We’re a knowledgeable connector of people, physicians and health care places.

One way we keep physicians and patients connected is through a Personal Health Record (PHR), available for each Arkansas Blue Cross, Health Advantage and BlueAdvantage Administrators of Arkansas member. A PHR is a confidential, Web-based, electronic record that combines information provided by the patient and information available from their claims data.

A PHR can help physicians by providing valuable information in both every day and emergency situations.

To request access, contact PHR Customer Support at 501-378-3253 or personalhealthrecord@arkbluecross.com or contact your Network Development Representative.
The AHA has been at the forefront of the passage and reauthorization of the Arkansas Private Option. Early in the program’s development, we predicted many positive outcomes from the initiative. Although the Arkansas Private Option is still in its early stages, it is now gratifying to see that our predictions were correct. The results are all positive.

Out of the approximately 225,000 eligible uninsured Arkansans with incomes below 138% of the federal poverty level (FPL), almost 205,000 have now completed enrollment in the Arkansas Private Option. Another 7,000 eligible Arkansans are in the process of completing their enrollment.

Arkansas Private Option enrollment, combined with enrollment of individuals with incomes above 138% FPL through the Health Insurance Marketplace, has led to a dramatic drop in the uninsured rate in our state. A Gallup survey published in August reported that 12.4% of Arkansas adults lacked insurance as of midyear this year, which is a drop of 10.1 percentage points compared with 22.5% who lacked insurance last year. This 10.1% reduction leads the nation.

Of those enrolled in the Private Option, 67% are between the ages of 19-44. It is no secret that insurance costs are adjusted based on risk and a younger population generally means less risk. Arkansas has the second youngest insurance marketplace pool in the nation, which means that as premiums increase in other markets, the rates in Arkansas won’t increase as quickly.

In fact, one of the biggest positives is that insurance premium costs announced for the products sold on the 2015 marketplace in Arkansas will be 2% lower than they were in 2014. In addition, as more Arkansans are able to access the healthcare system, Social Security Disability claims have been reduced by 15%.

I invite you to visit with your hospital CEO or CFO about how the Arkansas Private Option is affecting your hospital’s bottom line. I am sure you will hear that while the Arkansas Private Option is affecting your hospital’s bottom line. I am sure you will hear that while the Arkansas Private Option is contributing to a dramatic drop in the uninsured rate in our state, it is positively impacting uncompensated care costs.

While the numbers prove that the Arkansas Private Option is fulfilling its role in reducing the number of the uninsured and lowering the burden of uncompensated care, serving our patients and their friends and families – our neighbors – is the reason we exist. As the anecdotal stories of the positive effects continue to spread, it is clear that there is no substitute for good health.

There are countless stories of individuals who are now able to fill prescriptions they could not afford to fill in the past, who are finally able to access care for long-standing chronic conditions or who have a primary care physician for the first time in their lives – all of which lead to a more productive life. Improving the lives of our neighbors is the most important “positive” of the Arkansas Private Option.

As you approach the November 4th elections, I ask that you do some research. Seventy-five percent of each chamber of the Arkansas legislature must vote to reauthorize the Arkansas Private Option. In your local elections for state senator and state representative, please determine if they are supportive of the reauthorization of the Arkansas Private Option, and then go vote for them.

Bo Ryall
President and CEO
Arkansas Hospital Association
Can Laboratory Testing Improve Patient Care and Lower Costs?

Yes. Let us show you how.

AEL is a medically-led, community-based laboratory with personal service.

A partner for hospitals to reduce the cost of referrals and in-house testing by using the most modern technology.

To learn more about AEL and its innovative technology to assist in utilization management call Pam O’Brien at 901.405.8200.
Like our hospitals, we at the Arkansas Hospital Association are constantly working to improve. As part of that process, we are making some changes in Arkansas Hospitals. You will see some new design features in this issue that we hope you enjoy. Our goal is to incorporate new ideas in both the layout and content, while continuing to provide the high quality publication you’ve grown to expect over the years.

To succeed, however, we need to hear from you. Just as you rely on data to drive your strategic planning, we need data too. We need to know your interests and your priorities. That’s why we are planning our first readership survey for later this year. We know our readers are incredibly busy people, so the survey will be short and to the point. Plus, to sweeten the deal, we will be giving away an iPad mini to one lucky reader who completes the survey!

You don’t have to complete a survey to talk to us though. We always welcome feedback from our readers and would love to hear your opinions about the design changes, as well as article ideas, thoughts and opinions. Please feel free to reach out to me by email at elisawhite@arkhospitals.org or call me at 501-224-7878.

In the meantime, happy reading.

Elisa White, Editor-In-Chief

Transformations

An internet search for “transforming healthcare” yields more than 10 million results in less than half a second. These days, it may seem that the only constant for those of us in the healthcare industry is change itself. Yet the essence of healthcare remains the same – passion for and dedication to taking care of patients to help them lead healthier, more productive lives.

Arkansas Hospital Association

EDUCATION CALENDAR

October 30-31, Morrilton
Arkansas Healthcare Human Resources Association Fall Conference

October 30-31, Little Rock
Arkansas Healthcare Financial Management Association Fall Conference

November 6, Little Rock
Behavioral Health Integration in the Continuum of Care

November 11, Little Rock
Compliance Roundtable and Luncheon

November 12, Little Rock
Arkansas Health Executives Forum Annual Face-to-Face Workshop

November 14, Little Rock
Arkansas Social Workers in Healthcare

November 14, Little Rock
Arkansas Association for Healthcare Quality

November 18, Little Rock
AHA’s ARbestHealth Quality Seminar: Building Partnerships with Patients and Families to Improve the Experience of Care and Reduce Harm

December 5, Jonesboro
December 9, Camden
December 10, Little Rock
CPT® 2015 Procedure Coding Changes

December 11, Little Rock
Arkansas Healthcare Financial Management Association December CPA Session

December 12, Little Rock
Chargemaster Program: CDM Review Strategies for Improved Charging and Reimbursement

Program information available at www.arkhospitals.org/events.
NEWSMAKERS and NEWCOMERS

- **PETER BANKO**, president and chief executive officer of CHI St. Vincent in Little Rock has been named Catholic Health Initiatives (CHI) group executive officer for the east/southeast division, and chief integration officer. He will oversee operations of CHI St. Vincent, CHI Memorial (Chattanooga, TN), CHI St. Joseph Health (Reading, PA) and Saint Clare’s Health System (Denville, NJ). In addition, he will assume responsibility for the CHI national integration team.

- **DAN MCKAY** has been appointed CEO of Sparks Health System (Fort Smith) and Summit Medical Center (Van Buren), which are a part of Community Health Systems (CHS) network of hospitals in Arkansas. For the last five years, McKay has served as CEO of Northwest Health System, also part of the CHS network. Prior to serving as CEO at Northwest, McKay was a vice president at CHS Professional Services Corporation, where he supported the management of operations at hospitals across the U.S.

- Northwest Health System of Springdale announced its appointment of veteran hospital executive **SHARIF OMAR** to the position of CEO. A Louisiana native who earned his MHA from Tulane University, Omar has more than 15 years of hospital management experience, most recently as CEO of Pottstown Memorial Medical Center in Pottstown, PA.

- **TOM SLEDGE** is the new chief operating officer (COO) for Northwest Medical Center Springdale. He had served as the interim COO since May 1 before accepting the permanent position in July. Prior to joining Northwest Health System, he served as COO of Weatherford Regional Medical Center in Weatherford, Texas, and he was assistant chief executive officer of Women and Children’s Center in Lake Charles, Louisiana.

- **ANNA STRONG** has joined Arkansas Children’s Hospital in the newly created position of executive director of child advocacy and public health. In the new role, Strong is responsible for leading development and implementation of community health initiatives, and will also oversee and track the hospital’s community engagement goals. Before joining ACH, Strong previously served as healthcare policy director at Arkansas Advocates for Children and Families.

all about HOSPITALS

- In honor of its former CEO and President Russ Harrington’s retirement after 40 years of service, **BAPTIST HEALTH** has renamed its Little Rock campus the Russell D. Harrington, Jr. Campus. New signage located at the front entrance of the campus was unveiled earlier this summer. More than 325 employees, friends and family made a monetary donation to the Baptist Health Foundation in Harrington’s honor, and a keepsake book with their names was presented to Harrington on the same day as the unveiling. Harrington expressed his appreciation to the system, stating that he was honored “to be a part of this healing ministry and to be able to serve the healthcare needs of our state for 40 years.”

- Hoping to improve care for stroke victims in Arkansas, **WASHINGTON REGIONAL MEDICAL CENTER** recently opened the Northwest Arkansas Neuroscience Institute, which includes a 1,545 square foot surgical suite, and introduced several new neurosurgeons to the northwest Arkansas area. Among the new surgeons are Dr. Mayshan Ghiassi and Dr. Mahan Ghiassi, each of whom completed post-graduate training in both neurosurgery and endovascular techniques. The new hybrid operating suite at the institute was designed to accommodate both endovascular and open neurosurgical cases.

- The **MEDICAL CENTER OF SOUTH ARKANSAS** has unveiled a newly renovated 8,100 square foot emergency department. The project was completed in two phases to ensure that the emergency room remained open and available to meet the needs of the community during the construction. Part of the remodel included installing the latest technology and enhancements to the efficiency of the space to improve the overall quality of patient care.
From Vision to Results

Submitted to the Arkansas Hospital Association by Joe Tye

When Midland Memorial Hospital in west Texas opened a gorgeous new facility with all state-of-the-art private patient rooms, they expected patient satisfaction to skyrocket. Surprisingly, it did no such thing; it actually declined. They soon realized that by opening the beautiful new building, they had raised patient expectations dramatically but had done nothing to change the attitudes and behaviors of people working there, so patients got the same old treatment. The new building made the gap between patients’ expectations and the reality of their experience wider than it was before.
With help from our team at Values Coach, they began working on a Cultural Blueprint for the Invisible Architecture™ of their organization. When it comes to the things that really matter, including employee engagement and patient satisfaction, Invisible Architecture is more important than the visible architecture of bricks and mortar. In a very real sense, it is the soul of an organization. In this article, I’ll share some of the strategies and the most important lessons for creating positive culture change.

