization learn the four key facts that reach the most uninsured:

1. All insurance plans will have to cover doctor visits, hospitalizations, maternity care, emergency room care and prescriptions.
2. Arkansans may be able to get financial help to pay for a health insurance plan.
3. If you have a pre-existing condition, insurance plans cannot deny you coverage.
4. All insurance plans will have to show the costs and what is covered in simple language with no fine print.

We expect that 75% of the newly eligible will want in-person assistance to learn about and enroll in coverage. Many hospitals are getting staff trained as Certified Application Counselors, but it is also important to be able to identify Navigators and other assisters in the community who can help, and perhaps even to partner with a local organization to develop referral relationships, or to offer space in the hospital for assisters to meet with patients.

And we must help spread the word! Include information about www.healthcare.gov and www.getcoveredamerica.org on voicemail messages, on-hold messages and websites; hang posters in waiting rooms; provide a trained staff person to listen and to help.

Perhaps the most important message is that cost and affordability of healthcare coverage are now going to be within the financial reach of uninsured Arkansans, whether they receive federal assistance to pay their premiums in full or qualify for partial subsidies based upon income.

The Arkansas Insurance Department is publicizing the state’s online Insurance Marketplace through its “Get In” campaign. The website, www.ARHealthConnector.org, provides individuals, self-employed workers, small businesses and others detailed information about their options for the new coverage and the enrollment process. Yet, it is the face-to-face, up close and personal communications that might turn the tide.

Because many of the uninsured already turn to our hospitals for needed healthcare, they are the most likely source of those personal interactions. So, Arkansas hospital leaders, employees, medical staff and workers are key players in the overall effort to help our uninsured understand their options.

Like Medicare was almost 50 years ago, this will be a monumental change for healthcare and likely will encounter some rough patches. But, if we are patient, it has the potential to be good for the state and its families, individuals, patients and hospitals for years to come.

Bo Ryall
President and CEO
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Dolbey was one of the first companies in the CAC arena in 2005
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Dolbey has the best local service and support
Dolbey has developed all their own CAC Software
Embedded Encoder (TruCode) provides option to lower cost of existing encoder contract 25% while increasing productivity
**Governor Mike Beebe** has named Alicia Storey, oncology programs manager, St. Bernards Healthcare, Jonesboro, to the Breast Cancer Control Advisory Board replacing Tammy Gavin, FACHE, COO, White River Medical Center in Batesville. Storey’s appointment expires January 1, 2017.

**Governor Mike Beebe** has appointed infectious-disease specialist Nathaniel Smith, MD as director and state health officer of the Arkansas Department of Health. Smith has served as interim director for the department following the departure of Dr. Paul Halverson in May. Smith has been with the department since 2004 and served previously as state epidemiologist and as deputy director for health programs.

David R. Fox, CRA, FACHE, FAHRA, president of St. Vincent North, has been elected for a three-year term as president of the American Healthcare Radiology Administrators (AHRA), the professional organization representing management at all levels of hospital imaging departments, freestanding imaging centers and group practices. The mission of AHRA is to be a resource and catalyst for the development of professional leadership in medical imaging management.

Rex Jones has been named CEO of Bradley County Medical Center in Warren. He succeeds Brandon Gorman, CFO who has been acting in an interim capacity during the search for a permanent CEO since the retirement of Harold Mitchell in January. Jones was with Quorum Health Resources from 1998 to 2011, and during that time was CEO at Howard Memorial in Nashville, and three hospitals in Kansas and Oklahoma.

Dan McKay, CEO of Northwest Health System, has announced that Ben Casmer has been named administrator/COO at Northwest Medical Center – Bentonville. Casmer most recently served as assistant CEO at Weatherford (Texas) Regional Medical Center and previously served as assistant CEO of Medical Center of South Arkansas in El Dorado.

Julie Ginn Moretz has been named associate vice chancellor for patient- and family-centered care, a new position at UAMS in Little Rock. A nationally-known advocate for engaging patients and their families in healthcare decisions inspired by her late son’s battle with congenital heart disease, Moretz came to Little Rock from Augusta, GA where she worked as director of the Family Services Department at the Medical College of Georgia, which has one of the first model programs for the movement. She also recently served as director of special projects at the Institute for Patient-and Family-Centered Care in Bethesda, MD.

Michael Perkins, vice president and administrator of Baptist Health Extended Care Hospital in Little Rock, has been appointed by Governor Mike Beebe to the Tobacco Prevention and Cessation Advisory Committee replacing Ron Rooney of Paragould. His appointment expires September 30, 2015.

Eddie Phillips, MD has been named chief medical officer for Baptist Health in Little Rock. Dr. Phillips has been a member of the Baptist Health Medical Center-Little Rock professional staff since 1980 as an obstetrician and gynecologist. He also has served as section chief for obstetrics and gynecology as well as chairman of the quality review committee. Dr. Phillips currently serves on the advisory board of Baptist Health Physician Partners. He succeeds Dr. Guy Gardner, who retired as the system’s chief medical officer.

St. Vincent Health System has named two physicians to new leadership positions within the System. David Foster, MD has been named president of the St. Vincent Medical Group. His focus is engaging physicians to
St. Bernards Healthcare of Jonesboro has broken ground on a $14.5 million complex for patients with Alzheimer’s disease and those who need more care than an assisted living facility can offer. The complex, called St. Bernards Villa, will add 40 workers when it opens the first phase with 45 beds in the fall of 2014. “We know there is a staggering need for Alzheimer’s care,” says Chris B. Barber, president and CEO of St. Bernards Healthcare. “And this development represents another instance in which St. Bernards is stepping up to meet an overwhelming community need. That is what we have done for nearly 113 years at St. Bernards. The Olivetan Benedictine sisters of Holy Angels Convent who established St. Bernards in 1900 in response to a malarial fever epidemic continue today to focus on developing programs and services that meet needs in the communities we serve for many years to come.”

Voters in two Arkansas counties supported by wide margins tax measures in special elections August 13 to keep their hospitals open. In Hot Spring County, residents approved extending a 20-year, half-cent sales tax to continue maintenance of HSC Medical Center in Malvern. Sheila Williams, CEO of the Malvern facility, said, “There is always that fear inside that people won’t show up to vote, but we knew, in the end, that people would end up doing the right thing. We have a very supportive community. They know that without this tax, the hospital would not be able to operate in the long term. It’s definitely vital to our success.” Lawrence County voters approved extending a half-cent sales tax and adding another half-cent sales tax to operate Lawrence Health Services, which operates Lawrence Memorial Hospital and a nursing home in Walnut Ridge.

Baxter Regional Medical Center has begun a $2 million “Building for Babies” capital campaign for the renovation of the Women and Newborn Care Center in the hospital. Ron Peterson, President and CEO of Baxter Regional, says that since 2006, more than 5,000 babies have been born at BRMC. The facility has been designated as a Level 2 Neonatal Intensive Care with the statewide ANGELS program through the University of Arkansas for Medical Sciences. The renovated facilities will provide additional rooms to allow mothers and babies to stay together throughout labor, delivery and recovery.

Capella Healthcare and Mercy Health have ended their discussions at this time to join together National Park Medical Center and Mercy Hot Springs, officials announced June 27. This announcement comes after more than a year of due diligence and the investment of significant resources to create a stronger, more efficient healthcare delivery system for the region. The proposed partnership was subject to approvals by both the Federal Trade Commission (FTC) and the Vatican.
Meet AHA’s New Chairman – Doug Weeks

Doug Weeks, FACHE, Senior Vice President, Hospital Operations at Baptist Health in Little Rock, has been installed as the 72nd chairman of the board of directors of the Arkansas Hospital Association (AHA) during the association’s October 9-11 Annual Meeting in Little Rock.

“Growing up as the son of a Baptist minister, one of my earliest memories is spending many hours in the waiting room of Baptist Hospital on 12th and Marshall Streets near downtown Little Rock while my Dad visited sick church members,” recalls Weeks. Little did he know those many years ago that he would spend a major part of his career as a top executive in that same hospital system.

The “old Baptist Hospital,” as many folks in Little Rock call it, moved westward in 1974 and now has grown to the largest healthcare system in Arkansas with seven hospitals, rehabilitation facilities, family clinics, specialty centers, therapy and wellness centers, long term care, a retirement village, a hotel focused on the comfort of patients and families, and a school of nursing and allied health under its banner. Russell D. Harrington, Jr., FACHE, is president and CEO of Baptist Health.

“I believe Doug Weeks is well positioned to lead the AHA board as its chairman. His greatest strengths are hospital operations and his understanding of today’s difficult healthcare environment. He has significant ability to drive decision making through consensus building. These attributes should serve as a good fit for the AHA board during the next two years,” said Harrington.

Weeks’ father’s career necessitated many moves to communities in Arkansas and northern Louisiana. Weeks became interested in healthcare administration from a church member at his father’s church in El Dorado. Phillip Gilmore, now CEO at Ashley County Medical Center in Crossett, was then leading the former Warner Brown Hospital in El Dorado, and shared information about his vocation with the young college student. Weeks was living in New Orleans at the time and found that Tulane University had a master’s program in healthcare administration, thus his future path was set.

“Through high school, I spent evenings and summers sacking groceries and working produce aisles in local groceries. I credit hard-nosed bosses at Piggly Wiggly and Brookshires for instilling in me a customer service mindset,” he said. “Occasional roofing jobs and one stint at an incineration plant in El Dorado helped keep me focused on my studies in college…”

After earning his master’s degree in healthcare administration, he looked to Little Rock and Baptist Health in hopes of his first job in healthcare – and he hasn’t looked back since that time. “I was fortunate that they were looking for young administrator candidates, and have to this day felt that it has been a perfect fit. Russ Harrington has been an outstanding role model, leader and mentor for me,” says Weeks.

Weeks began his almost 25-year healthcare career as assistant administrator at Baptist Health Rehabilitation Institute (BHRI) in 1990, becoming administrator of the facility in 1994. Three short years later, he moved over to Baptist Health Medical Center-Little Rock (BHMC-LR), an 827-bed facility, as Senior Vice President/Administrator, where he served for 14 years.

During that period, he saw much change in the Baptist Health system and in the two hospitals. He was responsible for the development of 20 outpatient satellite therapy clinics and achieving specialty accreditation from the Commission on Accreditation of Rehabilitation Facilities in spinal surgery and brain injury at BHRI; led construction of a 36-bed ICU at BHMC-LR; initiated implementation of the 37-bed long-term acute-care hospital, Baptist Health Extended Care Hospital; initiated implementation of the high-risk maternal fetal medicine program; and assisted in acquiring the former Southwest Hospital campus for use by BHMC-LR.

In the spring of 2012, Baptist Health made some significant changes in its leadership team and Weeks was promoted to Senior Vice President, Hospital Operations for the system. His new role consolidates overall management continued on page 10
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of the system’s seven hospitals into a single organizational structure. The leadership changes were moves to prepare the hospital system for the future.

