Partners in Caring

Hospitals and Their Volunteers

BONUS PULLOUT SECTION:
SALUTE TO HOSPITAL QUALITY
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.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
For Arkansans, this election carries major consequences when it comes to health care. It’s important to listen to what candidates for national office are saying, particularly about cuts to health care reimbursement.

At the federal level, more cuts to Medicare or changes to Medicaid policy can hurt not only Arkansans, but the hospitals that take care of them. America’s hospitals have borne the brunt of too many cuts already. More reimbursement cuts are unthinkable.

In addition, the American Hospital Association has requested U.S. Health and Human Services Secretary Sylvia Burwell to consider policy and operational changes that directly impact insurance exchanges, due to large insurers pulling out of some state insurance marketplaces. Insurance exchange stability is important to all of us, but especially to the nearly 308,000 Arkansans insured through the Private Option (which, in December, changes to Arkansas Works).

Statewide elections matter for those 308,000 insured Arkansans, as they do to every hospital and every patient or potential patient in Arkansas. The future of Arkansas Works matters. We need to listen to the platforms of candidates for the Arkansas General Assembly. What do the candidates say about supporting Arkansas Works? What do they say about supporting Arkansas hospitals? Most important, what do they say about improving the health of Arkansans?

So, our message regarding the coming elections is short and sweet. Please listen closely to the candidates, with an ear that’s keying in on health care. Please learn what the candidates are saying, and when you have a chance, ask them specifically how they will support Arkansas hospitals going forward.

Please carefully consider all of the options, and please vote. More than ever, words matter, and it’s important that we’re paying attention.

Bo Ryall
President and CEO
Arkansas Hospital Association

• Early Voting Begins October 24
• Election Day is November 8
SHARE Launches Clinical Analytics Tool to Help Providers Collect and Report on Patient Data

Arkansas’s State Health Alliance for Records Exchange (SHARE) is launching a clinical analytics tool to ingest, aggregate and normalize data from disparate data sources - including unstructured data. This tool will assist SHARE’s Participants in health care data analysis and reporting by providing a platform that supports both current and future data reporting requirements.

By using SHARE’s clinical analytics tool, health care providers will be able to view their patients’ records based on disease states and will be able to make population health based interventions. In addition, providers will be able to analyze patient data and deliver valuable reports for quality metrics and clinical reporting. These reports will help meet state and federal reporting requirements and help drive decisions around population health management, regulatory reporting, and will include the following benefits:

- Assistance with reporting PQRS, STARS, NQF, AHRQ and other industry-mandated reporting on clinical quality measures
- Data analysis using integrated charts and graphs
- Real time results from query and report runs
- No more waiting for hours or days to gain access to reporting results
- Improved quality of care monitoring at the individual patient level
- Consistent reporting results
- Timely, more accurate population health monitoring

About Arkansas’s State Health Alliance for Records Exchange (SHARE):
With over 1.7 Million patient records, SHARE is the statewide Health Information Exchange committed to driving excellence and innovation through healthcare data management. SHARE is dedicated to transitioning hospitals and clinics from paper to electronic health records and securely connecting systems to SHARE, where patient health records are accessible to all participating treating providers. The vision is a “healthier state population and a greatly improved health care system in which caregivers and patients have electronic access to more complete health records, and are empowered to make better health decisions with this information.”
I’ll admit it. I am a Mister Rogers fan. There was always something so comforting about watching Fred Rogers step inside his door, put on his tennis shoes and cardigan, then end our time together telling me I’d made the day special “just by being me.” Our hospital volunteers do just that every day. They are the helpers whose work makes their hospitals and communities a bit better each day for everyone.

Mister Rogers also reminded us of the importance of caring for our neighbors — a vital part of any community hospital’s mission.

Volunteers are essential partners in hospitals’ efforts to identify and address community health needs. Year after year, these generous individuals contribute time and energy to help care for patients and families, improve quality, provide financial support, promote wellness and improve community health.

Volunteers are running gift shops and hosting fundraisers to sponsor scholarships, provide essential equipment and pay for community outreach initiatives. They are serving on advisory councils and in peer support networks, acting as patient guides and as health coaches. Together, hospitals and their volunteers care for patients and strengthen communities outside the hospital walls.