**BLUEPRINTING YOUR INVISIBLE ARCHITECTURE**

When helping clients create a Cultural Blueprint for their Invisible Architecture, we use a construction metaphor in which the foundation is core values, the superstructure is organizational culture and the interior finish is workplace attitude. As with visible architecture, in a well-designed organization there is a seamless interconnection between the foundation, the superstructure and the interior finish.

Unfortunately, in many hospitals, core values are a pro-forma plaque on the wall for which there is little employee ownership. Culture has evolved haphazardly and without conscious design, resulting in a fragmented patchwork throughout the organization, and attitudinal expectations have not been established and enforced. This is why you hear terms like “lateral violence” and “nurses eat their young” – which should be zero tolerance behaviors (ZTBs) in a healthcare setting.

**The Foundation of Core Values**

A hospital’s statement of core values should define who you are, what you stand for, and what you won’t stand for. Many hospital values statements suffer from two serious weaknesses: 1) they are written in boilerplate language that does nothing to inspire pride and commitment on the part of people who are expected to live those values; and 2) they do nothing to differentiate that organization from every other hospital claiming to care about excellence, compassion and quality. And while values statements that lend themselves to a memorable acronym can be effective, it’s usually obvious when words have been force-fit into something like I CARE (the letters will almost predictably stand for integrity, compassion, accountability, respect and excellence).

When we worked with Memorial Hospital of Converse County in Douglas, Wyoming, they had a statement of values spelling out the acronym CARE, but nobody — including people with the word “chief” in their job titles — knew what the letters stood for. At one leadership retreat, we divided people into small groups and gave them just three minutes to define the values that inspired them as individuals. In a three-minute exercise, these groups came up with values statements that were more inspiring and meaningful than the plaque that had been tacked on the wall.
wall for nobody knew how long. Over the next year, MHCC engaged employees, providers, board members, volunteers and others in a dialogue about values. They went from the insipid acronym CARE to a robust statement with seven core values, each defined by a statement of philosophy and reinforced by 5-6 statements of behavioral expectation, as shown in Illustration 1.

When we helped Tucson Medical Center work on creating a new statement of values, they defined four core values, each reinforced by three statements of principle, but they didn’t stop there. They had a professional graphic designer create a beautiful image incorporating those values, as shown in Illustration 2. A great statement of values like this lends itself to promoting the hospital and to recruiting the sort of people who share those same values.

Midland Memorial Hospital has never had a formal statement of values, so over the past several months we’ve conducted focus group sessions with employees, physicians, board members and others. Through that process, it has become very clear that three core values drive the organization: pioneering spirit, caring heart and healing mission. The hospital’s leadership team is now working to define specific values-based cultural norms and behavioral
expectations for each of the three. Because they want something that every employee can embrace and be proud of, they’ve also asked me to write a fictionalized account of the history and future plans of the hospital in which its values, culture and behavioral expectations are illustrated by the characters in an engaging story.

The Superstructure of Organizational Culture

One of the exercises we conduct in leadership retreats is asking participants to define their culture in just six words. Paradoxically, the stronger an organization’s culture, the easier it is to succinctly define. At Southwest Airlines, for example, they define their culture in a 6-word motto “Servant’s Heart, Warrior Spirit, Fun-Loving Attitude.” At Cypress Semiconductor, they simply call themselves “The Marine Corp of Silicon Valley.” When your culture is so clear and distinct that you can define it in just a few words, you almost never make hiring mistakes, your people are clear about the organization’s behavioral expectations, and customers always know what to expect.

It’s a rare hospital that’s that clear about its culture. Rather, you see a fragmented culture that’s more like a patchwork quilt. The culture in nursing is different than that in lab, pharmacy, housekeeping, administration or the business office, and within nursing, there are different cultures in med-surg, operating rooms, emergency department and newborn nursery. There’s a different culture on day shift and night shift, and yet another on weekends. At one hospital leadership retreat, responses to the 6-word culture definition exercise ranged from “We love patients and each other” to “This place sucks then you quit.”

We have put a great deal of thought into what six words would define a culture of ownership in a healthcare organization and it’s this: Emotionally Positive, Self Empowered, Fully Engaged. One of the resources at The Florence Challenge website (www.TheFlorenceChallenge.com) is a Certificate of Commitment to these three qualities as shown in Illustration 3. When everyone in a department or nursing unit signs and publicly posts these certificates (often with their pictures next to the signature), it serves as both a daily reminder to employees and a notice to patients and visitors of the expectations they have placed upon themselves. Many hospitals, including those mentioned in this article, launch their values and culture initiatives by sharing the book The Florence Prescription with some or all of their employees.

One of the most powerful ways of crafting culture is the combination of simple rituals coupled with success stories from those practices. For example, at Midland Memorial Hospital, all managers have been encouraged to

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lead their staff in reading each day’s promise from The Self-Empowerment Pledge, and a growing number of employees are wearing wristbands for each day’s promise. The Pledge is included in Illustration 4. As people have begun to take these seven promises to heart, they’re starting to share impressive stories about achieving goals, redefining priorities, and in at least one case even breaking a long-standing drug addiction.

**Interior Finish of Workplace Attitude**

One of the most important lessons I’ve learned in my twenty years with Values Coach is this: culture does not change unless and until people change. That’s why we always begin a values and culture initiative with a culture assessment survey for all employees. This is an excellent way of encouraging managers to remove the rose-colored glasses we often wear when assessing our own cultures, and the results are almost always less than we would hope for. The good news is that holding up this cultural mirror often provides the spark of motivation that is needed for people to pay attention to, and work to change, negative attitudes and behaviors.

Following are some of the questions we typically include in this culture assessment survey (rated on a 5-point scale with responses from “strongly agree” to “strongly disagree”). We have

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**KEY LESSONS FOR FOSTERING A CULTURE OF OWNERSHIP**

In working with hundreds of organizations over the past twenty years, we’ve learned some important lessons about effective culture change. These are the most important:

**LESSON #1:** Senior leadership must be visibly committed, but this often takes the form of high-leverage symbolic actions. At Midland Memorial Hospital, for example, CEO Russell Meyers references The Pickle Challenge and The Self Empowerment Pledge in his Monday staff emails, and members of the executive team wear wristbands for the seven daily promises of The Self Empowerment Pledge.

**LESSON #2:** Middle management must be engaged and not allowed to opt out. In our experience, this is the single-best predictor of a successful values and culture initiative. When the middle management team is solidly behind the effort, we’re surfing a powerful wave. When even a few convey the message to their people that they’ve opted out of what they consider to be a ridiculous waste of time, we end up swimming against a very strong countercurrent.

**LESSON #3:** Define specific actions that people can take to show commitment to your values and cultural expectations, but be clear about the personal benefit since, as the late Zig Ziglar reminded us, everyone listens to the same radio station – What’s In It For Me? When sharing The Pickle Challenge and The Self Empowerment Pledge, we always stress how living these promises not only contributes to organizational excellence, it also helps individual employees more effectively achieve their own personal and professional goals.

**LESSON #4:** Resistance is inevitable from people who, for whatever reason, have a vested interest in preventing positive culture change. If the leadership team perseveres in the face of this resistance, some of the most negative employees will eventually get on board and become real Spark Plugs, while those who don’t will become marginalized and eventually leave or be asked to leave. If the leadership team does not persevere, though, they end up contributing to the self-fulfilling prophecy of just another program of the month.

**LESSON #5:** Integrate the principles of your Invisible Architecture into policies and procedures, recruiting and retention activities, new employee orientation, performance appraisals and continuing education activities.

**LESSON #6:** Engage the medical staff in a serious manner. Physicians can have a disproportionately positive impact on a values and culture initiative when they are visibly engaged and supportive, but they can also undermine the effort by siding with the cynics who want it to fail.

**LESSON #7:** Don’t be afraid to ask people to assess progress. There is no such thing as “survey fatigue.” People only get fatigued by filling out surveys that are not acted upon. Take off the rose-colored glasses and don’t try to excuse or explain away unacceptable results.

**LESSON #8:** Continue building your momentum. At Midland Memorial Hospital, for example, the next phase will be training a core group of employees to become Certified Values Coach Trainers who in turn will share our course on The Twelve Core Action Values with the rest of the organization during 2015.
never seen a hospital with an average score higher than 4.0 on any question, and it’s not uncommon for some questions (especially those related to positive attitudes and respectful behavior) to have an average score of well below 3.0.

- Our people are creative, productive and enthusiastic about work and their own personal and professional development.
- Our people are fully engaged in their work and committed to the mission of our organization.
- Our people know the values of this organization, and are committed to assuring that those values are reflected in the way that they do the work they do.
- Our people reflect positive attitudes, treat others with respect, and refrain from complaining, gossiping or pointing fingers.
- Our people effectively manage change and are advocates for progress.
- Our people feel a great sense of pride in being a member of our team.

Another question asks people to estimate what percent of total paid hours in their organization are wasted on complaining, gossiping and other forms of toxic emotional negativity. At Midland Memorial Hospital the initial survey suggested that about 12% of all paid hours were so wasted. As bad as that sounds, it is not at all atypical of hospital survey results. The second survey conducted four months into the Values and Culture Initiative suggested that total has been cut in half, resulting in more than $7 million in wage and salary expense being directed into more productive activities. And this does not account for the positive impact of greatly enhanced patient satisfaction and more positive community image that have been direct results of these attitude and behavior changes on the part of individuals.

continued on page 14
One of the most powerful tools we use to raise awareness of toxic emotional negativity in the workplace is The Pickle Challenge. This is based upon the simple promise included in Illustration 5. Midland Memorial Hospital has embraced this by having pickle jar decorating contests, a fund-raising initiative in which people are fined a quarter for each complaint and the money is donated to their catastrophic employee assistance program, and other activities. In their recent accreditation survey, surveyors commented upon how impressed they were with the impact The Pickle Challenge has had on the overall organizational culture.