In addition to his hospital duties, Weeks is an enthusiastic member of the Arkansas Hospital Association. He is a member of the AHA’s Board of Directors having served as the Metropolitan Hospital District representative from 2007 to 2011. In October 2011, he was elected to serve a two-year term as chairman-elect, thus beginning a six-year term on the Executive and Finance Committees. Weeks also serves on the AHA’s Council on Government Relations and the Medicaid Committee.

“The AHA is a steady and trusted source of information, advice and advocacy as we all navigate today’s changing and unsteady waters. I call on our leaders routinely for assistance, and they always provide excellent feedback. It is a pleasure serving on the AHA board!” said Weeks.

In addition to his state association role, Weeks is completing a three-year position as Section for Healthcare Systems delegate to the American Hospital Association’s Regional Policy Board (RPB) 7. The RPBs provide input on public policy issues considered by the national association, serve as ad hoc policy development committee when appropriate, and identify needs unique to a region and assist in developing programs to meet those needs.

Active in the Little Rock community, he is a board member for the Central Arkansas Division, American Heart Association; former board member and volunteer for the Big Brother Big Sisters program and CARTI; a member of the Mount St. Mary Academy Marketing Committee, and 2007 Chairperson of the Diabetes Association’s “Walk for Diabetes.”

When his children were younger, he coached their soccer and Life CHAMPS football teams. Jokingly, Weeks says, “No, we didn’t win any championships, but no one was badly injured or kicked out of any games!”

Professionally, he is a Fellow in the American College of Healthcare Executives and has served on that group’s Regent’s Advisory Council. He served as president of the Arkansas Health Executives Forum (AHEF) and in 1999 received the AHEF’s C. E. Melville Young Administrator of the Year Award.

“One of my best memories as administrator at Baptist Health was when President George W. Bush visited our campus during tort reform. We had a one-week notice of his planned visit and it is amazing the preparation necessary to host a President. It was about as hard as I have ever worked in one week, but worth it as it gave us the opportunity to really brag about the wonderful care provided by physicians, nurses and all other healthcare workers at Baptist Health.”

In his January 24, 2004 radio address, President Bush said, “This week, I will travel to Little Rock, Arkansas, to visit Baptist Health Medical Center. For Baptist and
other hospitals across the nation, frivolous lawsuits have dramatically increased the cost of medical liability premiums. These costs are passed on to patients in higher bills. These costs are driving doctors from important work, such as delivering babies. And these costs are driving some doctors out of medicine entirely.

“In order to protect the doctor-patient relationship, Congress should pass medical liability reform that removes the threat of frivolous lawsuits and the needless costs they impose on our healthcare system,” continued President Bush.

Weeks and his wife Leighton, a nurse at the Arkansas Pregnancy Resource Center, have two children – daughter Connelly, a graduate of Mount St. Mary Academy, who attends Texas Christian University in Fort Worth, Texas, and son Steven, who attends Holy Souls Catholic School in Little Rock.

When asked about his philosophy of hospital administration, Weeks replied, “I feel extremely privileged to work in a field that allows us to serve our community through lifesaving, healing and restorative services. We have a duty to strive daily to determine ways to measure and improve quality, increase customer service and utilize resources in the most efficient manner. While doing this, we should strive to make healthcare more accessible to the communities we serve.”

The Arkansas Hospital Association board and staff members look forward to the next two years under the chairmanship of Doug Weeks. •
Arkansas’ Health Insurance Marketplace, the state’s health information exchange required under the Patient Protection and Affordable Care Act of 2010, began enrollment October 1. In July, the Arkansas Insurance Department (AID) issued contracts to 26 groups and organizations that are responsible for helping prospective buyers make their way to and through the portal where choices for insurance products will be made. Arkansas hospitals should follow all information pertaining to the qualified assisters closely in order to make sure they are positioned to help patients and others in their communities with the enrollment process.

**Qualified Assisters**

Assisters will help consumers apply for and enroll in health coverage. There are four types of assisters, each of which requires a license under Arkansas law.

- **Navigators** are individuals designated to provide outreach and education about the exchange and to help individuals complete electronic or paper applications to enroll in health coverage through the exchange. Navigators are funded directly by the federal government through federal grants. Navigator training began in September.

- **In-Person Assisters** perform the same services as navigators, but they are funded through contracts with the AID, which has issued a Request for Qualifications (RFQ) for entities who are interested in providing in-person assisters. Several entities have been approved by the AID. The RFQ is open-ended, so additional entities may apply. The RFQ is available on the exchange website, [http://hbe.arkansas.gov/](http://hbe.arkansas.gov/).

- **Certified Application Counselors** are a third type of assister defined in a HHS proposed rule. Under the proposed rule, these counselors would perform many of the same functions as navigators and in-person assisters, including helping individuals complete an application for coverage. They would not receive federal or state funding through the exchange for these services. HHS has identified staff at community hospitals as potential certified application counselors.

- **Agents and brokers** also will be allowed to assist with enrollment in the exchange in Arkansas, as long as they are licensed and certified to do so through the AID. The AID has established a three-phase training approach for these consumer assisters. Phases I and III are provided at the state level, while Phase II is the federally-required training provided through the federal website. In-person assisters will be required to complete all three phases of training, while navigators, certified application counselors and agents/brokers are required to complete only phases II and III. Everyone who assists individuals with enrollment through the exchange must complete the required training and be licensed by the AID.
The AID has an inter-agency agreement with the Arkansas Department of Higher Education and the Arkansas Association of Two Year Colleges for development and delivery of the required state-level training.

Coverage begins in January of 2014 and it is likely that patients who will now qualify for insurance coverage will look to their community hospitals for help to navigate through the system.

**Steps to becoming Certified Application Counselors**

Hospitals have the opportunity to provide individual assistance to consumers seeking coverage in the marketplace by arranging for appropriate employees and/or volunteers to become Certified Application Counselors (CACs).

Because the Arkansas marketplace is a state-federal partnership, both federal and state training are required for CACs. In addition, Arkansas Act 1439 requires each individual CAC to be licensed by the Arkansas Insurance Department prior to assisting consumers with enrollment through the Health Insurance Marketplace.

**Step 1: Organization Must File Federal Application.**

In order to provide CACs for enrollment assistance, a hospital first needs to submit an application to the federal government. The application may be found at [http://marketplace.cms.gov/help-us/cac-apply.html](http://marketplace.cms.gov/help-us/cac-apply.html). According to CMS, each legal entity must apply separately, but a single legal entity with multiple locations within the state may submit one application for all of its locations. According to the Arkansas Insurance Department, CMS will communicate directly with the hospital once its application is approved and will issue the hospital a federally assigned number as a CAC organization.

**Step 2: Each CAC Must Complete Federal and State Training.**

After a hospital has been designated at the federal level as a CAC organization, the individual hospital staff and volunteers who will provide application assistance must complete both federal and state CAC training.


After successfully completing the federal training, individuals will need PDF copies of the Training Certificates from the federal website to register for the state CAC site.

**Step 3: Each CAC Must Apply for an Arkansas License.**

When individuals successfully complete the state (Phase III) training, they will receive an email with a link to the Application for Licensure and background screening form. If you want to review the license application, it is available at [http://www.insurance.arkansas.gov/License/LicenseFormfiles/AID-AHC-HC.pdf](http://www.insurance.arkansas.gov/License/LicenseFormfiles/AID-AHC-HC.pdf).

Submit the completed application, notarized authorization for a background screening and the $35.00 license fee to the Arkansas Insurance Department. The hospital may make arrangements to pay for all of its CACs by check by contacting Sandra Cook at (501) 683-7236 or sandra.cook@arkansas.gov. Otherwise, the only acceptable method of payment is a money order.

Contact Elisa White at the AHA, (501) 224-7878 or elisawhite@arkhospitals.org, if you have questions or need additional information. The Arkansas Insurance Department contact for CAC issues is Sandra Cook, sandra.cook@arkansas.gov.

In July, the Arkansas Insurance Department (AID) issued contracts to 26 groups and organizations that are responsible for helping prospective buyers make their way to and through the portal where choices for insurance products will be made. Arkansas hospitals should follow all information pertaining to the qualified assisters closely in order to make sure they are positioned to help patients and others in their communities with the enrollment process.
Questions about the Health Insurance Marketplace

Two new publications from the Centers for Medicare & Medicaid Services answer questions that healthcare providers and patients may have about the Health Insurance Marketplace where individuals and small businesses may purchase health coverage beginning Oct. 1. For details, see “10 Things Providers Need to Know” and “10 Things to Tell Your Patients” about the Health Insurance Marketplace.

Health Insurance Marketplace: 10 Things Providers Need to Know

A primary goal of the Affordable Care Act is to help the 16% uninsured and eligible Americans gain access to quality, affordable health care. Central to this goal is the creation of the Health Insurance Marketplace. Through the Marketplace, eligible Americans will be able to enroll in a health plan to get coverage that starts as soon as January 2014.

As a trusted source for health information, your patients may look to you for help navigating the Marketplace. Here are 10 things you should know:

1. The Marketplace is a new way to shop for health coverage. A single, online source will let consumers get information about their health coverage options in a way that makes it easy to make side-by-side comparisons of private insurance plans’ benefits, quality, and price, and find out if they’re eligible for assistance with the costs of health coverage.
2. Each state will have a Marketplace, run either by the state, through a state-federal partnership, or by the federal government.
3. Open Enrollment begins on October 1, 2013, and ends on March 31, 2014. Coverage can begin as soon as January 1, 2014.
4. Health plans offered in a Marketplace will generally offer comprehensive coverage, including a set of “essential health benefits” with at least these items and services:
   - Ambulatory patient services
   - Emergency services
   - Hospitalization
   - Maternity and newborn care
   - Mental health and substance use disorder services, including behavioral health treatment (which includes counseling and psychotherapy)
   - Prescription drugs
   - Rehabilitative and habilitative services and devices
   - Laboratory services
   - Preventive and wellness services and chronic disease management
   - Pediatric services, including oral and vision care.
5. Individuals can buy insurance through a Marketplace if they live in the United States, are U.S. citizens or U.S. nationals (or are lawfully present), and aren’t currently incarcerated.
6. Nobody can be turned away or charged more because of their gender or a pre-existing condition.
7. Depending on household income and family size, many individuals may qualify for tax credits to help lower their share of monthly premiums, or help that reduces deductible, copayment or other cost-sharing amounts.
8. Individuals will be able to choose a Marketplace plan by health plan category (bronze, silver, gold, or platinum). The differences among the categories will be based on the average percentage of the costs the plan will cover. This system makes it easier to compare similar plans based on price and coverage. Catastrophic plans and stand-alone dental plans also may be available.
9. Using a single application on HealthCare.gov, consumers can find out if they and/or their family members are eligible for Medicaid, the Children’s Health Insurance Program (CHIP), or for financial help paying for a private health insurance plan offered in the Marketplace.
10. Resources are available now.
   - Marketplace.cms.gov: Where organizations and individuals looking to help can get the latest resources and learn more about the Marketplace.
   - HealthCare.gov: Where individuals can learn about the Marketplace and the benefits (including where they can find local assistance), or be connected to appropriate resources in states that are running their own Marketplace.
   - Health Insurance Marketplace Call Center: If you have questions, call 1-800-318-2596. TTY users should call 1-855-889-4325.