**RESULTS**

As you might imagine, we have seen results ranging from minimal sustained impact to profound cultural transformation. At Fillmore County Hospital in Geneva, Nebraska, CEO Paul Utemark said, “I got a whole new team and didn’t have to change any of the people.” At Star Valley Medical Center in Afton, Wyoming, CEO Charlie Button says their work on values and culture was the key factor in that organization being designated one of the Top 20 critical access hospitals in America by the National Rural Health Association.

At Midland Memorial Hospital, there have been dramatic improvements since they launched their Values and Culture Initiative this past spring (the first survey was conducted in February and training began in April). As shown in Illustration 6, the proportion of employees disagreeing with the statement that they treat others with respect and refrain from toxic emotional negativity was more than cut in half, and the proportion of employees agreeing with that statement has nearly doubled. Similar changes were seen in other questions relating to pride in the organization, being engaged in the work and effectively managing change. It is no coincidence that since the initiative started, patient satisfaction scores have trended strongly upward and are now at all-time highs.

**CONCLUSION**

It’s often said that culture eats strategy for lunch, but it would be more accurate to say that the greatest source of competitive advantage is strategy that is supported by an Invisible Architecture of core values that are enthusiastically embraced, a positive organizational culture, and workplace attitudes that optimize a spirit of ownership. Every organization has a strategic plan. You should also have a culture plan that defines your expectations for the organization’s Invisible Architecture.

Joe Tye is CEO and Head Coach, Values Coach Inc. and author of The Florence Prescription: From Accountability to Ownership.

Special offer from the author: If you would like a complimentary copy of The Florence Prescription, either email Michelle Arduser (Michelle@ValuesCoach.com) or call the Values Coach office at 319-624-3889.
President Obama signed an Executive Order on September 18 directing federal departments and agencies to take action to implement the administration’s newly released National Strategy on Combating Antibiotic-Resistant Bacteria. At the same time, the White House announced the release of a new report by the President’s Council of Advisors on Science and Technology, which “provides actionable recommendations . . . for combating antibiotic resistance.”

Effective January 1, 2015, The Joint Commission is including a new “Patient Safety Systems” chapter in the Comprehensive Accreditation Manual for Hospitals. The new chapter does not contain new standards or requirements. Instead, it explains how existing Joint Commission requirements can be applied to enhance patient safety.

On September 15, the Centers for Medicare & Medicaid Services (CMS) issued a Survey & Certification Letter announcing updates to its Hospital Interpretive Guidelines. Among other changes, CMS noted that it expects the governing body to consult directly with the head of the medical staff periodically throughout the year and at least twice in a fiscal or calendar year. The discussion is expected to include quality of care.

A study recently released in the journal Pediatrics shows dramatic reductions in the rates of central line-associated bloodstream infections, ventilator-associated pneumonias and catheter-associated urinary tract infections in neonatal and pediatric intensive care units across the United States.

AHRO’s Patient Education Materials Assessment Tool (PEMAT) helps health professionals and others select educational materials that are easy for patients to understand and use. The tool received high marks for internal consistency, reliability and validity in a research article published in the September issue of Patient Education and Counseling. The PEMAT and its Users’ Guide are available at: http://www.ahrq.gov/pemat. No additional training is required to use the tool.
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High Reliability

As the complexity of healthcare and the acuity of patients treated in hospitals increases, there is an even greater likelihood of errors unless attention is given to the systems in play to provide that care. One of the ways to address this is to consider the essential components of high reliability.

The science of high reliability has its roots in other industries that are considered high risk and accident prone. Healthcare can learn from these industries and strive to incorporate those essential principles in not only its culture but in its day-to-day operations.
THE FOUNDATION

According to The Joint Commission's Mark Chassin and Jerod Loeb, before beginning the journey to become a high reliability organization, an organization must have three things:

- Leadership commitment
- Organizational culture of safety
- Robust process improvement

It is no accident that leadership commitment is the first item on the list. Without this essential foundation, organization improvement cannot succeed. Commitment to the hard work and dedication necessary to become a high reliability organization must start at the board level, be supported by senior management and be embraced by each member of the organization's team.

This leadership model is essential to the second item on the list, an organizational culture of safety. At the heart of the culture of safety is trust. Without the trust necessary to feel comfortable identifying, discussing and reporting safety concerns, including near misses, improvement efforts will stall. Employees must trust one another enough to work together to address concerns, and they must trust that management will address concerns that are raised.

With committed leaders and a culture of safety, organizations can establish a systematic approach to improvements. Using Lean, Six Sigma or other process improvement approaches to examine the systems that contribute to a quality or safety issue, the organization can make tremendous strides toward high reliability.

Establishing the 3-pronged foundation for high reliability is just the start of the real work, however. Truly becoming a high reliability organization is a multi-year endeavor. According to Drs. Juan Sanchez and Paul Barach, there are five principles of high reliability organizations:

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise.

PREOCCUPATION WITH FAILURE

Having a preoccupation with failure means treating each event, lapse or near miss as the symptom of a systems problem that can result in harm. What may seem like an isolated small event, when coupled with other small events, could potentially cause a catastrophic failure. Examples of this principle in action are pre-surgery huddles where clinicians discuss what could go wrong or the potential for unexpected events and bedside huddles during handoffs to discuss potential patient risks.

RELUCTANCE TO SIMPLIFY INTERPRETATIONS

Complex systems can be highly unpredictable and require attention and insight. High reliability organizations are resistant to cutting corners or skipping steps – no matter how small – in these systems. A great example of this principle is the utilization of a 2-person independent check for dispensing high risk medications or in conducting sponge counts in the operating room. Staff recognize that cutting corners and having only one person do the check creates a process that increases the risk to the patient from human error.

SENSITIVITY TO OPERATIONS

In high reliability organizations, there is an emphasis on having access to the most current and accurate information available and using it quickly in decision-making, particularly when unexpected deviations are detected. Communication and collaboration are critical here, as is establishing an environment in which staff feel comfortable speaking up and where people are encouraged to identify problems or issues. Communication must occur frequently, and every staff member must understand what resources are available to them, especially in the course of the unexpected.

COMMITMENT TO RESILIENCE

Resilience is simply being able to recover quickly from an event and to contain the impact or effects of that event. This is accomplished through response planning and having a preplanned protocol for potential events. High reliability organizations must focus on competencies and simulations for preparedness throughout the organization. Organizational success depends upon the ability to recover from small lapses.

DEFERENCE TO EXPERTISE

When a problem is identified within a high reliability organization, decision-making migrates to those with the most expertise in the problem at hand, regardless of their authority or rank. Co-workers must be aware of each other’s unique skills and knowledge, and when problems arise, they must take advantage of the unique skills of their colleagues. High reliability organizations cannot eliminate crises. But when a patient crisis occurs in these organizations, people rapidly pool their collective expertise to attempt to resolve it.

Another characteristic of note for high reliability organizations is “collective mindfulness.” Collective mindfulness means that everyone who works in these organizations is acutely aware that even small failures in safety protocols or processes can lead to catastrophic adverse outcomes. As a matter of routine, workers in these organizations are always searching for the smallest indication that the environment or a key safety process has changed in some way that might lead to failure if some action is not taken to solve the problem.

Continuously uncovering these safety concerns permits an organization to identify safety or quality problems at a stage when they are easily fixed. In healthcare we are too often in the position of investigating severe adverse events after they have injured patients, which means that we have missed opportunities to pinpoint and correct quality problems before they cause harm.

REFERENCES:

-Chassin & Loeb 2011.
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Celebrating HEN Success:
Arkansas Hospitals Achieve Quality Goals

The Arkansas Hospital Association’s ARbestHealth quality team congratulates the Arkansas hospitals who have met the Partnership for Patients national quality and patient safety goals through their work with the AHA/HRET Hospital Engagement Network.

According to the most recent data (as of October 9), the following Arkansas hospitals have achieved this tremendous milestone:
• Baxter Regional Medical Center,
• Fulton County Hospital,
• Great River Medical Center, and
• Magnolia Regional Medical Center.

The full national list is published on the American Hospital Association’s HRET Website at http://hret-hen.org — under “About HEN.” Click on “High Achieving HEN Hospitals” for a state-by-state list, which is updated monthly.

Keep up the great work, and the ARbestHealth team looks forward to adding more hospitals to this list!

For more information about the AHA/HRET Hospital Engagement Network and other Arkansas Hospital Association quality initiatives, contact Pam Brown, Vice President of Quality and Patient Safety, at 501-224-7878 or pbrown@arkhospitals.org.

Arkansas Hospitals Improving Care:
14 Hospitals Receive Inpatient Quality Incentive Awards

Arkansas Medicaid, the Arkansas Foundation for Medical Care (AFMC) and the Arkansas Hospital Association (AHA) announced the winners of the 2014 Inpatient Quality Incentive (IQI) awards on October 9 at the Arkansas Hospital Association Annual Meeting.

These awards are bonus payments and recognition given to hospitals that improve the quality of patient care according to Arkansas Medicaid’s clinical priorities. This year, IQI set forth nine performance measures and one submission measure for improving hospital inpatient quality. The measures are related to transitions of care, obstetrics and tobacco screening and treatment.

Now in its eighth year, the IQI program was jointly developed by Arkansas Medicaid, AFMC and the AHA as the first pay-for-performance program for hospitals in the nation to include a validation component.

The program has earned national recognition for its innovation and healthcare community involvement.

In 2014, 45 hospitals participated in the IQI program, with 13 hospitals receiving bonus payments and one critical access hospital receiving recognition. In all, IQI will hand out
Now in its eighth year, the IQI program was jointly developed by Arkansas Medicaid, AFMC and the AHA as the first pay-for-performance program for hospitals in the nation to include a validation component.

more than $2.6 million in incentive bonus payments to the 2014 winners. Hospitals earning awards for 2014 include:
• Baptist Health Medical Center – Little Rock
• Baptist Health Medical Center – North Little Rock
• Conway Regional Medical Center
• Jefferson Regional Medical Center
• Johnson Regional Medical Center
• Medical Center of South Arkansas
• Mena Regional Health System
• Mercy Hospital Northwest Arkansas
• Saline Memorial Hospital
• Sparks Regional Medical Center
• St. Bernards Medical Center
• Washington Regional Medical Center
• White County Medical Center

Chicot Memorial Hospital also met the criteria as a critical access hospital. Chicot Memorial will receive recognition for its achievements.

Since the program began in 2007, the IQI has paid out more than $30 million to reward Arkansas hospitals for their commitment to quality and for providing evidence-based care to their patients.
Better Care for Moms and Babies: Arkansas Hospitals Reducing Early Elective Deliveries

Arkansas hospitals and their medical staffs are continuing to reduce the number of early elective deliveries (EEDs), giving more Arkansas babies a healthy start in life. Hospitals across the state have embraced the principles of the March of Dimes “Healthy Babies are Worth the Wait” campaign, which urges women to wait for labor to begin on its own if their pregnancy is healthy, rather than scheduling delivery before 39 weeks.

Since 2013, the Arkansas Hospital Association and the March of Dimes have partnered in a campaign to recognize hospitals for their work to reduce early elective deliveries, those deliveries that are scheduled for convenience prior to the baby reaching 39 weeks gestational age.

Hospitals that complete the March of Dimes 39+ Weeks Banner Checklist and pass a March of Dimes review of materials are visited by a team from the March of Dimes and the AHA, who deliver a 3 x 6 foot vinyl banner recognizing the hospital for its commitment to improving the quality of care for moms and babies.

The most recent hospital honorees are Mena Regional Health System and North Arkansas Regional Medical Center. In receiving their awards, the CEOs of both organizations recognized the dedication of their expert teams of physicians and nurses who implemented policies to avoid elective inductions or cesareans before 39 weeks except when medically necessary.

The AHA and the March of Dimes look forward to honoring many more hospitals for their excellent work in this area.
Arkansas MEDICAID

Educational Conference

Thursday, Dec. 11
Little Rock, Embassy Suites

This year’s free, full-day conference will focus on the newest information from the Arkansas Department of Human Services, plus topics of interest to Arkansas health care providers, including:

- Payment Improvement/Episodes of Care
- Patient-Centered Medical Home
- ICD-10

Agenda subject to change.

This educational conference will not be offered again regionally. Make plans to attend the Little Rock event today.

Arkansas Foundation for Medical Care (AFMC) is applying for continuing education credits. For current information about CE, visit the website below.

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Save the date!

MEDICAID Educational Conference
Thursday, Dec. 11
Little Rock, Embassy Suites

Space is limited! For more information or to register, call 501-212-8686 or visit mmcs.afmc.org/events.
Conway Regional Medical Center Wins Governor’s Quality Award

Governor Mike Beebe presented Conway Regional Medical Center with the Governor’s Quality Award for Performance Excellence during the 20th Annual Awards Celebration for the Governor’s Quality Award Program on September 15 at the Marriott Hotel in downtown Little Rock. This award is the highest one bestowed by the program, and Conway Regional is the first organization from its five-county market area (Faulkner, Perry, Van Buren, Cleburne and Conway counties) to achieve one.

Sixteen past Governor’s Award for Performance Excellence recipients also were recognized during the 20th Anniversary celebration, which was attended by more than 400 business and civic leaders from throughout Arkansas.

The awards ceremony includes four award levels of Performance Excellence (in descending order of qualifications): the Governor’s Award, the Achievement Award, the Commitment Award and the Challenge Award.

Two hospitals were honored at the ceremony, with Conway Regional taking home a Governor’s Award, and Saline Memorial Hospital of Benton receiving an Achievement Level Award.

The Governor’s Quality Award program provides opportunities for all organizations in the state to measure their progress toward performance excellence. Organizations that apply to the program answer questions within the Criteria for Performance Excellence to produce an application. The Criteria are the same as those used for the Malcolm Baldrige National Quality Award Program. Trained examiners then assess each application, conduct site visits and produce a feedback report telling the applicant organization its strengths and opportunities for improvement using the Criteria as a benchmark.

Not only do award winners receive well-deserved recognition, but the application process itself is a valuable tool for quality improvement.

“Our journey through the award application process has reaped amazing rewards for our hospital team,” said Conway Regional CEO, Jim Lambert. “It simply doesn’t work unless we focus on every patient, every day, in every encounter.” Lambert noted that the process of improvement will continue long after the award ceremony.

The goal of the Governor’s Quality Award Program is to encourage Arkansas organizations to engage in continuous quality improvement, which leads to performance excellence, and to provide significant recognition to those organizations. Created as a not-for-profit organization, the program is dedicated to assist in building a strong infrastructure for Arkansas businesses. That dedication is reflected in the program’s vision to be a catalyst for excellence in organizational performance.

Organizations and companies interested in participating in the program should contact Governor’s Quality Award Executive Director Sue Weatter with the Arkansas State Chamber of Commerce by calling 501-372-2222 or go to www.arkansas-quality.org.
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The QIO program traces its roots back to 1984 when CMS issued its first set of contracts to one organization in all 50 states, DC and other territories to serve as that state or jurisdiction’s contractor. These contractors were called Peer Review Organizations, or PROs, until 2002, when they were renamed Quality Improvement Organizations, or QIOs.

“Since [1984], the field of healthcare quality improvement has blossomed tremendously,” CMS wrote in a May 2013 letter to the field. “The need for QIOs has evolved from utilization review alone to convening complex local communities that can span state boundaries, particularly as health delivery systems become more horizontally and vertically integrated and new alliances form.” In response to this change in healthcare quality improvement, CMS reorganized the QIO program in order to “maximize program efficiency while improving the quality of care Medicare beneficiaries receive.”

The QIO functions previously performed by the Arkansas Foundation for Medical Care as the designated Arkansas QIO, now will be performed by two different QIOs, each with distinct areas of responsibility.

**BENEFICIARY AND FAMILY-CENTERED CARE QIO**

Phase I of the CMS QIO restructuring, announced on May 9, reduced the number of QIOs performing reviews and appeals from 53 to just two nationwide. These two QIOs, designated as Beneficiary and Family-Centered Care QIOs (BFCC-QIOs), are Livanta, LLC, of Annapolis Junction, Maryland, and KePRO of Seven Hills, Ohio. The BFCC-QIOs are responsible for quality of care reviews, discharge and termination-of-service appeals, beneficiary complaints and medical necessity reviews.

Effective August 1, KePRO became the BFCC-QIO charged with performing all reviews and appeals for Arkansas hospitals. KePRO was awarded the CMS contract for Areas 2, 3 and 4, which include the following jurisdictions:

**AREA 2:** District of Columbia, Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
AREA 3: Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, North Dakota, New Mexico, Oklahoma, South Dakota, Tennessee, Texas, Utah, Wyoming

AREA 4: Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin

Each hospital is required by law to have a Memorandum of Agreement (MOA) in place with KePRO. In addition, to ensure efficient communication with the BFCC-QIO, Arkansas hospitals should ensure that they have completed a Provider Update Form designating a QIO Liaison and Medical Record/Appeal Contact for the organization. Both the MOA and Provider Update Form are available at https://www.keproqio.com/providers/agreement.aspx.

According to CMS, the BFCC-QIOs are responsible for ensuring consistency in the review process with consideration of local factors important to beneficiaries.

QUALITY INNOVATION NETWORK QIO

On July 18, CMS completed Phase II of its restructuring when it awarded contracts to 14 Quality Innovation Network QIOs (QIN-QIOs). According to CMS, the primary role of the QIN-QIO is to drive quality by providing technical assistance, convening networks for sharing best practices, and collecting and analyzing data for improvement.

Specifically, each QIN-QIO will work on strategic initiatives such as reducing healthcare associated infections, reducing readmissions and medication errors, working with nursing homes to improve care for residents, supporting clinical practices in using interoperable health information technology to enable the exchange of essential health information to improve the coordination of care, promoting prevention activities, reducing cardiac disease and diabetes, reducing healthcare disparities and improving patient and family engagement. QIN-QIOs will also provide technical assistance for improvement in CMS value-based purchasing programs, including the physician value-based modifier program.

The Texas Medical Foundation (TMF) received the contract for the region including Arkansas, Missouri, Oklahoma and Texas. To serve the 4-state region, TMF subcontracted with two longtime, successful quality improvement entities, Primaris and the Arkansas Foundation for Medical Care (AFMC), which served as the QIO for Arkansas for 30-plus years.

According to TMF, it plans to provide assistance and engage providers “through numerous Learning and Action Networks, [which] serve as information hubs to monitor data, engage relevant organizations, facilitate learning and sharing of best practices, reduce disparities and elevate the voice of the patient.”

PROBLEMATIC TRANSITION

The transition from a single state-based QIO to two QIO prime contractors based out-of-state has been far from smooth. Since the transition date of August 1, hospitals across the country have reported significant difficulty contacting and communicating with their appointed BFCC-QIO.

On August 22, the American Hospital Association and the Federation of American Hospitals sent a joint letter to CMS listing some of the challenges faced by patients and hospitals, including the following:

- Excessive wait times – in some cases 10 or more days – for a decision from the QIO on whether a discharge should occur.
- Lengthy waits to reach the QIO by phone, with patients or family members on hold for up to two hours and some hospital staff on hold for as long as six hours before reaching a BFCC staff member to file an appeal request.
- Paperwork that has been lost by the QIO in several instances.
- BFCC reviewing physicians overwhelmed with the volume of requests and charts.
- BFCC decisions being sent to patients instead of hospitals and conflicting information given to patients and hospitals about what the BFCC’s decision was on an appeal.

CMS has been working with the BFCC-QIOs to address these issues, and it reports that there has been a reduction in the number of repeat callers requesting a case review status update, as well as reduction in call center wait times. The QIOs have increased the number of staff on hand to receive calls, and both BFCC-QIOs are reporting significant improvement in case review backlog reduction.

On September 8, KePRO sent a letter to providers, including Arkansas hospitals, apologizing for the lack of information provided regarding the QIO Program restructuring and offering the following contact information:

**Address**
KEPRO
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131

**Telephone**
Local: 216-447-9604
Toll Free: 844-430-9504
TTY: 855-843-4776

**Facsimile**
844-878-7921

In addition to concerns about the BFCC-QIO transition, many hospitals are reporting concerns that the regionalization of the QIN-QIO work will mean less hands-on technical assistance from QIO quality improvement personnel. Over the years, AFMC has provided valuable on-site assistance to Arkansas hospitals for a variety of quality improvement projects, enabling hospitals to make great strides in improving care for Arkansans.