Help your patients get ready

Consumers can learn more through local community groups and special events. Trained assisters and navigators will be available in communities nationwide to help consumers understand their choices and apply for coverage. Starting October 1, consumers were able to apply for health coverage on HealthCare.gov or by calling the Marketplace Call Center at 1-800-318-2596.
Health Insurance Marketplace: 10 Things to Tell Your Patients

1. If you don’t already have health coverage, the Health Insurance Marketplace is a new way to find and buy health coverage that fits your budget and meets your needs.

2. Open Enrollment started October 1, 2013, and ends on March 31, 2014. Plans and prices will be available then. Coverage starts as soon as January 1, 2014.

3. Not only can you view and compare health insurance options online, but with one simple application, you can have those options tailored to your personal situation and find out if you might be eligible, based on your income, for financial assistance to lower your costs.

4. The same application will let you find out if you and your family members might qualify for free or low-cost coverage available through Medicaid or the Children’s Health Insurance Program (CHIP).

5. The information is all available online, but you can apply 4 ways: online, by phone, by mail, or in-person with the help of a trained assister or navigator.

6. Each health plan will generally offer comprehensive coverage, including a core set of essential health benefits like doctor visits, preventive care, maternity care, hospitalization, prescription drugs, and more.

7. No matter where you live, there will be a Marketplace in your state, offering plans from private companies where you’ll be able to compare your health coverage options based on price, benefits, quality, and other features important to you before you make a choice.

8. Health insurance companies selling plans through the Marketplace can’t deny you coverage or charge you more due to pre-existing health conditions, and they can’t charge women and men different premiums based on their gender.

9. Marketplaces will be operated by your state, the federal government, or a partnership of the two, but each Marketplace will give you the same access to all of your Marketplace coverage options.

10. For more information, visit HealthCare.gov. Or, call the Health Insurance Marketplace Call Center at 1-800-318-2596, 24 hours a day, 7 days a week. TTY users should call 1-855-889-4325.

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Clinton Touts Health Insurance Positives, Calls on Bipartisan Fixes

Former President Bill Clinton used the forum of his Presidential Library September 4 to advocate for the Affordable Care Act, which hit a major milestone on October 1 when health insurance exchanges opened a new online marketplace.

Introduced by Mara D’Amico, a Clinton School student who revealed she has a pre-existing condition – Type I diabetes – she also noted that she would be losing her parents’ health insurance coverage when she turns 27 years old later this year. Pre-existing conditions and extended student coverage are two key provisions of the healthcare law.

Clinton said that he has had an active interest in healthcare improvement since the days of his first elected office as Arkansas Attorney General. Clinton said studying the issue of Medicaid fraud in nursing homes as AG sparked his initial interest in the subject.

As Arkansas Governor, he noted that seeing rural communities with “virtually no access” to healthcare also encouraged him to push for changes to the healthcare system. “I’ve been involved in this subject for a long time,” said Clinton, who failed to achieve a massive national overhaul during his two terms as President.

Following the Federal Law

Clinton spent his speech at the Clinton Center chronicling the positives and negatives of the current federal law, the Affordable Care Act. He also promoted Arkansas’ “private option” plan and, in prepared remarks, recited the mechanics of how citizens can access the forthcoming options in Arkansas.

“I’m still amazed at how much misunderstanding there is about our current system of healthcare,” Clinton said. “We’d be better off working together to make the healthcare law work rather than fighting the same old battles.”

Clinton cited six reasons why the Affordable Care Act should be followed and possibly improved:

• It’s better than the current system;
• It gives states a chance to provide plans that work locally;
• Not cooperating means states’ funds will go elsewhere;
• The problems with the current law can be solved;
• It gives the best chance ever for universal coverage, lower costs; and
• It is the law.

“We’ve all got an interest in trying to faithfully execute the law,” Clinton said.

Clinton argued that lowering healthcare’s percentage of GDP from its current point of 18% to 12% – which would be in line with other advanced countries – would inject $1 trillion back into the American economy.

“That’s money that could be spent on pay raises or investments in businesses,” he said.

What Could Go Wrong?

Clinton discussed problems he sees in the federal law and called on a bipartisan approach to fixing them.

He noted that workers with modest incomes – in the $20,000 to $30,000 range – may be eligible for health insurance through their employers, but their families may not qualify. Subsequently, because a household income may be too high to qualify for low-income help, Clinton said spouses and children may not be eligible for coverage.

“It’s obviously not fair,” said Clinton. “If this is the only unintended consequence of the law, it needs to be fixed.”

Clinton also said tax credits for businesses need to be expanded and more generous. He noted that a
small business with fewer than 50 full-time workers isn’t required to provide health insurance. If more tax credits were designed properly and provided, those smaller firms could also be inclined to join the health insurance pools.

Thirdly, Clinton said that the U.S. Supreme Court decision to allow states to opt in or out of Medicaid expansion participation needs a solution.

“The law said that the federal government would run an exchange if states didn’t,” he said. “But they never dreamed anyone would turn down the Medicaid money.”

About half of the states have opted not to receive Medicaid expansion funds. Clinton said this means low income workers below 138% of the federal poverty level may not qualify for any health insurance options.

“This is a serious problem,” Clinton said adding that it would increase uncompensated care.

In his closing remarks, Clinton called for a bipartisan approach to solving the issues he outlined. He said there was no room for those “rooting for reform to fail and refusing to fix relatively simple matters.”

He cited the Arkansas legislature’s “private option” approach as a blueprint for federal fixes.

“I hope Congress will follow the lead of many, many Republicans and Democrats at the state level and try to implement this law,” said Clinton. “The health of our people, the security of our families, and the strength of our economy are dependent on getting healthcare right.”
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Formally organized with the assistance of federal Health Resources and Services Administration (HRSA) Network Planning grant funds in 2008, the Greater Delta Alliance for Health (GDAH) Inc. is a non-profit, horizontal hospital organization comprised of eight, independently owned Southeast Arkansas rural hospitals.

The mission of the GDAH is to create and implement sustainable community solutions to improve Southeast Arkansas rural healthcare infrastructure by improving access to healthcare services, improving health information technology, promoting healthy lifestyles and reducing healthcare costs through advocacy. The seven Arkansas counties covered by the grant are Ashley, Bradley, Chicot, Desha, Drew, Lincoln and Arkansas.

The eight hospital members of the Alliance and their CEOs who serve as board members are:

- Ashley County Medical Center, Crossett; Phillip Gilmore, FACHE
- Baptist Health Medical Center, Stuttgart; Terry Amstutz, FACHE
- Bradley County Medical Center, Warren; Rex Jones
- Chicot Memorial Medical Center, Lake Village; David Mantz
- Delta Memorial Hospital, Dumas; Darren Caldwell
- DeWitt Hospital and Nursing Home; Darren Caldwell
- Drew Memorial Hospital, Monticello; Michael Layfield
- McGehee Hospital; John Heard

In August, the Greater Delta Alliance for Health was awarded $474,522 in HRSA Delta States Network Development Grant funds as part of a $6.2 million project to fight chronic health diseases in the Delta Region.

“A healthy Delta workforce is vitally important to the strength of the Region,” said Delta Regional Authority Federal co-Chairman Christopher Masingill. “That contributes to a stronger economy and a stronger America. This announcement to support investments that address chronic health diseases is exactly what Delta families need and continues the White House’s commitment to growing and investing in the nation’s rural communities.”

The GDAH will use the funds to provide the following initiatives in the Arkansas Delta counties of Arkansas, Ashley, Bradley, Calhoun, Cleveland, Chicot, Dallas, Desha, Drew, Grant, Jefferson, Lee, Lincoln, Lonoke, Monroe, Phillips, Ouachita, St. Francis, and Union:

- Health Education for Local Providers (HELP) Project
- Expansion of the Delta Medicine Assistance Program
- Arkansas Delta Healthcare Provider Network & Annual Summit

The three-year grant project will have a focus each year on diabetes, cardiovascular disease, and obesity. The GDAH’s Health Education for Local Providers (HELP) Project will provide access to free chronic disease education for healthcare providers in hospitals, community health centers, and rural clinics throughout

continued on page 20
the nineteen county South Arkansas Delta, utilizing the educational expertise of UAMS Center for Rural Health and UAMS Center for Distance Health and the telehealth capabilities throughout the service area.

Specialists from disciplines addressing the three focus areas will contribute expertise and management practices through a coordinated scheduling program that offers free and accessible continuing education opportunities and credits to healthcare professionals at their current locations. The teleconferences will be custom-tailored to address evidence-based care by considering the needs of rural providers practicing in the Delta. Faculty will discuss how national standards can be translated into clinical care in rural, underserved areas that are home to health disparities, poor access to medical care, and racial and cultural diversities that must be considered when individualizing plans of care.

The GDAH and partners will also expand the current Delta Medicine Assistance Program (DMAP) throughout the proposed service area. The DMAP program is designed to assist persons who have difficulty obtaining prescription medications due to fixed incomes, lack of insurance or other circumstances that limit their ability to fully comply with their physician’s protocol to treat chronic health conditions.

In the past three years, DMAP has proven to be effective saving patients approximately $3,745,701 dollars and serving 4,472 patients. The program serves patients throughout the respective hospital’s service area and provides service to all the admitting physicians in their respective communities. With the placement of these positions through the requested expansion project, it is estimated that the program will serve an additional 105 physicians in the state of Arkansas assisting patients throughout Arkansas with an average of fifteen healthcare providers per location.

The GDAH, with the support of its partners, would also like to expand its own mission of improving the Arkansas Delta rural healthcare infrastructure by promoting communication among all healthcare providers.
across the nineteen counties in the South Arkansas Delta and improving access to care for residents throughout the service area by initiating an Arkansas Delta Healthcare Provider Network.

In addition to the latest grant funds, the GDAH is working on the following grant-funded projects:

- Provider Education Program ($71,576 from Blue & You, Arkansas Blue Cross and Blue Shield): The primary goal of the PEP project is to improve the health of local residents and reduce emergency room visits in the region by providing local healthcare providers with the ability and tools to communicate with their patients.

- Access Project Pink ($72,000 from Susan G. Komen Foundation): Access Project Pink provides direct breast health services and education in the region serving the uninsured and underinsured population of South Arkansas by assisting women (and men) of all ages with navigation and easy access to free breast screening services.

- Southeast Arkansas HIV Outreach Project ($67,000 from Arkansas Department of Health): In its third year, the HIV Project has increased the number of HIV tests, increased HIV testing among those who are HIV infected and do not know their status.

- Revolving grants from the Arkansas Department of Health: Five of the hospitals in the region have received revolving grants for the next year to provide assistance with community health needs assessment, teleconference video equip-

ment, and congestive heart failure outreach.

Additionally, the GDAH has applied for funds to address the need for worksite wellness projects in southeast Arkansas.

Mellie Bridewell is contracted to the Greater Delta Alliance for Health as the executive director through the UAMS Center for Rural Health. She oversees all grant activities and provides oversight for all GDAH projects. In addition, she assists all member hospitals with individual grant applications for equipment needs and outreach projects, and will oversee GDAH member hospital community health needs assessments and implementation.
Rural communities throughout the state of Arkansas will have the opportunity to receive funding to connect their hospitals to the state’s health information exchange (HIE), Delta Regional Authority Federal Co-Chairman Chris Masingill and Office of Health Information Technology Director Ray Scott announced in September.

The SHARE Critical Access & Small Rural Hospital Connectivity Program will make available awards to designated Critical Access Hospitals (CAHs) and Small Rural Hospitals (SRHs) to help with the costs of connecting the hospitals’ hospital information systems (HIS) with SHARE (State Health Alliance for Records Exchange), the statewide HIE. The awards of up to $10,000 per facility will assist with implementation costs. Currently, HIS vendor-quoted costs of $6,000-$15,000 for implementation are a barrier to some hospitals in the state. This program is designed to mitigate these cost barriers to interoperability.

“Providing our communities with quality healthcare options and supporting a healthy workforce is crucial to economic development in the Delta,” Masingill said. “Because of this investment, Arkansas’s rural communities will be better connected to cutting-edge and cost-effective healthcare.”

CAHs and SRHs across the state have transitioned from paper records to electronic medical record systems. However, these hospitals may not be able to efficiently exchange patient information with larger hospital systems and other healthcare providers without connecting to SHARE.

“These small hospital systems are a critical part of the Arkansas healthcare network,” said Ray Scott. “Having them connect to SHARE will give them access to more complete health information about their patients, and improve their ability to coordinate their patients’ care with other providers.”

The Delta Regional Authority (DRA) was notified by Governor Beebe’s office that funding was needed, and the project was approved by the DRA in mid-September. The Authority will contribute $125,300 in total investment that will support program awards directed to 12 eligible CAHs and SRHs in the Delta region, in addition to $70,000 in funds committed by the Arkansas Office of Health Information Technology (OHIT) to support vouchers for seven eligible hospitals located outside the Delta.

The connectivity program consists of two tracks: A DRA Grant or an OHIT Voucher. Hospitals that meet the eligibility criteria and are located in the Delta Regional Authority service area (Arkansas, Ashley, Bradley, Chicot, Clay, Dallas, Desha, Drew, Fulton, Izard and Randolph) qualify for a DRA grant. Hospitals that meet eligibility criteria and are located in all other Arkansas counties qualify for an OHIT voucher. Eligibility for either track for this program is based on the following criteria:

1. Must have an average daily census of less than 50
2. Must provide a quote or receipt from a Hospital Information System (HIS) vendor for the HIE interface
3. Must not be owned or operated by any other hospital system
4. Must agree to use the funds available from these programs to offset the costs of interfacing their HIS to SHARE.
5. HIS interface to SHARE must include, but is not limited to:
   a. Admissions, Discharges, Transfers (ADT)
   b. Lab reports
   c. Radiology reports
   d. Transcribed documents
   e. Public Health Registries
   f. Orders interface between hospital and practices

Visit www.SHAREarkansas.com/CAH for more information about eligibility and the application process.

The Delta Regional Authority is a federal-state partnership that is congressionally mandated to help create jobs, build communities, and improve lives in the 252 counties and parishes of the Delta. In the past eleven project cycles, the Authority created or retained nearly 17,000 jobs and leveraged $2.5 billion in other public and private investments.

The State Health Alliance for Records Exchange (SHARE) is Arkansas’ statewide health information exchange (HIE) that allows healthcare providers, related health services professionals, and public health authorities in Arkansas to access and exchange with each other real-time, secure, electronic patient information that is protected by privacy and security laws. Through its implementation and use, SHARE will reduce medical errors and duplicate testing, promote improved management of chronic diseases, and improve patient care coordination among unaffiliated healthcare providers.

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Sparks Fitness Center Supports Air National Guard

The Marvin Altman Fitness Center at Sparks Health System in Fort Smith and three of its associates were recently recognized by the Arkansas Air National Guard for contributing to the 188th Fighter Wing’s Wingman Day 2013.

As a part of the June 1 event, fitness center trainers Josh Geske and Tyler Schuster spoke to a group of nearly 1,000 Air National Guard members about proper nutrition and the benefits of exercise. The duo also got the guardsmen on their feet for a 10-minute high intensity exercise session. Their lessons are now being used as a model for other units across the country.

Don Ridgley, fitness center manager, along with Geske and Schuster, were each awarded a Certificate of Appreciation for participating in the joint training event. The awards were presented July 12 by 1st Sgt. Brian Anible of the 188th Fighter Wing.

In addition, Anible presented the staff of Marvin Altman Fitness Center with a Department of Defense Statement of Support for the Guard and Reserve. The document details the fitness center’s dedication to United States service members and their valued place in the workforce.

The Marvin Altman Fitness Center is fully hospital integrated. Trained instructors offer a wide range of programs and classes at the health club, and a variety of exercise equipment is also available for use.

5 Arkansas Hospitals Honored for Years Without Work Related Injury

The Arkansas Department of Labor presented distinguished Accumulative Years Safety Awards to five AHA Workers’ Compensation Self-Insured Trust (AHAWCSIT) members September 19 in Little Rock. This award is designed to reward small employers that maintain years without a lost-time day away from work due to a work-related injury or illness, have an effective safety program and have a safety committee made up of both employees and management. The recipients are:

- McGehee-Desha County Hospital: 5.5 years
- Ouachita County Hospital: 2.7 years
- Howard Memorial Hospital: 2 years
- John Ed Chambers Memorial Hospital: 1.8 years
- Little River Nursing & Rehab: 1 year

The award demonstrates ongoing commitment to the safety and health of its employees and its stringent and rigorous approach to maintaining productive, safe and quality work environments.

Edward House, Deputy Director, Arkansas Department of Labor (from left), presents a safety award to Brad Sullivan and Jane Eden representing Little River Nursing and Rehab in Ashdown.
The Health Information Technology for Economic and Clinical Health Act of 2009, more commonly referred to as HITECH, mandates that hospitals and physicians not just adopt health IT, but use it in a meaningful way.

This Act, along with delivery system transformation, has improved the results found through the Hospitals & Health Networks’ 15th annual Health Care’s Most Wired Survey, the results of which debuted in August. Hospitals have deployed technologies that improve patient documentation, advance clinical decision support and evidence-based protocols, reduce the likelihood of medication errors, and rapidly restore access to data in case of disaster or power outage.

While struggles continue for hospitals to achieve the goals of the Act, one Arkansas hospital, Jefferson Regional Medical Center in Pine Bluff, has achieved the requirements set forth in the four focus areas of the “Most Wired Hospitals and Health Systems.” The focus areas are infrastructure, business and administrative management, clinical quality and safety, and clinical integration. If any of the requirements is not met, then the organization does not achieve the Most Wired designation.

“Being named Most Wired is a tremendous recognition,” says Walter Johnson, JRMC president and CEO. “For more than ten years, we have been developing and implementing integrated clinical solutions at JRMC which have increased efficiency, reduced costs and enhanced the overall quality of care at our facility. Being a leader in this field benefits the patients, the hospital and ultimately, the entire Southeast Arkansas community.”

Patrick Neece, assistant vice president and chief information officer at JRMC, offered examples of how JRMC achieved recognition this year. “One is our utilization of bar code technology while administering meds to the patient. Another is the use of wireless technology on the patient floors, which allow physicians, nurses and other clinicians to carry mobile devices closer to the patient.”

Meeting July 26, the AHA Workers’ Compensation Self-Insured Trust board of directors voted to return anticipated unused premiums for the fund years of 2004, 2008 and 2009 to current members that were members of the Trust in each of those fund years respectively. A total return of $100,000 for fund year 2004, $200,000 from fund year 2008 and $200,000 for fund year 2009 was unanimously passed by the board after reviewing the financial solvency of each fund year since the 2003 inception of the Trust. A percentage of the profit is being returned to members based on each member’s contribution to the surplus of each fund year, which is based on the premium paid and the incurred losses of each member.

The Trust is committed to providing a workers’ compensation program of excellence in which its members share the success and profits. As a member of the Trust, controlling losses and maintaining an aggressive workers’ compensation program in a pro-active manner allows the Trust to return unused premiums to members, as opposed to an insurance carrier that retains those profits for the company. Percentages of the Trust’s income returned have averaged from 23% to 27% over the years while maintaining a healthy fund balance to meet the group’s workers’ compensation obligations. To date, the Trust has returned a total of $6,021,166 to its members.

In addition to the approved dividend distribution, the board voted unanimously to adopt the Workers’ Compensation manual rates as prescribed by the National Council on Compensation Insurance effective July 1, 2013 for the Trust’s 2014 fund year. The adopted rates have decreased from the rates currently in effect.
“For more than ten years, we have been developing and implementing integrated clinical solutions at JRMC which have increased efficiency, reduced costs and enhanced the overall quality of care at our facility.”

devices while they are documenting and checking on patients from room to room. Most recently, JRMC has started participating in the statewide Health Information Exchange with other hospitals and clinics in the state. This technology is utilized on all facets of the hospital, to improve patient outcomes and patient safety, reduce overall costs and enhance the patient experience.”

The survey also recognizes small and rural hospitals that reflect development in certain survey areas. Stone County Medical Center in Mountain View was recognized as one of 25 rural hospitals in the nation for its implementation of EMR (electronic medical records),

“...I’m very proud of the dedication our staff has shown during the implementation of SCMC’s electronic medical records,” said Renie Taylor, administrator of the hospital before her retirement October 1. The 25-bed critical access hospital was recognized for the level of completion of a paperless medical record system that will improve the patient experience through information technology. ●

King Faisal Specialist Hospital & Research Centre Tours St. Vincent

King Faisal Specialist Hospital and Research Centre, located in Riyadh and Jeddah, Saudi Arabia, recently toured St. Vincent Infirmary Medical Center in Little Rock to review and observe the successful implementation of Clairvia - a patient management system that encompasses patient flow, staffing, care coordination and equipment tracking that aims to improve patient care while better managing the resources of the hospital.

The team selected St. Vincent over 200 other hospitals in the country/world using Clairvia. In addition to learning about the system’s clinical applications, the team received briefings on Clairvia-supported financial planning and operations improvement, a day in the life of a St. Vincent Nurse Manager and toured the neurosurgical ICU, the oncology unit and the staffing office at St. Vincent Infirmary where Clairvia is used to manage patient care.

“We are truly privileged to be a showcase facility for other hospitals literally around the world to see how we are proactively addressing patient care, nursing and care coordination. I’m sure the leaders from King Faisal Specialist Hospital in Saudi Arabia will learn from our experiences and enjoy our St. Vincent hospitality,” said Peter D. Banko, President and CEO of St. Vincent Health System.

“A team from Faisal Specialist Hospital and Research Centre consult with Brian Williams (left), Executive Director of Nursing Operations, and Niki Miner, RN, BSN, CNRN (second from left), Nurse Manager, from St. Vincent Health System on the Clairvia patient management system.