Hospitals hope that the regionalization of this QIO improvement work will not mean a move away from this model. While hospitals appreciate virtual learning and support, there simply is no substitute for in-person assistance in advancing quality improvement.

The Arkansas Hospital Association has enjoyed a collaborative relationship with the Arkansas QIO and is ready to assist in any way possible to smooth the transition to the newly restructured QIO model.
Arkansas Health Insurance Marketplace in Year 2: Gearing Up for Continued Success

With its first year of providing high-quality and affordable coverage to more than 220,000 Arkansans coming to close, the Arkansas Health Insurance Marketplace is preparing to help even more people in its second year of operations. Now is the perfect time to reflect on the past year and make plans for open enrollment for the 2015 plan year, which begins November 15.

**ARKANSAS MARKETPLACE ENROLLMENT**

As of October 5, approximately 226,000 Arkansans had acquired coverage through the Arkansas Health Insurance Marketplace. The vast majority of enrollees are covered under the Arkansas Private Option (APO), the state’s innovative program that uses funding available through the Affordable Care Act to provide private health insurance for low income Arkansans. There are two groups of individuals covered through the Health Insurance Marketplace in Arkansas – Private Option Enrollees and Standard Marketplace Enrollees.

**OPEN ENROLLMENT FOR 2015**

The Open Enrollment period for 2015 coverage is November 15, 2014 to February 15, 2015. Individuals whose incomes are above 138% FPL can enroll in plans through the Marketplace only during open enrollment.

Hospitals are encouraged to work with local coalitions to help get people enrolled during the open enrollment period. This year’s enrollment period is only half as long as the enrollment period for last year.

**RE-ENROLLMENT FOR 2015**

Some hospital patients may be confused about their re-enrollment options. Those already enrolled should be on the lookout for notices mailed to them which will inform them of all of the details about how to re-enroll for 2015. For additional information, your patients may want to contact the Arkansas Health Connector Resource Center at the Arkansas Insurance Department (AID) at 1-855-283-3483.

**RESOURCES**

The Arkansas Insurance Department Health Connector Division has four consumer-focus cards available – How to Use Health Insurance, Health Insurance Special Enrollment, 2015 Open Enrollment (English and Spanish versions). The cards may be downloaded and printed from the Division’s website at [http://ahc.arkansas.gov/assisters/get-informed/](http://ahc.arkansas.gov/assisters/get-informed/), and a limited number are available through the Division by contacting Bruce Donaldson, acting Consumer Assistance Specialist at the AID, at 501-683-7077 or at bruce.donaldson@arkansas.gov.
Certified Application Counselors: An Essential Hospital Resource

From the Arkansas Department of Insurance

Uncompensated care has drained hospitals of much-needed resources for years. The Health Insurance Marketplaces created by the Affordable Care Act have provided financial relief for hospitals by getting patients insured.

Insured customers mean hospitals, doctors and other healthcare providers are properly compensated for helping people recover from illnesses, and in many cases, for saving lives.

Many Arkansans, however, have yet to take advantage of the new health insurance options available to them. Many hospital bills remain unpaid.

So, what can Arkansas hospitals do to convert this non-paying consumer base to being among the insured?

By becoming Certified Application Counselor (CAC) organizations, hospitals can help sign up consumers for Marketplace plans. Individual CACs are required to be associated with a “CAC organization” and be licensed by the Arkansas Insurance Department (AID). There is federal and state training required through the AID and a licensing fee of $35 for an individual CAC.

About a dozen hospitals in Arkansas so far have taken the steps necessary to be designated as CAC organizations. There are currently 237 individuals licensed as CACs associated with about 30 CAC organizations statewide.

The CAC program provides a way for healthcare providers and community-based organizations to help uninsured Arkansans apply for and enroll in health coverage through the Health Insurance Marketplace.

As a designated “CAC organization,” a hospital makes available trained staff to assist people with getting health coverage through the Marketplace. Once trained and licensed, the individual CACs can help people understand, apply and enroll in quality health plans through the Marketplace and the Arkansas Healthcare Independence Program (Private Option).

To apply to become a “CAC organization,” the organization must file the federal approval letter with the Arkansas Insurance Department by emailing it to: bruce.donaldson@arkansas.gov. All individual CACs must be affiliated with a CAC organization.

To apply to become a “CAC organization,” complete the application online at http://marketplace.cms.gov/help-us/cac-apply.html.

Once an organization is granted federal approval to become a “CAC organization,” the organization should begin the process immediately to license staff and volunteers it wants to serve as individual CACs, as open enrollment for 2015 begins Nov. 15, 2014. This process will involve ensuring that these staff and volunteers have completed the required CMS-approved training and examination, as well as the Arkansas state-specific training, examinations and licensing.

The Arkansas Insurance Department has notified all current CACs that they must be re-licensed for 2015.

For more information about the CAC program, contact Bruce Donaldson, acting Consumer Assistance Specialist at the Arkansas Insurance Department, at 501-683-7077 or at bruce.donaldson@arkansas.gov.
Safe Surrender

From the Arkansas Department of Human Services

More than a decade ago, the Arkansas legislature passed the “Safe Haven Act,” which allows a parent to give up a baby who is 30 days old or younger at a hospital emergency department or law enforcement agency with no questions asked. Enacted to protect the lives of newborns, the Arkansas law allows a parent to relinquish the baby anonymously and without fear of prosecution for abandonment. Until this year, however, there was no funding available to educate parents, hospitals or law enforcement agencies about the law.
Through the efforts of Senator Cecile Bledsoe during the 2014 fiscal session of the Arkansas legislature, funding was allocated for the Safe Haven Act educational effort. The public outreach campaign focuses on providing information not only to parents who may find themselves in crisis and unable to take care of their babies, but also to the people who will be accepting those babies at safe haven locations.

As the Arkansas Department of Human Services (DHS) rolls out the Safe Haven education campaign, DHS wanted to ensure all hospital emergency department employees are aware of what the Safe Haven law means for them.

The public outreach campaign focuses on providing information not only to parents who may find themselves in crisis and unable to take care of their babies, but also to the people who will be accepting those babies at safe haven locations.

“We felt it was important to think about what hospital staff might need to know when a scared mom comes in with a baby,” said DHS Communications Director Amy Webb. “So we created a simple toolkit that has been mailed to hospitals and is available online.”

Your hospital may already have received the packet of information from DHS, which includes:

- Protocols and guidelines for emergency department employees to follow when a parent surrenders an infant,
- Frequently asked questions about the law and associated answers,
- A vinyl sticker with the Safe Haven logo that hospitals are encouraged to place on the emergency department door or window as a way of identifying the hospital as a Safe Haven location,
- Information cards to be given to the parent surrendering an infant,
- Informational posters,
- And voluntary medical information forms that should be offered to the parent.

DHS has launched a newly created website, www.arkansassafehaven.org, where additional copies of all these materials can be found or requested. The website includes a list of all Safe Haven locations, guidelines for law enforcement agencies and hospitals, as well as an educational video about the law and its impact.

Though few parents have chosen to surrender babies under Arkansas’s Safe Haven Act, the law does provide a safe alternative to leaving an infant outside where he or she could die from exposure or in an unsafe location where the baby may not be found until it is too late. With additional outreach and education about the law, parents in crisis will know about the availability of this option as a safe alternative to criminal infant abandonment.

If you have questions about the website or educational materials, or would like to request additional copies, please contact Amy Webb at the Arkansas Department of Human Services at amy.webb@dhs.arkansas.gov.

THE ARKANSAS SAFE HAVEN LAW

- What Age Child May Be Left at a Safe Haven? A baby who is 30 days of age or younger may be left at a safe haven.

- Who May Leave a Baby at a Safe Haven? Either parent may relinquish the child.

- Where Are the Safe Havens? Law enforcement agencies and hospital emergency departments are the only safe haven locations under the law.

- What Protections Do the Parents Have? The parents are protected from prosecution for abandoning the baby. If there was abuse or neglect before the baby was left at the safe haven, the parents still may be prosecuted for those actions.

- What Should Hospitals Do for a Safe Haven Baby? The law requires hospitals to accept emergency protective custody of the baby and provide necessary medical care. Hospitals also must contact the DHS Division of Children and Family Services at 1-800-482-5964.

- What Protections Do the Safe Havens Have? Hospitals and law enforcement agencies have no criminal or civil liability for good faith acts or omissions under the Safe Haven Act.

- Elisa M. White, Vice President and General Counsel, Arkansas Hospital Association
AHA 2014 Diamond Awards

Recipients of the Arkansas Hospital Association’s 2014 Diamond Awards have been selected. The 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 Awards and Certificates of Excellence 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 134 entries. The top awards (Diamond) were presented at the Awards Dinner on Thursday, October 9, during the Arkansas Hospital Association’s 84th Annual Meeting and Trade Show at the Little Rock Marriott.

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

AHA Debuts Price Transparency Toolkit

In support of continuing efforts to improve how hospitals and health systems are communicating price information with their patients and their community, the American Hospital Association’s (AHA) Community Connections initiative has developed “Achieving Price Transparency for Consumers: A Toolkit for Hospitals,” a resource designed to spark conversation and action by allowing hospitals to assess their current efforts and learn from others through case examples and sample price transparency tools.

The toolkit, which will be updated regularly, can be found at http://www.ahacommunityconnections.org/tools-resources/transparency.shtml. It contains action items and a self-assessment checklist to help identify where organizations are on the price transparency journey, and where their next steps may lie. Other information includes:

- Case Examples – Learn from other hospitals’ insights about their work in price transparency; includes contact information for follow-up interest.
- Sample Web-based Tools – Review examples of websites from hospitals, health systems and state hospital associations that allow consumers to find price estimates.
- Resources – Browse and tap into this collection of price transparency tools, documents and publications to support your efforts.

Congratulations to all of the 2014 Diamond Award Winners!