“I don’t think anyone could ever have imagined 125 years ago when St. Vincent was founded that leaders from the hospital used by the royal family in Saudi Arabia would travel to Little Rock to learn how to improve patient care from our world-class organization.” ●
AHA Holds First CMO Workshop

The U.S. healthcare system is undergoing historical changes that will require closer alignment for clinical integration between hospitals and physicians. To succeed, hospital and health system boards must work in partnership with senior management and clinical leaders to develop a strategic approach for addressing fundamental changes in the delivery of healthcare services, as well as in hospital/physician relationships, in a way that can benefit patient care, safety and quality.

This task is complicated by a medical education system that excels at producing the best physicians in the world, but is weaker at fostering team dynamics and leadership skills among its physician graduates. To successfully teach leadership among physicians, a top-down approach is needed, anchored by effective Chief Medical Officers who already are leaders in their hospitals.

The Arkansas Hospital Association (AHA) and St. Bernards Medical Center in Jonesboro teamed up to focus on this issue through a first-time program aimed at educating physicians to lead within the hospital culture. The Hospital CMO Leadership Workshop was held September 17 at the AHA Headquarters in Little Rock. Dr. Jay Kaplan of the Studer Group and Dr. Steve Berkowitz of SMB Health Consulting presented a program aimed at preparing physician leaders to guide hospitals through these changes and to prepare for clinical integration.

Steve Berkowitz, MD, of Austin, TX demonstrates to Arkansas hospital chief medical officers the evolution of healthcare reform on hospital markets.

AHA 2013 Diamond Award Winners

The Arkansas Hospital Association’s (AHA) 2013 Diamond Awards competition, co-sponsored by the Arkansas Society for Healthcare Marketing and Public Relations, is designed to recognize excellence in hospital public relations and marketing. Diamond and Excellence Awards were possible in four divisions (hospitals with 0-25 beds, hospitals with 26-99 beds, hospitals with 100-249 beds and hospitals with 250 or more beds) in 15 categories. The competition drew 135 entries.

The top awards (Diamond) were presented during the AHA’s 83rd Annual Meeting and Trade Show at the Little Rock Marriott. The Awards Dinner was Thursday evening, October 10. Certificates of Excellence will be mailed to recipients following the annual meeting.

Judging for each entry was based on goals and objectives, audience to whom directed, reasons for choosing the format, frequency and quantity, portions that were created internally/externally, results/evaluation and total budget.

The Diamond Award-winning hospitals are:

- Arkansas Children’s Hospital, Little Rock
- Arkansas Heart Hospital, Little Rock
- Arkansas Hospice, North Little Rock
- Arkansas Methodist Medical Center, Paragould
- Baptist Health, Little Rock
- Baptist Health Medical Center, Heber Springs
- Baxter Regional Medical Center, Mountain Home
- Conway Regional Health System
- Jefferson Regional Medical Center, Pine Bluff
- Methodist Family Health, Little Rock
- NEA Baptist Memorial Hospital, Jonesboro
- Ouachita County Medical Center, Camden
- Ozark Health Medical Center, Clinton
- Saline Memorial Hospital, Benton
- Sparks Health System, Fort Smith
- St. Bernards Medical Center, Jonesboro
- Summit Medical Center, Van Buren
- White County Medical Center, Searcy
- White River Health System, Batesville

Congratulations to all the 2013 Diamond Award winners!
As you may know, Arkansas is one of 11 states in the country to receive a federal stroke grant from the Centers for Disease Control and Prevention (CDC) to support the Arkansas Stroke Registry (ASR). As a part of this effort to improve the quality of stroke care, and to decrease stroke patient morbidity and mortality statewide, the ASR recently added Vital Link EMS to lead the EMS Stroke Care Quality Improvement (QI) initiative. Vital Link has conducted ambulance operations in Arkansas for nearly 30 years. With a home office located in Batesville, Arkansas, Vital Link currently provides paramedic ambulance service from five bases spread across Independence, Izard, and Stone counties.

Vital Link Paramedic and QI coordinator, Greg Johnson, is the Stroke Program Coordinator for Vital Link. Greg has been involved in EMS in Arkansas for 25 years and has held nearly every position in the EMS industry, including being an owner/operator for more than 15 years. Since being added to the ASR team earlier this year, Greg and Vital Link have been working closely with other ASR team members to lay the foundation for a statewide EMS stroke care QI plan.

Much progress has been made in a relatively short time. Vital Link has teamed with White River Medical Center in Batesville to develop a pilot program aimed at optimizing pre-hospital stroke patient care from the time of EMS dispatch, through EMS/ED handoff.

Primary objectives for the pilot are to:
• Promote early ED notification for suspected stroke patients,
• Implement a standardized stroke screen in the pre-hospital setting,
• Streamline the transition of suspected stroke patients from EMS to ED care,
• Provide timely treatment through “ambulance direct to CT” for suspected stroke patients,
• Establish an effective system for critical data collection and mutual clinical feedback designed to promote continuous QI, and
• Create a model that can be easily replicated by virtually any EMS provider and Emergency Department across Arkansas. It is believed the pilot plan has accomplished this goal by being short and to the point, with clearly defined procedures requiring minimal effort or expense.

The pilot program was tested very early on; in fact within a few hours of being implemented the first “CODE STROKE” was activated. Although the patient was ultimately diagnosed with a hemorrhage and unfortunately the prognosis is poor, the process functioned exactly as planned and the patient was delivered directly from the ambulance to CT. As a result of the Stroke QI Plan, the hemorrhage was diagnosed within minutes and air medical transportation to a neurosurgery center was arranged very quickly.

Although much remains to be done, Arkansas EMS is primed to assume a prominent role in the push to remove Arkansas from the “top of the charts” for the highest death rate associated with stroke. If you have any questions about this pilot program, please contact Greg Johnson, Vital Link EMS at gjohnson@vitallinkems.org, or David Vrudny, Arkansas Stroke Registry Program Manager, Arkansas Department of Health at david.vrudny@arkansas.gov.

Additional information about the stroke registry may be found at www.arstrokeregistry.com.
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The Arkansas Hospital Association Career Center is a true, niche job board exclusively for recruiting candidates across a variety of specialties. When it comes to recruiting Arkansas medical professionals, generic healthcare job boards fall short. This audience turns to the AHA Career Center to quickly access the largest selection of jobs and consume the latest news in their field from one convenient source. The audience includes thousands of qualified professionals in:

- Academics and Research
- Administration/Executive
- Allied Health
- Counseling and Social Services
- Dietetics/Nutrition
- Healthcare IT
- Nurse practitioner
- Nursing
- Pharmacy
- Physician/Surgeon
- Physician Assistant
- Radiologic Technologist/Medical Imaging
- Therapy

Through the support of HEALTHeCAREERS Network, the Arkansas Hospital Association Career Center is structured in a way that drives response from qualified Arkansas based candidates no matter where they start their online search. AHA Career Center can deliver:

- Maximum exposure to postings – Your jobs are cross-posted across the HEC Network, relevant association job boards and job distribution partners (Indeed and Simply Hired) all for free.
- Affordable price point – We offer competitive pricing and volume discounts for every budget.
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Chris Barber, FACHE, president of St. Bernards Healthcare in Jonesboro, is the ACHE Regent for Arkansas and the contact for ACHE questions.

The local affiliate of the ACHE is the Arkansas Health Executives Forum headquartered at the Arkansas Hospital Association. By joining the national organization, members automatically become members of the local chapter and begin receiving the AHEF quarterly newsletter and educational resource materials. Brian Barnett, FACHE, executive director of Arkansas Specialty Orthopaedics in Little Rock, is the current president of AHEF.

For information about either group, please contact Beth Ingram at bingram@arkhospitals.org or click on www.ache.org.

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Don’t Overlook Revised CAH Operations Manual

A revised version of the State Operations Manual for critical access hospitals (CAHs) was released by CMS on June 7, 2013. These extremely important revisions include, but are not limited to:

- C-0151 Standard: Compliance with Federal Laws and Regulations
  - Regarding physician ownership, MD/DO 24/7 On-site presence
- C-0160 Condition of Participation (CoP): Status and Location
- C-0165 Standard: Location Relative to other facilities or necessary provider certification
- C-0221 Standard: Construction

CAHs expecting a survey soon should check to make sure that they can demonstrate full compliance with the revisions, which are printed in red-font in the State Operations Manual.

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Preparedness is a Process

Preparedness pays. We’ve seen it time and again as hospitals launch preparedness plans to care for victims of natural and man-made disasters. We looked on in admiration as hospitals in and around Boston, the town of West, Texas, Oklahoma City and countless other places provided not only care for patients, but comfort for communities after unthinkable events. On a more personal level, we have been grateful to see the lights of our local hospital still shining when a loved one needed care in the middle of the night.

While preparedness pays, it also costs. Providing emergency care around the clock demands constant staffing of the emergency department and much more – laboratory, radiology, pharmacy, surgical services, general and intensive care units, labor and delivery. Patient volume can vary greatly, hour to hour and day to day even in normal times, so hospitals maintain additional on-call staff. One in six Americans lacks healthcare coverage, increasing the likelihood they will delay seeking care until it is an emergency – but hospitals must care for all patients who seek emergency care, regardless of their ability to pay. This means that it costs your hospital far more to provide services – but it is this level of readiness and responsiveness that defines hospitals and benefits communities.

When major disasters strike, the stakes are even higher. Communities look to hospitals not only to mobilize the resources to care for the ill and injured, but also to provide food and shelter and help coordinate relief and recovery. Being ready for any event means hospitals must, for example, invest in communications and emergency power systems, purchase personal protective gear, build decontamination units and stockpile medical supplies. They must be part of comprehensive community disaster plans, training, drills and surveillance systems. These are formidable investments in an era of cost-cutting.

Hospitals have always planned and practiced for emergencies. Events like the Sept. 11 terrorist attacks, the Boston Marathon bombings, mass shootings and a string of destructive natural disasters in recent years have driven expectations about hospitals’ emergency preparedness and response higher than ever before. At a time when hospitals are facing lower Medicare and Medicaid reimbursements, any further cuts will strain hospitals’ ability to be prepared to care. Additionally, funding for the federal government’s primary grant program for hospital emergency preparedness has already declined by almost 30 percent over the past decade. While this funding is just part of how hospitals cover the costs of providing 24/7 emergency coverage and building the infrastructure needed to be ready for disasters, cuts symbolize a further erosion of public support for disaster preparedness.

Americans are justifiably proud of the preparedness shown by their first responders, including hospitals, during recent emergencies. They understand that preparedness is not a one-time investment: It’s a process that must be nurtured and grown over time. Let’s make certain the care is there when we need it by providing reasonable funding to ensure hospital emergency preparedness.

Joplin Tornado Offers Response Lessons for Hospitals

On May 22, 2011, an EF-5 tornado ripped through Joplin, Missouri. The storm killed more than 160 people, injured more than 1,000 others and destroyed nearly 7,000 homes. Businesses were destroyed, trees stripped and St. John’s Regional Medical Center was destroyed.

Disasters like this can strike any hospital, just like the February 5, 2008 tornado that nearly destroyed Stone County Medical Center in Mountain View, Arkansas. Since the Joplin tornado in 2011, several hospitals have been affected by serious natural disasters, including Hurricane Sandy in 2012 and a deadly EF-5 tornado in Moore, Oklahoma in May this year.

Although each disaster situation is unique, hospitals can improve their emergency plans and their disaster response by lessons learned from previous events. A new video produced by the American Society of Healthcare Engineering (ASHE), “The Joplin Tornado: Emergency Preparedness and Beyond,” explores the story of St. John’s, which has been rebuilt and is now called Mercy Hospital Joplin. The video tells the story of the disaster and the hospital’s response, and offers critical lessons learned from the clinical, facilities and C-suite perspective.

The video is available for order at www.ashestore.com for $75 for ASHE members and $125 for non-members.
A key theme in my speaking and writing over the past several years has been the importance of fostering a strong culture of ownership, which is one of the most powerful ways of creating competitive distinction for both recruiting great people and earning “raving fans” customer loyalty. Helping organizations build that sort of culture is why we’ve created the new Cultural Blueprinting Toolkit and Culture Mechanic advisory service (details at www.CulturalBlueprint.com).

But culture doesn’t change unless people change. The one and only way to foster a stronger culture of ownership is for individual employees to do more to think and act like owners. I’ll share three reasons why, wherever you work, it is in your own best interest to do this.

**Reason #1: It’s good for your career – and your income**

In the new inspirational book *Create a Life You Can’t Wait to Live* recently published by Simple Truths, the late Zig Ziglar wrote: “When your employer sees you assuming ownership and responsibility for the company’s image, reputation, products, and profitability, your value to the company will skyrocket.”

People who think and act like owners treat resources as if they were their own; don’t waste their time (which their employer is paying for!) on complaining, gossiping, and other forms of toxic emotional negativity; represent their organization in a positive way, both on and off the job; and are always on the lookout for better ways to serve customers (and patients in healthcare settings). They take ownership for the work, whether or not it’s in their job description, and don’t just rent a spot on the organization chart until something better comes along.

People like that tend to become indispensable and tend to get ahead in the organization and tend to be noticed for bigger opportunities in their organizations and elsewhere (though they also tend to be unpopular with disengaged workers, who refer to them with names like “overachiever” and “quota buster”).

**Reason #2: It’s good for your mental and emotional health**

Edward Hallowell is a leading psychiatrist (he wrote some of the best books for the layperson on ADHD and toxic worry), but he also studies engagement in the workplace. He wrote an article for the *Harvard Business Review* in which he said: “Disengagement [is] one of the chief causes of underachievement and depression.”

Being disengaged from one’s work – thinking like a renter and not an owner – is the cause, and not the effect, of many of the problems people blame their work for. Disengaged people have more financial problems and relationship troubles because they are disengaged – they aren’t disengaged because they are in debt and their family lives are miserable.

The number one medication being prescribed for employees by almost every employee health program in the country is antidepressants. What Hallowell – a psychiatrist who is not opposed to the appropriate use of medication – is saying is that many people are trying to medicate away their unhappiness when the solution lies in being more engaged in their work.

**Reason #3: It’s good for your family**

It breaks my heart when I meet parents who have a toxically negative attitude about their job and about their employer, because I know that they will go home and dump those negative attitudes on
their kids, setting them up for a lifetime of frustration and failure. A young adult whose attitude about the world of work has been shaped by a parent who could have stepped right out of a Dilbert cartoon doesn’t have a chance to get ahead when competing against someone else whose attitude reflects that expressed by poet David Whyte in his book *The Heart Aroused*: “Work is the very fire where we are baked to perfection, and like the master of the fire itself, we add the essential ingredient and fulfillment when we walk into the flames ourselves and fuel the transformation of ordinary, everyday forms into the exquisite and the rare.”

**It’s not the job – it’s you**

It’s ironic that the most unjust word in the English language is the word just when it is used in the context of describing one’s work, as in: I’m just a (fill in the blank). Your job title should never be a barrier to or an excuse for not thinking and acting like an owner where you work.

I have worked with hospital housekeepers who have an incredible sense of ownership for the place where they work, and I have worked with senior executives who always have one eye on the phone waiting for a headhunter to call with a better offer. Thinking and acting like an owner is not determined by your current job title or your income – though it almost certainly will have a significant impact on your future job titles and income.

**Imagine a world where…**

In his new book *The Coming Jobs War*, Gallup CEO Jim Clifton notes that only one-in-four employees are engaged in their work. He says that doubling that number (which would still mean that half of all of us would go through the workday disengaged) would eliminate virtually every crisis we face.

He’s right. The education crisis would go away if every teacher came to school every day with the sense of ownership reflected in Taylor Mali’s poem “What Teachers Make.” The healthcare crisis would be reduced to a healthcare problem if every physician, nurse, therapist, business office clerk, and C-suite manager worked with a spirit of ownership. For that matter, the environmental crisis would be much easier to resolve if more of us thought of our great grandchildren and treated the earth as if we were responsible owners.

I’ll conclude with a passage from my book *The Florence Prescription*: “If we each do our parts, we can change our lives for the better. If we all do our parts, we can change our organizations for the better.” And I’ll add this: if enough of us change our organizations, we can change the world for the better.

Joe Tye is CEO and Head Coach of Values Coach, which provides consulting, training and coaching on values-based leadership and cultural transformation for hospital, corporate and association clients. Joe is the author or coauthor of twelve books on values and culture. Prior to founding Values Coach in 1994, he was chief operating officer for a large community teaching hospital. He was founding president of the Association of Air Medical Services, and a leading activist fighting against unethical tobacco industry marketing practices. Contact Joe by email at joe@joetye.com or by phone at 800-644-3889.

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The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide incentive payments to eligible professionals and hospitals (including critical access hospitals) to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Eligible professionals can receive up to $44,000 over five years through the Medicare EHR Incentive Program and up to $63,750 over six years through the Medicaid EHR Incentive Program.

Below are the most current EHR Incentive Program payments made to Arkansas healthcare providers according to CMS:

**Arkansas Medicaid EHR Incentive Payments as of August 31, 2013**

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<tr>
<th>Classification</th>
<th>Payments</th>
<th>Payment Amount</th>
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<tr>
<td>Dentist</td>
<td>138</td>
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<tr>
<td>Hospital</td>
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<tr>
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<tr>
<td>Nurse Practitioner/APN</td>
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<tr>
<td>Physician</td>
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<tr>
<td>Pediatrician below 30%</td>
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<td>$300,342</td>
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<tr>
<td>Physician Assistant</td>
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<tr>
<td>Total</td>
<td>1477</td>
<td>$55,131,845</td>
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**Arkansas Medicare EHR Incentive Payments as of July 31, 2013**

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<th>Classification</th>
<th>Payments</th>
<th>Payment Amount</th>
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</thead>
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<tr>
<td>Hospital</td>
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<tr>
<td>Total</td>
<td>1843</td>
<td>$111,773,061</td>
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</table>

**Grand Total**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tr>
<td><strong>Payment</strong></td>
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A new report released in late August by the Government Accountability Office (GAO) supports hospitals’ contentions that they are subject to an inordinate amount of costly external reviews by various government contractors. The GAO suggests that CMS should make post-payment review more efficient for healthcare providers by improving consistency across the four Medicare private contractors, and calls for CMS to examine contractor post-payment review requirements to determine those that could be made more consistent; communicate its findings and time frame for taking action; and reduce differences where possible without impeding efforts to reduce improper payments.

“Having inefficient processes that complicate compliance can reduce effectiveness of claims reviews, and is inconsistent with executive-agency guidelines to streamline service delivery and with having a strong internal control environment,” the report states. It found that Recovery Audit Contractors (RAC) – which are paid contingency fees on the amount of claims recouped – conducted almost five times as many reviews as all other Medicare auditors combined in fiscal year 2012.

Four of Arkansas’ six-member congressional delegation are co-sponsors of The Medicare Audit Improvement Act of 2013 (S. 1012/H.R. 1250), companion bills that would correct persistent operational problems by the RACs, establish manageable limits on record requests, correct CMS policies that provide hospitals with less than full payment for necessary care, and require transparent reporting of RAC audits and appeals. To read the GAO report, go to http://www.gao.gov/products/GAO-13-522.
July 2013 marked the first anniversary of implementation of the Arkansas Healthcare Payment Improvement Initiative (APII), an effort that has positioned Arkansas as a national leader for innovation in healthcare delivery and payment redesign. Early indications are that the initiative is having a positive impact on the system: Medicaid is growing at its lowest rate in 25 years, many providers are reviewing their practice patterns and shifting their delivery of care accordingly, and the federal government is now supporting the initiative financially.

The initiative is a central component of Arkansas’ overall health system transformation. Private and public insurers, initially including Arkansas Medicaid, Arkansas Blue Cross and Blue Shield, and QualChoice of Arkansas, have worked to align financial incentives to reward healthcare providers for high-quality, cost-effective medical care. The initiative includes episode-based care delivery, patient-centered medical homes (PCMH) and health homes.

State Innovation Model

Earlier this year, the Centers for Medicare & Medicaid Services’ (CMS) Center for Medicare & Medicaid Innovation (CMMI) awarded the state a $42 million State Innovation Model (SIM) grant, one of six nationwide. The grant will be used to implement and test the initiative over the next 42 months and to support further development of episode-based care delivery, PCMH and health homes.

This award signifies the federal government’s engagement and interest in the model as one that could be applied more broadly. The state launched its episode-based payment delivery model in July 2012 with an initial focus on five conditions, and aims to launch its PCMH model later this year.

Medical Homes

Within the next three to five years, most Arkansans will have a PCMH that offers local access to preventive care and proactively manages a patient’s health. Primary care practices will adopt this role. Today, visits to primary care doctors often focus on acute illnesses rather than prevention or chronic condition management. The medical home will reward providers for supporting patients and connecting them with a health services team that will address their individual needs. Medical homes also will actively promote prevention services and give patients the information they need to stay healthy.

The first wave of Arkansas’ PCMH implementation was accelerated last year when the state was selected as one of seven markets to participate in the CMMI’s Comprehensive Primary Care Initiative (CPC). In all, 69 primary care practice sites in Arkansas were chosen to participate. As a common design structure of Arkansas’ broader PCMH model, these sites receive enhanced per-member-per-month (PMPM) payments to support practice transformation and care coordination necessary to meet specific performance metrics and transformation milestones. Some CPC practices have used PMPM payments to hire more staff for improved care coordination and/or have reorganized their practice environment to improve workflow and team cohesion. Practices also have the potential to share in system savings by lowering the total cost of care of their patient panel.

The second wave of PCMH roll-out will begin this fall. While there will be an emphasis on including pediatric patients, all practices that are early adopters may enroll as a PCMH. Wave 3 of PCMH implementation will continue in 2014, with the goal of all primary care practices in Arkansas operating in a PCMH model.