Arkansas Children’s Hospital, Little Rock
Arkansas Heart Hospital, Little Rock
Arkansas Hospice, North Little Rock
Arkansas Methodist Medical Center, Paragould
Baptist Health Medical Center-Hot Spring County, Malvern
Baxter Regional Medical Center, Mountain Home
Conway Regional Health System
Harris Hospital, Newport
Howard Memorial Hospital, Nashville
Jefferson Regional Medical Center, Pine Bluff
Mena Regional Health System
Mercy Hospital Berryville
NEA Baptist Memorial Hospital, Jonesboro
Ouachita County Medical Center, Camden
Ozark Health Medical Center, Clinton
Sparks Health System, Fort Smith
St. Bernards Medical Center, Jonesboro
Summit Medical Center, Van Buren
Washington Regional Medical System, Fayetteville
White County Medical Center, Searcy
Building Arkansas’ Newest Hospital

Baptist Health Medical Center-Conway
Opening 2016

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Rendering by GSR Andrade Architects, Inc.
New Survey Shows Physician Appointment Wait Times

By Michelle Murphy, Merritt Hawkins

Access to healthcare insurance is expanding, but what about access to physician services? A new survey from Merritt Hawkins, the nation’s leading permanent physician and allied jobs placement service, addresses this question.

The national survey of 1,399 medical offices tracks the average time needed to schedule a new patient doctor appointment in 15 large metropolitan areas. The survey reports average new patient doctor appointment wait times in five different medical specialties: cardiology, dermatology, obstetrics/gynecology, orthopedic surgery and family practice.

Boston is experiencing the longest average doctor appointment wait times of the 15 metro markets examined in the survey: 72 days to see a dermatologist, 66 days to see a family physician, 46 days to see an ob/gyn, 27 days to see a cardiologist, and 16 days to see an orthopedic surgeon. On average, it takes over 45 days to schedule a new patient doctor appointment in the Boston area, the survey indicates. In each of the three years Merritt Hawkins has released the survey (2004, 2009, 2014) Boston has averaged the longest physician appointment wait times among the 15 cities.

Other average physician appointment wait times tracked by the survey include 28 days to see a cardiologist in Denver, 49 days to see a dermatologist in Philadelphia, 35 days to see an ob/gyn in Portland, 18 days to see an orthopedic surgeon in San Diego, and 26 days to see a family physician in New York. Physician appointment wait times tracked in the survey varied from as little as one day to over eight months, with an overall average in all metro areas and all specialties of about 19 days.

The survey underlines the fact that finding a physician who can see you today, or three weeks from today, can be a challenge, even in urban areas where there is a high ratio of physicians per population. The challenge can be potentially more daunting in states like Arkansas, where physician-to-population ratios often are below the national average.

The survey also tracks how many physician practices accept Medicaid as a form of payment in the 15 metro markets. Boston has the highest rate of Medicaid acceptance tracked in the survey at 73%, while Dallas has the lowest at 23%. The overall average rate of Medicaid acceptance for all five specialties in all 15 markets is 45.7%, the survey indicates.

As these numbers suggest, having health insurance does not always ensure access to a physician. More physicians will need to be trained, and access to other types of providers expanded, to ensure that healthcare delayed does not become healthcare denied.

Any Arkansas Hospital Association member may request a complimentary copy of the survey by contacting Michelle Murphy at 800-876-0500 or michelle.murphy@merritthawkins.com.

Michelle Murphy is a Marketing Consultant with Merritt Hawkins, the nation’s leading physician search firm and a company of AMN Healthcare.
The AHA Workers’ Compensation Self-Insured Trust Board of Trustees approved at its quarterly meeting on July 25 a $700,000 Return of Premium for hospitals that qualify and were participating in the program during the 2010, 2011 and 2012 calendar years. Return of Premiums are based on the 2010, 2011 and 2012 net income of the Trust and are calculated based on a hospital’s loss ratio for the premium year. The premium was remitted to each member in September 2014. Percentages of the Trust’s incomes returned have averaged 23-27% since 2003, while continuing to maintain a healthy fund balance to meet all workers’ compensation obligations.

The program offers workers’ compensation for Arkansas Hospital Association members and grows more successful each year. The board of trustees is composed of the following: Chairman David Deaton, Vice Chairman Barry Davis, Phillip Gilmore, Peggy Abbott, Luther Lewis, Bob Trautman and Group Manager Tina Creel, nonvoting. The AHA Workers’ Compensation Self-Insured Trust is administered by Risk Management Resources, a subsidiary of Ramsey, Krug, Farrell and Lensing in Little Rock.

Hospitals interested in participating with the program should contact Tina Creel at 501-224-7878. Or, contact Floyd McCann, RMR’s Arkansas representative, at 800-690-4540.
Arkansas Payment Improvement Initiative

By Paul Cunningham, Executive Vice President, Arkansas Hospital Association

For years, Arkansas has trailed the pack in health rankings, at least the biggest part of the pack. Pick any survey conducted over the past decade that assesses state health environments and you’d likely find Arkansas ranked anywhere from 45th to 50th among all states. Whether the results come from the United Health Foundation, Gallop-Healthways or USA Today, Arkansas historically has been cited for an amalgam of unhealthy characteristics related to smoking, obesity, diabetes, preventable hospitalizations, poor mental healthcare and other shortcomings.
You might think there would be a correlation between Arkansas’s dismal state of health and overall spending on healthcare services, but you’d be wrong. In 2011, a Kaiser Family Foundation report showed that Arkansas’s per capita health spending outpaced 33 other states, including several neighboring states which share Arkansas’s poor health rankings. Like the kudzu that is slowly overtaking the southeastern United States, a variety of deep-rooted health-related issues is clearly choking the physical and financial well-being from the state: and they appear to be resistant to eradication by money alone.

Today, just as groups are combining with joint efforts to rid states of the kudzu that engulfs over seven million acres of the Deep South, there are a lot of people working together in a joint effort to establish a new healthcare delivery model that could resolve the issues keeping Arkansas among the unhealthiest of states.

COMING TOGETHER

In 2010, the Arkansas Department of Human Services’ (ADHS) Medicaid Program, facing an unsustainable spending growth rate averaging 7%-8% per year – a part of that health spending problem – developed a vision for transitioning the state’s healthcare system into one that is “patient-centered” across payer groups with the triple aim of improving the health of the population; enhancing the patient experience of care, including quality, access and reliability; and reducing, or at least controlling, the cost of healthcare services delivered in both inpatient and outpatient settings. That vision is known as the Arkansas Payment Improvement Initiative (APII).

At its core, this coordinated multi-payer, statewide effort is built around care delivery models which focus on patient needs rather than any particular delivery system structure, evidence-based care and the coordination of patient care across provider settings.

The idea to pursue such an encompassing change in both the mind-set and practical application of a healthcare delivery model stemmed from the state’s need to rein in Medicaid spending, but the general consensus was that the APII couldn’t be successful without the involvement and buy-in of other Arkansas payer organizations and healthcare providers. There was even a glimmer of hope that the federal Medicare program could be convinced to join.

So, state officials began courting leaders of the two largest private payers in the state, Arkansas Blue Cross and Blue Shield and QualChoice of Arkansas, who also saw an opportunity to make a meaningful change, which, if successful, would put Arkansas at the forefront of healthcare innovation. Together, ADHS and the two health plans, along with the McKinsey consulting group and the Arkansas Center for Health Improvement (ACHI), began crafting a conceptual design for the APII. In 2011, workgroups comprised of healthcare providers and other stakeholders started contributing the technical expertise required for the sheet metal, hydraulics and avionics that would lift the system and make it fly for the benefit of patients, as well as providers of high-quality, cost effective care.

OVERVIEW

The first components of the APII were implemented in 2012 with a goal of fully adopting two complementary strategies for promoting clinical innovation on a multi-payer basis across the entire state including:

- **Population-based care delivery** through medical homes, health homes and other care delivery models that bear responsibility for the complete needs of a population.
- **Episode-based care delivery** with coordinated, team-based management of services provided to a patient frequently spanning multiple encounters with the delivery system, such as hip replacement or pregnancy and delivery. The new system is meant to provide Arkansans with easy-to-access, evidence-based preventive care, chronic care management, acute/post-acute care and supportive care where needed.

It will also significantly increase the use of health information technology to deliver patient care, facilitating better coordination and quality outcomes.

Medicaid, Blue Cross and QualChoice agree on basic concepts of the two strategies, but implement them under their individual standards.

Coordinating the APII statewide and among multiple payers ensures that providers need not operate under conflicting systems nor shoulder the complexity of different business rules and reporting requirements for different patient populations. The multi-payer approach also creates sufficient “critical mass” to make incentives substantial enough to support changes in provider infrastructure, clinical decision-making and operational processes.

The APII also has significance beyond Arkansas, especially for other states having predominantly rural populations who are served primarily by independent practitioners in small practices. Successful implementation in Arkansas could present an important model not only for similar states in the Delta region, but also for states across the country that do not have high levels of provider consolidation.

POPULATION-BASED CARE DELIVERY

The vehicle that will carry the majority of the weight of the APII is the patient-centered medical home (PCMH), which is a way of organizing and delivering primary care via a comprehensive, team-based approach that emphasizes care coordination and communication, and is focused on quality and safety. Arkansas’s APII includes two different efforts to advance the use of PCMHs across the state.

Ideally, the PCMHs will enhance the capability to coordinate the care provided through physicians, advanced practice nurses or physician assistants, pharmacists, medical assistants, lab and x-ray technicians, care managers, dieticians, financial counselors, mental health providers, developmental disabilities providers, long-term care providers and home health workers to best serve each patient’s needs.

Care coordination makes better patient care plans within the medical home and provides linkages to community resources for patients’ underlying social needs, such as

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continued on page 38
The new system is meant to provide Arkansans with easy-to-access, evidence-based preventive care, chronic care management, acute/post-acute care and supportive care where needed.

transportation to appointments or help in overcoming physical limitations. Enhanced access for patients is achieved through extended hours of operation and electronic communication. Provider performance is enhanced through real-time access to patient disease registries and individual patient records – positively impacting each patient’s quality of care and leading to improved health outcomes. Medical homes also actively promote prevention services and empower patients with the education they need to stay healthy. Plans call for most Arkansans to have a PCMH by 2018, giving them local access to preventive care and the ability to proactively manage their health.