Financial Incentives

The Arkansas PCMH initiative changes the payment mechanism to support the costs of primary care practice transformation and to reward providers for effective population health management. Through upside-only gainsharing opportunities, providers will be rewarded financially for proactively meeting the needs of patients, especially in the areas of prevention and chronic disease management. Primary care physicians can achieve gainsharing in two ways: based on the physician’s performance

continued on page 38
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Medicare/Medicaid

The Centers for Medicare & Medicaid Services (CMS) on August 2 issued a final rule updating fiscal year (FY) 2014 Medicare payment policies and rates for inpatient stays at inpatient prospective payment system (IPPS) general acute care and long-term care hospitals (LTCHs). It also moves forward with healthcare delivery system reforms required under The Patient Protection and Affordable Care Act of 2010. These changes include a new program aimed at improving safety in hospitals and refining the Hospital Readmissions Reduction program.

Some of the key elements of the FY 2014 IPPS Final Rule include:

**FY 2014 Payment Update** – IPPS operating rates are being increased by 0.7% after accounting for inflation and other adjustments required by the law. This increase reflects a temporary reduction of 0.8% to implement the American Taxpayer Relief Act’s requirement to recoup additional overpayments from prior years as a result of alleged patient coding system issues. CMS is also making an additional 0.2% reduction to offset projected spending increases associated with changes to admission and medical review crite-

Improvements, and based on high performance compared with physicians statewide. Quality metrics must be met in both options.

This initiative also provides guidance and support for clinical leadership and autonomy. Providers may contract with pre-qualified vendors to support care coordination and practice transformation. The vendors’ goal is to support ongoing coordinated care and outline infrastructure and capabilities needed for a coordinated care approach and to improve patient outcomes.

Statewide health information exchange (HIE) connection and electronic health record (EHR) adoption by all providers is essential for PCMH implementation. It is important for hospitals and providers to sign up with the State Health Alliance for Records Exchange (SHARE) and be set up for secure email messaging. Provider EHR systems then need to be configured to transmit and receive admission/discharge/transfer (ADT) information through SHARE.

Health Homes

The Arkansas medical home model also includes health homes, a more specialized extension of PCMH for people who need a higher level of care coordination or face greater challenges in navigating the healthcare system, such as people with developmental disabilities and those living in long-term care facilities. A health home promotes more efficient, high-quality care and an improved patient experience. As with a PCMH, providers will be responsible for proactively considering the needs of their patients or clients, independent of whether they are seeking care, and will receive incentives for promoting wellness and achieving health outcomes. The health home will serve not as a gatekeeper, but as a hub from which the patient may connect with all the providers who form the patient’s health services team. The state is also developing complementary reforms in service payments and assessments of client needs. Health homes and associated reforms are being launched in phases in 2013 and 2014.

Looking Ahead

The Arkansas PCMH model complements the work already done with episodes, and the two have the same goal: reward high-quality, coordinated and efficient care. Providers will be better equipped to make efficient referrals and better decisions about care coordination through use of provider reports detailing their cost, utilization and quality metric information for each episode of care. Development of additional episodes of care and medical homes will continue simultaneously. As more practices transition to the PCMH model, providers will need to assess their existing operating model and identify and address barriers to practice transformation. Quality, cost and utilization data will help practices track progress and maximize shared savings. The initiative will continue to be guided by the core principles of designing a payment system that is patient-centered, clinically appropriate, practical and data driven.

For the latest updates on the APII, visit www.paymentinitiative.org.
ria for inpatient services. LTCH PPS payments should increase by 1.3%, or approximately $72 million, in FY 2014.

**New Hospital-Acquired Condition (HAC) Reduction Program** – As part of the HAC Reduction program created by the Affordable Care Act, beginning in FY 2015 hospitals that are in the lowest quartile for medical errors or serious infections that patients contract while in the hospital will be paid 99% of what they otherwise would have been paid under the IPPS. This rule finalizes the criteria to rank hospitals with a high rate of hospital-acquired conditions.

**Readmissions Reduction Program** – The maximum reduction of payments for hospitals with excess 30-day patient readmissions for heart attack, heart failure and pneumonia increases from 1% in FY 2013 to 2% in FY 2014. Hip and knee surgery and chronic obstructive pulmonary disease are being added to the list of conditions used to determine the reduction effective in FY 2015. CMS has also increased the number and types of planned readmissions that no longer count against a hospital’s readmission rate.

**Admission and Medical Review Criteria for Inpatient Services** – The final rule provides greater clarity regarding when inpatient hospital admissions are generally appropriate for Medicare Part A payment. Under the rule, if a physician expects a beneficiary’s surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights and admits the beneficiary to the hospital based on that expectation, it is presumed to be appropriate that the hospital receive Medicare Part A payment. It emphasizes the need for a formal order of inpatient admission to begin inpatient status, but permits the physician to consider all time a patient has already spent in the hospital in an outpatient observation status or in the emergency department, operating room, or other treatment area, in guiding their two-midnight expectation.

The rule also finalizes the provision in a March 2013 proposed rule that set the timeframe in which to bill Medicare Part B for hospital inpatient services inappropriately billed under Part A at one year from the date of service. This portion of the rule makes clear that its terms apply to admissions with dates of service on or after October 1, 2013.

**Medicare Disproportionate Share Hospitals (DSH)** – The final rule revises the methodology used to recalculate the additional amount Medicare pays hospitals that serve a disproportionate share of low-income patients. Under the new rules, part of those payments will be distributed to hospitals based on an estimate of how much uncompensated care they provide relative to other hospitals.

The final rule sets the total amount of money available as uncompensated care payments based on a federal fiscal year determination of the uninsured.

**Other changes** – The rule also finalizes a number of payment policies as proposed, such as rebasing the hospital market basket and the method to recover documentation and coding; and it also will allow the LTCH 25% patient threshold payment adjustment policy moratorium to expire.

The rule’s changes to Medicare quality incentive programs will reduce providers’ reporting burden in both the Electronic Health Record (EHR) Incentive Program and the Hospital Inpatient Quality Reporting (IQR) Program. It finalizes new measures for the Hospital Inpatient Quality Reporting Program, the Hospital Value-Based Purchasing program and quality reporting programs for LTCHs, PPS-Exempt Cancer Hospitals and Inpatient Psychiatric Facilities.

In the rule, CMS rejected requests to reconsider its use of nationwide budget neutrality in applying wage index changes under ACA Section 3141 that unjustifiably reward hospitals in Massachusetts and a few other states and again claimed it needs statutory authority to make a change to its application of nationwide budget neutrality for wage index purposes.

9 Ways to Respond Respectfully to the Entitled Patient

Have you cared for patients like these?
• The woman who thinks she shouldn’t have to wait because she donates to the hospital.
• The physician’s buddy who played golf with him on Saturday – “Just tell him it’s me. He’ll see me first.”

You probably know patients who present with entitled attitudes and you may think there’s not much you can do about them. Entitled patients often demand excessive attention and may question your competence when they are not satisfied with how important you make them feel.

By using one or more of the following approaches, you can manage the situation respectfully while reducing your risk of stress and burnout.

#1. Be on the same side.
When an entitled patient brags about knowing your CEO, your best strategy is to praise your CEO with a lot of specifics.

“You know our CEO George Doria? Isn’t he amazing? When he makes rounds on our unit, he’s the most down-to-earth guy. He never fails to ask how my son is doing in baseball.”

The entitled person immediately sees that threatening to complain to the CEO is not going to intimidate you. And it may dawn on the entitled patient that you’re in a position to complain to the CEO about the entitled attitude he presented.

#2. Use empathy to absorb tension.
George Thompson and Jerry Jenkins, authors of Verbal Judo, suggest: “Empathy Absorbs Tension.” Without an obvious demonstration of empathy, the entitled patient will view you as the obstacle to what he wants.

“I’m sure being here is taking time away from other important things you need to do. I don’t like waiting either and know it’s frustrating. As soon as the doctor is available, I will immediately let you know.”

Subtle emphasis of “immediately” will convey that you understand the need for urgency.

#3. Take patients as you find them.
Ten percent of the time, patients will be annoying. If you allow that ten percent to control your entire day, you’re at greater risk for stress and burnout. Consider acceptance as part of the patient’s treatment plan say Marian Stuart and Dr. Joseph Lieberman, authors of The Fifteen Minute Hour: Therapeutic Talk in Primary Care. Your tone of voice conveys how you really feel, so focus on making it non-judgmental.

“Let’s see what we can do to make this better.”

#4. Refuse to let the patient push your hot button.
When the entitled person succeeds in getting you to say or do something out of character, you’ve lost. Focus on slowing down your responses. Pause before answering, and if possible, try to find some point you can agree on.

Patient: “You’re not helping me! I need to see the doctor now. I’ve already been waiting a long time!”

You: “You’re right; you have been waiting some time. I’m going to check right now to get an update for you.”

#5. Focus on the person, not the personality.
Make it a point to listen when you have time. Everyone wants to feel unique and special. What does the entitled person do when he is not there being your patient? If he drops
the names of the hottest restaurants, could you ask for advice for a special occasion coming up? It isn’t easy to do this, but it may be just the technique that turns the entitled person into an easier patient.

#6. Set an objective to learn more.

Once you label someone as entitled, it feels rational to believe they always act that way because they’re wealthy, or because angry demands have gotten them what they want in the past.

“Can you tell me a little more about why this is important to you?”

Christine Beechner, vice president of patient and guest relations at Greenwich Hospital in Connecticut, tells a story about a patient who insisted on an appointment by a certain date so she could go on a cruise. The schedule was fully booked and you can almost imagine the receptionist’s sigh, can’t you? The patient was insistent and it was hard to sympathize with her. If you don’t know the rest of the story, it’s easy to label this woman as entitled. However, the scheduler did ask why it was important and learned that the person was terminally ill and wanted to take one last vacation with her husband. The patient’s reluctance to play the sympathy card made her appear demanding, when in reality she was afraid that she would have to miss the last vacation she could ever take.

#7. Invoke fairness.

People whose sense of entitlement is ingrained aren’t skilled at considering the needs of others. Sometimes it’s helpful to explain the consequences of their demands.

“In order to get you in to see the doctor today, I’ll have to cancel someone else’s appointment. What do you think would be fair?”

Remember – your tone of voice will make all the difference in how a comment like this is received.

Part of fairness is to publish your policies – in your reception area, on your website, etc. For example, a sign that reads “Patients are seen in order of appointment, not arrival.” Specificity reduces conflict. Well-understood standards encourage fairness.

#8. Use the million-dollar phrase.

Entitled people believe that what they want is fair, and when they can’t have what they want, they often react with criticism that is hurtful rather than constructive.

You need a safety net response to prevent situations from escalating out of control.

Listen to the criticism without interrupting or objecting. Then with all the sincerity and respect you can muster, pull out your million-dollar phrase:

“Mr. Forbes, thank you for telling me.”

#9. Find a team member to step in for you.

It can be interesting to learn that a patient behavior that drives your colleague crazy doesn’t bother you in the least, and vice versa. Consider a non-verbal signal to alert a colleague to come over and help the entitled patient. Remember to do the same for your colleague when his or her version of the difficult patient arrives!

Susan Keane Baker is a speaker specializing in physician-patient relationships. The author of Managing Patient Expectations, Susan presented the final workshop in the Arkansas Hospital Association’s Leadership Institute Workshop.
Congratulations to AHA Century Club Achievers!

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Howard Memorial Hospital
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Johnson Regional Medical Center
Lawrence Memorial Hospital
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McGehee Hospital
Medical Center of South Arkansas
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Mercy Hospital Fort Smith
Mercy Hospital Hot Springs
National Park Medical Center
North Arkansas Regional Medical Center
North Metro Medical Center
Ouachita County Medical Center
Ozark Health Medical Center
Piggott Community Hospital
Saint Mary’s Regional Medical Center
Saline Memorial Hospital
SMC Regional Medical Center
Stone County Medical Center
Summit Medical Center
UAMS Medical Center
White County Medical Center
White River Medical Center

For more information about the improvement elements involved with the AHA HEN, please contact Pamela Brown, AHA vice president, quality and patient safety, 501-224-7878 or pbrown@arkhospitals.org.

Healthcare Quality Week Celebrated October 20-26

The dedication of healthcare quality and patient safety professionals was celebrated during National Healthcare Quality Week (HQW), October 20-26. Plans for celebrating your organization were available in the 2013 HQW Planning Guide with resources and tips to make the most of your special week.

For those looking for more ways to promote your quality department, consider purchasing official HQW promotional items.

For complete Healthcare Quality Week information and additional celebration ideas, visit NAHQ.org/HQW.
New Guide from AHRQ Focuses on Patient and Family Engagement in Hospitals

Research shows that when patients are engaged in their healthcare, it can lead to measurable improvements in safety and quality. To promote stronger engagement, the Agency for Healthcare Research and Quality (AHRQ) developed a guide to help patients, families, and health professionals work together as partners to promote improvements in care.

The Guide to Patient and Family Engagement in Hospital Quality and Safety focuses on four primary strategies for promoting patient/family engagement in hospital safety and quality of care.

• Encourage patients and family members to participate as advisors.
• Promote better communication among patients, family members, and healthcare professionals from the point of admission.
• Implement safe continuity of care by keeping the patient and family informed through nurse bedside change-of-shift reports.
• Engage patients and families in discharge planning throughout the hospital stay.

The Guide to Patient and Family Engagement in Hospital Quality and Safety is a tested, evidence-based resource to help hospitals work as partners with patients and families to improve quality and safety.

The Guide –

• Describes critical opportunities for hospitals to engage patients and families and to create partnerships between patients, families, and hospitals around the same goals.
• Addresses real-world challenges.

The Guide was developed, implemented, and evaluated with the input of patients, family members, clinicians, hospital staff, and hospital leaders.

- Helps hospitals engage patients and families, which in turn can help improve quality and safety, respond to healthcare reform and accreditation standards, improve CAHPS® Hospital Survey scores, improve financial performance, and enhance market share and competitiveness.
- Facilitates implementation and evaluation of each strategy with detailed guidance and customizable tools.

The Guide’s sections include –

• Information to Help Hospitals Get Started addresses:
  □ How to select, implement, and evaluate the Guide’s strategies.
  □ How patient and family engagement can benefit your hospital.
  □ How senior hospital leadership can promote patient and family engagement.
• Strategy 1: Working with Patients and Families as Advisors shows how hospitals can work with patients and family members as advisors at the organizational level.
• Strategy 2: Communicating to Improve Quality helps improve communication among patients, family members, clinicians, and hospital staff from the point of admission.
• Strategy 3: Nurse Bedside Shift Report supports the safe hand-off of care between nurses by involving the patient and family in the change of shift report for nurses.
• Strategy 4: IDEAL Discharge Planning helps reduce preventable readmissions by engaging patients and family members in the transition from hospital to home.

You may access the new AHRQ Guide, which underwent pilot testing at three hospitals and was refined based on feedback from patients, family members, health professionals, and hospital administrators, at http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/patfamilyengage-guide/index.html.
Free HPOE Guide Offers Compendium of Patient Safety Checklists

A new guide from the American Hospital Association’s Hospitals in Pursuit of Excellence initiative offers patient safety checklists for each of the ten focus areas in the Partnership for Patients campaign.

Its checklists aim to prevent:
1. Adverse drug events
2. Catheter-associated urinary tract infections
3. Central line-associated bloodstream infections
4. Early elective deliveries
5. Injuries from falls and immobility
6. Hospital-acquired pressure ulcers
7. Preventable readmissions
8. Surgical site infections
9. Ventilator-associated pneumonias and ventilator-associated events
10. Venous thromboembolisms

Each checklist identifies the top ten evidence-based interventions hospitals can implement, as well as tools, detailed steps and process maps for implementing these best practices.

By following the adverse drug events checklist, hospitals would identify “look-alike, sound-alike” medications and create different labels or alternate packaging to reduce errors. Another checklist item involves using alerts to avoid multiple narcotics prescriptions.

The checklist for preventable readmissions advises hospitals to identify and include the primary caregiver in education and discharge planning. Using teach-back to ensure patients and caregivers understand post-discharge instructions is another task to complete.

The AHA’s Health Research & Educational Trust affiliate operates a Hospital Engagement Network to support the Centers for Medicare & Medicaid Services’ campaign, which aims to reduce inpatient harm by 40% and readmissions by 20%. For more information on HRET’s HEN, including toolkits and resources http://www.hret-hen.org/.

Ten Tips For Creating a Healthy Work Environment

Before turning to healthcare as a career in 1994, Kathleen Bartholomew, RN, MN held positions in marketing, business, communications and teaching. It was these experiences that allowed her to look at nursing from a different perspective and speak poignantly to the issues that affect nurses today.

Speaking in August to more than 100 members and guests of the Arkansas Organization of Nurse Executives, Ms. Bartholomew discussed lateral violence in nursing and ways to prevent problems in the workplace. Below are her 10 tips for creating a healthy work environment:

1. Compliment a co-worker every day. Be specific. Point out the skill or art. (e.g. “You did a great job de-escalating Mr. Jones’s anger.”)
2. Never be a “silent witness.” Never stand by and listen while a co-worker is gossiping, criticizing or talking badly about a peer.
3. Be a team player. If you see someone in need of help, offer assistance. The greatest patient safety net cast to catch mistakes is only as strong as your relationships.
5. Ask someone you don’t know very well to share a meal.
6. Never insist on only working with certain nurses – every time you do, you are rejecting other nurses. Exclusion hurts.
7. Always stay patient focused. When in doubt, ask, “If this patient was my mother, father, baby, what would I do?”
8. Address issues head-on. Take classes in conflict management and increase your confrontation skills. Ask your manager to help role-model difficult conversations with you.
9. Recognize non-verbal innuendos and forms of communicating are damaging. Say what you see; call these non-verbal messages out into the open.
10. Hold yourself accountable. Professionals ask for peer feedback. Ask: “What is it that I do well?” and “What would you like to see more of?”

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QUALITY/PATIENT SAFETY
You think English is easy?? Let’s face it, folks – English is a crazy language and the American pronunciation of the language is even crazier!!! Consider the fact that there is no ‘egg’ in eggplant, nor ‘ham’ in hamburger: neither ‘apple’ nor ‘pine’ in pineapple. English muffins weren’t invented in England or French fries in France. We take English for granted and in America we take for granted the meaning and pronunciation of the sentences: “The insurance was invalid for the invalid” or: “The bandage was wound too tight for the wound” or: “The dump was so full that it had to refuse more refuse” or: “He could lead if he could get the lead out.” Communication is a basic human need. From a baby’s first cry onward people communicate to express their needs and desires. Difficulty in communicating can cause profound emotional changes and may reduce a person’s potential in life.

Success in our society depends upon one’s ability to communicate clearly and effectively. However, such a level of communication can be difficult to obtain. With more and more foreign nationals seeking training, employment and a new life in the United States, many parts of our culture are now a veritable melting pot of accents and linguistic variations. While many of these émigrés bring with them a strong grasp or mastery of English, individual speech patterns may limit their ability to fully express themselves or be understood.

These limitations may result in frustration and embarrassment, and these individuals may be unable to fully make their unique and valuable contributions to society. Fortunately a way exists to relieve the frustration and isolation these individuals may feel because of their accents.

American accent training was created to help people “sound American” for lectures, interviews, teaching, business situations and general daily communication. Strong foreign accents, though certainly not a disorder, can cause severe communication difficulties on the job. Non-native individuals with excellent professional skills may not be able to express themselves clearly in English to colleagues or even patients. They lose self-confidence, as well as hope for desired promotions.

Many people feel that after a certain age, it’s not possible to learn a new accent. However, one can ask himself, “Can a classical musician learn to play jazz?” Of course he can, if he practices enough. Learning an American accent is just a matter of identifying the different sounds, learning the techniques to produce them, and setting aside time to practice, practice, practice.

English as a Second Language (ESL) is taught with the emphasis mainly on learning the vocabulary and grammatical forms, often with reading and writing being taught at the same time. The result is that most people learn the vocabulary and grammar of English but still remain poorly prepared to speak and be understood in their newly acquired language. A good accent modification program will pick up where conventional ESL programs end and thus will aid people with foreign accents to improve their “spoken English.”

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be achieved. The program begins with a personal analysis of the client’s speech. This analysis reveals exactly how their pronunciation varies from standard American English and identifies specific areas for concentration. The analysis also assists in determining whether a group or individual course is more appropriate.

During the thirteen weeks of training a speech professional teaches the client appropriate speech modification techniques, as well as the basic sounds and principles of American English. The client learns to discriminate between different speech sounds, with special emphasis placed on:

- Pronunciation
- Complete word production
- Voice projection

The client also makes use of these language fundamentals by practicing conversational speech and giving presentations.

To modify a foreign accent takes hard work and dedication. It cannot be done in the classroom alone. Like the “classical” musician learning to play “jazz,” to achieve the greatest improvement possible, the client must practice outside of class by utilizing the available P-ESL practice materials. Upon completion of a P-ESL course, the client’s speech is analyzed again. The results are then compared to the initial analysis so the extent of the client’s improvement can be determined. Past comparisons have shown that students who attend all the appropriate sessions and practice diligently can expect the likelihood of 50% or greater improvement in accuracy and clarity of American English pronunciation.

An accent is not a negative issue. It is simply nonstandard and presents a problem to the American ear. There is a saying, “What do you call a person who speaks three languages?” – “Trilingual”; “What do you call a person who speaks two languages?” – “Bilingual”; “What do you call a person who speaks only one language?” – “American.”

Every language is equally valid or good, so every accent is good. But the average American ear truly does have a hard time understanding a nonstandard accent. If a listener pays more attention to how a person speaks, rather than to what he or she is saying, that person has a communication problem. Thank goodness help is available!

For more information on the P-ESL program call 1-800-256-0732 or go to www.englishmadeeasy.biz and leave your call back information.

REFERENCES:

Martha Basinger has been licensed in Arkansas for 30 years as a Speech/Language Pathologist with formal training in the area of speech production. Utilizing the training she received from the Compton Institute of Language and Phonology in 2009, she earned her certification as an “Accent Modification Specialist.” She may be reached at martha@englishmadeeasy.biz.
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