COMPREHENSIVE PRIMARY CARE INITIATIVE

The first wave of Arkansas’s PCMH implementation received a boost in 2012 when the state was selected as one of seven U.S. markets to participate in the Centers for Medicare and Medicaid Innovation’s Comprehensive Primary Care Initiative (CPC), a multi-payer initiative intent on improving collaboration between public and private healthcare payers to strengthen primary care. With the blessing of federal officials, Medicare agreed to work with the state and commercial health insurance plans on the medical homes program, which has been in place since 1994. More than 300 physicians located at 125 sites in the state not a part of the CPC have joined, and 289,000 Medicaid patients – about 79% of the eligible population for the program – are assigned to medical homes participating with either the CPC or Medicaid’s PCMH program.

While separate and distinct from the CPC initiative, the state’s PCMH model shares the same fundamental purpose to support primary care transformation with funding and expertise to assist physician practices in focusing on team-based strategies, chronic care coordination and healthier patient outcomes.

All practices serving as primary care provider to at least 300 Medicaid patients are eligible to enroll as a PCMH. Practices must also participate in the primary care case management program. Because Arkansas contains large geographic areas served only by small medical practices with modest infrastructure – most having three or fewer physicians – physicians from different parts of the state may align together to form a qualifying practice.

Providers receive a per-member-per-month (PMPM) medical home support payment to help with changes to their current practice operating model. But, participating practices also must provide verifiable evidence of progress in performing their medical home functions and be able to attest to a variety of medical home attributes, subject to validation. Support payments are tied to the success they have in identifying high-risk patients and setting up care plans; ensuring around-the-clock live voice access to a health professional; flexibility on same-day scheduling; installment of meaningful use certified electronic health records, use of E-prescribing and other structural enhancements.

In addition to these ongoing per-member-per-month (PMPM) payments for care coordination, Medicaid pays another dollar PMPM to a technical support vendor to promote practice transformation for those PCMH practices that choose to participate. Plus, just as their counterparts in the CPC practices, physicians who are a part of the PCMH program can earn additional payments through a shared-savings arrangement, if their patient volumes are sufficient.

Also, practices which serve at least 5,000 Medicaid patients who have been attributed to those PCMHs for at least six months are eligible to participate in the PCMH shared-savings program. Since few practice sites qualify for those volume standards on their own, Arkansas Medicaid allows two practices or multiple providers with the same tax I.D. number to pool their patients to achieve the 5,000 patient enrollment threshold, as long as the pooled practices are accountable for their combined quality metrics and attributes of a medical home as outlined in program specifications.

Wave 3 of PCMH implementation will bring along remaining primary care
practices, with the goal of all primary care practices in Arkansas operating in a PCMH model.

**HEALTH HOMES**

Health homes are a more specialized extension of the PCMH model and are set up for people who need an increased level of care coordination or face greater challenges in navigating the healthcare system, such as those with developmental disabilities or behavioral health challenges and those living in long-term care facilities. A health home promotes high-quality care, an improved patient experience and more efficient care. As with PCMHs, providers are responsible for proactively considering the needs of their patients or clients, independent of where they are seeking care, and will receive incentives for promoting wellness and achieving health outcomes.

Health homes serve not as gatekeepers for medical care, but rather as a hub from which the patient may connect with a full array of providers who together form the patient’s health services team. Most individuals eligible for the health home are those who are dually eligible for Medicaid and Medicare (duals) and/or receive most of their services for behavioral health (BH), long-term services and support (LTSS), and/or developmental disabilities (DD).

**EPISODES OF CARE — FINANCIAL INCENTIVES AND SUPPORT FOR PROVIDERS**

APII also shifts away from fee-for-service payments that reinforce fragmented care and overuse of services to value-based payments, such as episode-based payments, that reward effective care coordination, quality and cost-containment. An episode of care is focused on all the care provided continued on page 40

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to treat a particular condition for a given length of time. Arkansas’s approach is clinically based, contains efforts to affect reimbursement and effectiveness of care, and is transparent to patients and providers.

Providers share in the savings or excess costs of an episode depending on their performance for each episode. The participating payers identify the principal accountable providers (PAP) for each episode through claims data. For each episode, all providers continue to file claims as they have previously and are reimbursed according to each payer’s established fee schedule. Providers input some basic information related to the care they provide into a provider portal. Then, through this portal, providers access reports that show the overall quality of care they delivered during a set time period—typically one year—and at what average cost.

At the end of the set time period, each PAP’s average cost per episode is calculated and compared with “acceptable” and “commendable” levels of costs. If the average cost is above the acceptable level, the provider will pay a portion of the “excess” costs. If the average cost is acceptable but not commendable, there will be no payment changes. If the provider offers high-quality care below the commendable level, then he or she will be eligible to share in the savings with the payer.

During the first phase of the payment initiative, Medicaid and the private insurers initially introduced five episodes of care: upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit/hyperactivity disorder (ADHD) and perinatal. In 2014, approximately ten more episodes have been in production, including colonoscopy, cholecystectomy (gallbladder removal), tonsillectomy, oppositional defiant disorder (ODD), coronary bypass grafting (CABG), percutaneous coronary intervention (PCI), asthma, chronic obstructive pulmonary disease (COPD), ADHD/ODD comorbidity and neonatal care.

To date, ADHS has distributed two “gain-sharing” dividends to PAPs whose cost and quality indicators have met or exceeded the adopted standards. Arkansas Blue Cross and Blue Shield and QualChoice have complete one cycle of the payments.

CONCLUSION

The question remains as to whether the APII will work as hoped for over the long run. Initial results have been promising both for the PCMHs and the episodes of care. The uptake on the PCMHs has been particularly surprising. And while neither component of the APII has been operational long enough to adequately measure the impact on costs, early indications are that they have had some effect on keeping the Medicaid spend growth rate at historically low increases for the past two years.

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Patient-Centered Medical Homes in Arkansas:
A Pathway to a More Satisfying Medical Practice

By J. Craig Wilson, JD, MPA, Director, Access to Quality Care, Arkansas Center for Health Improvement

Sam Smith is 38 years old. A couple of years ago his life changed dramatically when he decided to take a leap and start his own business. The new business was earning him a fairly good living, but one thing Sam had not considered was how much it would cost to replace the health insurance his former employer provided. After shopping around, he found that buying a policy on his own was more than he could squeeze out of his budget. He thought it was something he could do without. What Sam doesn’t know is that he has prediabetes, a precursor to type 2 diabetes that puts him at a 50 percent higher risk for heart disease and stroke.

Sam is not alone. In Arkansas more than half of the adult population are living with at least one chronic disease. Too many of these people are not receiving treatment or effectively managing their conditions. Some, like Sam, have not seen a doctor because they do not have health insurance. Still others, who have seen a doctor, continue on without effective management of their chronic diseases. Many wind up in the hospital over and over for the same conditions. Without effective management, chronic conditions eventually get worse and more costly, especially as people grow older. Absent significant restructuring of our healthcare system, Arkansas’s high burden of chronic disease and aging population will eventually bury us in an avalanche of costs.

The Patient Protection and Affordable Care Act (ACA) is intended to significantly reduce the number of Arkansans who are uninsured. However, the ACA does not do enough to improve the quality of care, reduce care costs or remedy the frustration many healthcare providers experience from trying to operate in a broken healthcare system. Even before the ACA went into effect, Arkansas leaders knew something had to change. We are now well down a path toward maximizing the benefits of the ACA for our citizens while leading the country in innovations designed to meet the needs of Arkansans. The Arkansas Health Care Payment Improvement Initiative (AHCIPII) is one of the innovations Arkansas has put in place to address these issues.

The AHCIPII is designed to improve Arkansas’s health system in three ways, each with its own quality assurance and cost reduction components. The three elements of the AHCIPII are:

- Patient-centered medical homes (PCMHs), focused on keeping people well, managing chronic conditions like diabetes or asthma, and proactively meeting the needs of patients.
- Health homes, to help patients with complex needs requiring additional guidance and care.
- Episodes of care providing incentives for improved management of specific conditions like joint replacement, pregnancy, or even the common cold.

For Sam and the many Arkansans living with chronic diseases, the PCMH approach is expected to optimize care across the healthcare continuum. The PCMH model offers a respite for healthcare providers frustrated with “assembly-line” medicine that is centered on acute, or sick care, rather than on keeping patients healthy. With a focus on team-based care coordination, PCMHs can be an ally for hospitals, helping to reduce avoidable hospitalizations and potential penalties through better coordination of care transitions. Hospitals can be a partner to PCMH providers in several complementary and supportive ways. One way is to join and optimize the use of Arkansas’s information technology infrastructure to provide PCMH practices with secure messaging of admission, discharge and transfer information for their patients seen by the hospital within the previous 24 hours. The Arkansas health information exchange, known as SHARE (State Health Alliance for Records Exchange), provides this capability and now does so in a more affordable way through SimpleSHARE. SimpleSHARE offers hospitals and other providers a way to connect to SHARE through an existing Health Information Service Provider (HISP) without having to invest in the full health information exchange integration.

PCMHs are not physical locations, but instead are care teams that take responsibility for the overall health of patients. A patient’s team is led by a designated primary care doctor who continues on page 42.
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an eligible panel of 2,000 patients could receive an average of $120,000 over 12 months to be used for new investments in clinical operations that achieve effective care coordination, patient engagement and improved outcomes. With anticipated multi-payer PCMH participation of private carriers in the health insurance marketplace (HIM) in 2015, the state is making a significant investment in the PCMH model to enable primary care practices to achieve these goals.

**SHARED SAVINGS**

PCMH practices can earn shared savings payments by either achieving risk-adjusted, average per person beneficiary spending below the established statewide benchmark or medium cost threshold ($2,032 for Medicaid for 2014), or by improving their own previous year performance. The shared savings model is an upside-only model, which means that practices are not currently at risk if they do not achieve savings.

Shared savings eligibility requires 5,000 Medicaid patients who have been attributed to a PCMH for at least six months. Since most practices do not have a sufficient number of patients to reach this threshold, Arkansas Medicaid allows practices to pool their patients to achieve the 5,000 patient enrollment requirement as long as the pooled practices are accountable for their combined quality metrics and attributes required of a PCMH. Some providers have formed collaborative pools with nearby practices to meet this requirement. In 2015, a statewide default pool will provide another way for practices to participate in shared savings.

**QUALITY METRICS**

PCMHs that are eligible for shared savings must achieve quality metrics that measure performance and help guide improvement. Quality measures include the percentage of patients who get well-child visits, diabetic monitoring and follow-up for attention deficit/hyperactive disorder (ADHD) care. Once electronic medical records and SHARE are more fully integrated, clinical data measures including blood pressure control and diabetic management will be added to the quality metrics.

**COMPREHENSIVE PRIMARY CARE AND MULTI-PAYER INVOLVEMENT**

Arkansas was selected as one of seven markets in the United States to take part in Medicare’s Comprehensive Primary Care (CPC) initiative beginning in October 2012, giving a boost to the state’s efforts to transition to patient-centered care. This included PMPM support and incentives from Medicare. Arkansas coordinated its CPC application to include Medicaid and its two largest commercial health insurance carriers, Arkansas Blue Cross and Blue Shield and QualChoice. Since that time Humana has also joined the CPC initiative.

There are now 63 practice sites participating in the CPC initiative. A subsequent rollout of Arkansas’s PCMH initiative has resulted in a total of 912 participating primary care providers, 20 percent of which opted to pool for shared savings. Arkansas Medicaid set a goal of having 40 percent of its beneficiaries enrolled in a PCMH. That target was exceeded, reaching 79 percent or 289,000 beneficiaries.

Self-insured employers including Walmart, the state and public school employees, and the state university system are also planning to participate in the PCMH model. In addition, state efforts are actively underway to secure other self-insured employer participation.

In addition, Arkansas’s Healthcare Independence Act of 2013, often referred to as the “private option,” requires all insurance carriers offering coverage on the HIM to participate in supporting the PCMH program, beginning January 1, 2015. The Arkansas Insurance Department is in the process of promulgating a rule that will reinforce the state’s PCMH model.

For Sam, who found affordable coverage on the new HIM, being enrolled in a PCMH has changed his life for the better. His high blood sugar levels were identified, and he has received counseling on the need for better nutrition and physical activity to control his condition. A nutritionist provides guidance in preparing healthy meals for him and his children. And, a care coordinator works with him to make sure he is getting routine monitoring.

In time, a system-wide adoption of the PCMH model will provide all Arkansans with coordinated, team-based care to help improve and maintain their health. At the same time, Arkansas will become a more satisfying and rewarding place in which to practice medicine.

**Framework for transformation**

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<th>Activity</th>
<th>Commit</th>
<th>Start</th>
<th>Evolve</th>
<th>Continue</th>
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<td>Identify Team Lead(s)</td>
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<td>0-3</td>
<td>6</td>
<td>12</td>
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<tr>
<td>Assess opportunities to improve</td>
<td>✔️</td>
<td>6</td>
<td>12</td>
<td>16-18</td>
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<td>Develop implementation strategy</td>
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<td>Survey patients</td>
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<td>Approach to preventive care contact</td>
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*Completion of activity and timing of reporting*
Looking back to 2010, major negotiations took place at the national level to create the Patient Protection and Affordable Care Act (PPACA). In those negotiations, hospitals took a reduction of more than $550 billion to Medicare reimbursements in the hope that the uncompensated care burdens all hospitals around the country were absorbing would be reduced. In exchange for accepting the reduced Medicare reimbursement rates, the Medicaid program – which in 1964 was designed specifically to ensure healthcare for families with very low incomes – would be significantly expanded to also cover the working poor, individuals up to 138% of the federal poverty level.

For a variety of reasons, mostly political, many of the PPACA provisions were called into question and were evaluated by a series of courts within the judicial system. Finally, the Supreme Court issued a ruling that no longer required each state to expand eligibility for current Medicaid programs. PPACA had provided a solution to the reduced Medicare payments by allowing more individuals to be eligible for the Medicaid program; however, the Supreme Court took away the guarantee of a significant increase in the number of overall covered individuals.

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This was bad news for hospitals. Arkansas hospitals, due to PPACA alone, faced an estimated $2 billion reduction in Medicare payments over ten years. On top of that, by the time the Supreme Court made its decision about PPACA, two more federal acts and a plethora of costly administrative regulations had passed that further reduced reimbursements to hospitals. Arkansas hospitals were left in a dire situation. With uncompensated care costs expected to reach more than $400 million each year, it appeared that forecasts of positive balance sheets for hospitals would be nothing more than a figment of hospital CEOs’ imaginations.

Prior to the 2013 regular legislative session, the Arkansas Hospital Association and a variety of stakeholders lobbied the Arkansas General Assembly for Medicaid expansion. It was evident that neither the members of the Arkansas General Assembly nor the Governor were interested in allowing Arkansas hospitals to buckle under the pressure of reduced Medicare reimbursements with no hope of decreasing the uncompensated care loads they were no longer able to absorb. However, many members of the General Assembly were clear that there was no way that Arkansas would expand the traditional Medicaid program. With the requirement that any funding for the Medicaid program be approved by 75 percent of the House and Senate, respectively, expanding the traditional Medicaid program was a non-starter!

As the pressure of reduced reimbursements were taking a toll on Arkansas hospitals, CEOs, CFOs and other hospital advocates began to be able to provide real data to legislators, policy makers and other stakeholders. The Governor and key leaders of the legislature began to craft a new idea, altogether – one that would help reduce the uncompensated care load that hospitals were suffering from while keeping poor, uninsured individuals from becoming enrollees of the traditional Medicaid program. This plan, now known as the Arkansas Private Option, provided a way to use the dollars that the federal government would have spent on expanding traditional Medicaid to purchase premiums through the Health Insurance Marketplace so that Arkansans had the ability to select private insurance plans.

The Arkansas Private Option is working incredibly well for Arkansans and for Arkansas’s hospitals. With more than 200,000 Arkansans covered and early signs of success, it is imperative that the program continue to make progress!

**THE PATH TO THE PRIVATE OPTION**

The Arkansas Private Option is an innovative approach to expanding healthcare coverage in Arkansas. It allows for the purchase of private insurance plans through the Health Insurance Marketplace, using federal funding that would have otherwise gone to expanding Medicaid. This approach has proven successful in reducing uncompensated care costs for hospitals and improving healthcare access for Arkansans.
The Arkansas Private Option idea was much better for Arkansas than traditional Medicaid expansion would have been. Medicaid reimbursements for most healthcare providers do not cover the cost of providing care for Medicaid patients, and many healthcare providers were already at their maximum capacities of Medicaid patients on their patient panels. The Arkansas Private Option provided healthcare providers with the opportunity to be reimbursed at private insurance rates, which have historically been higher than traditional Medicaid payment rates. For Arkansas's hospitals, this opportunity was a fantastic one.

**KEEPING OUR HOSPITALS HEALTHY**

Lobby efforts for the Arkansas Private Option were and still are full speed ahead. Barely reaching the requirement in the 2013 regular session and squeezing through the 2014 fiscal session with a few more legislative hurdles added to the administration of the program, ensuring the Arkansas Private Option’s longevity and continued success is certainly not guaranteed. The November 4 elections will all but seal the fate of the Arkansas Private Option. There are four General Elections in the State Senate and 38 in the House of Representatives. If all of the House of Representative incumbents who are contested in this cycle win re-election and continue to vote as they voted in the 2014 fiscal session, 21 or 22 NEW House members will need to vote for the appropriation for the Arkansas Private Option for Arkansas to be able to keep the program.

The data to support the Arkansas Private Option are promising. The Arkansas Hospital Association sent a voluntary survey to all acute care hospitals and received 42 responses. While only a snapshot, that survey suggested that the total number of emergency room visits is declining; that more individuals seeking care continued on page 46
in the emergency room are now insured; and that more individuals seeking inpatient care are insured. Another survey is being conducted by the AHA and HFMA and will be released very soon.

In addition to the business data, patient stories continue to define the Arkansas Private Option. After all, hospitals exist to serve patients and communities. With more than 200,000 Arkansans insured in Arkansas through the Arkansas Private Option, the likelihood of better health outcomes and a healthier Arkansas have a real shot at becoming a reality.

In the months leading up to the 90th General Assembly, which will begin in January with a new Governor and many new members of the legislature, it is imperative to continue to gather and report data on the progress of the Arkansas Private Option. The Arkansas Hospital Association and members of the healthcare community, as well as stakeholders for the Arkansas Private Option, will continue to tout the benefits of the program and will stand ready to continually improve it as opportunities present themselves.

Arkansas’s hospitals will forever be grateful to the Governor and the members of the 89th General Assembly for truly giving hospitals a fighting chance by creating the Arkansas Private Option. There is no rest for the weary, though. Today, Arkansas hospitals must keep fighting.
Bill’s first job after graduating college in 1974 was at the corporate headquarters of Hospital Corporation of America (HCA) in Nashville, Tennessee. Bill has a BSBA in Accounting, an MBA, and a Juris Doctorate from the University of Arkansas. He is also a CPA (Inactive). After leaving HCA in 1981, Bill has practiced law in Little Rock, Arkansas, representing hospitals and other healthcare providers.

Bill has extensive experience in complex issues inherent in healthcare laws which affect hospitals. He provides representation related to transactions such as the purchase or sale of healthcare facilities and also the purchase of physician practices and the formation of physician hospital joint ventures. Bill also provides representation related to resolution of Medicare and Medicaid reimbursement disputes, development of hospital compliance policies, development of HIPAA compliance policies, compliance with the Stark and Anti–Kickback statutes, tax-exempt matters for non-profit hospitals, development of PHO’s, Clinically Integrated Networks and ACO’s, and compliance with other laws which regulate hospitals. Bill Marshall has represented hospitals for 40 years.
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