In this edition of Arkansas Hospitals, we focus on volunteers and the value they bring to hospitals. Look around any hospital in Arkansas or across the nation, and you’re likely to see those helpers Mister Rogers told us about. They are quietly going about their work, reminding us there are still so many caring people in this world.

Elisa White, Editor-In-Chief
Arkansas Hospital Association

CALENDAR

October 5-7, Little Rock
AHA 86th Annual Meeting and Trade Show
The Little Rock Marriott

October 5-7, Little Rock
AHAA 58th Annual Meeting and Trade Show
Embassy Suites

October 5, Little Rock
AHA Board Meeting
The Little Rock Marriott
(in conjunction with AHA Annual Meeting)

October 6, Little Rock
ASHMPR 2016 Fall Luncheon
The Little Rock Marriott
(in conjunction with AHAA Annual Meeting)

October 6, Little Rock
ArONE 2016 Fall Luncheon
The Little Rock Marriott
(in conjunction with AHA Annual Meeting)

October 6, Little Rock
ASDVS Fall Meeting
Embassy Suites
(in conjunction with AHAA Annual Meeting)

October 13-14, Morrilton
AHHRA 2016 Fall Conference
The Winthrop Rockefeller Institute

October 14, Little Rock
SAHPMM 2016 Fall Conference
AHA Classroom

October 25, Little Rock
Passport Common Orientation Program Meeting
AHA Classroom

October 26, Little Rock
Advanced Medical Terminology & Anatomy and Physiology
AHA Classroom

October 28, Little Rock
AAHE Fall Conference
Baptist Health Medical Center

October 26-28, Little Rock
HFMA Fall Quarterly Meeting
Crowne Plaza

November 2, Little Rock
AHA Metro CEO District Meeting
AHA Board Room

November 4, Little Rock
AHAWSIT Annual/Quarterly Board Meeting
AHA Boardroom

November 4, Little Rock
ASWHC Fall Conference
AHA Classroom

November 10, Little Rock
AHAA Board Meeting
AHA Board Room

November 10-11, Franklin, Tennessee
CSR Fall Workshop
Embassy Suites by Hilton
Nashville South Cool Springs

November 11, Little Rock
AHA Board Meeting
AHA Board Room

November 16, Little Rock
Communicating, Networking and Getting Things Done
AHA Classroom
See Highlight

November 17, Little Rock
TCAB Collaboration Meeting
Hilton Garden Inn

November 17, Little Rock
2-for-1 Registration — Communicating, Networking and Getting Things Done: A How-To Guide
November 16

Because of her rave reviews, we’re bringing award-winning entrepreneur and author Kim Hodous back to share insight into the fine art of communicating well. In "Show Up, Be Bold, Play Big," she shares strategies for moving from average to extraordinary through vision-setting, commitment and shifting mindsets. Hodous offers tips to master in-person networking in "Social Networking the Old Fashioned Way," and in her “Talk Like a Man, Listen Like a Woman” presentation, she shares key insights into communicating effectively across gender lines. For more information, contact the AHA’s education team at 501.224.7878.

December 6, Little Rock
Compliance Roundtable and Luncheon
AHA Classroom

December 7, Little Rock
CPT Coding for 2017
AHA Classroom

December 9, Jonesboro
CPT Coding for 2017
Hilton Garden Inn

December 15, Little Rock
HFMA CPE
AHA Classroom
We’d like to thank, in advance, those vendors and sponsors who will exhibit at the 2016 Trade Show, held in conjunction with the Arkansas Hospital Association’s Annual Meeting. This year’s event is Thursday, October 6 at the Statehouse Convention Center in Little Rock. Their participation supports AHA programming. Thank you!
TRADE SHOW EXHIBITORS 2016

360 Degree Medicine
AAMSCO Identification Products
ACS - Administrative Consultant Services, LLC
Advanced Cabling System, Inc.
AHA Workers' Compensation
Self-Insured Trust
American Data Network
ArCom Systems, Inc.
Arkansas Center for Health Improvement (ACHI), UAMS
Arkansas Graphics, Inc.
Arkansas Health & Wellness Solutions
The Austin Company
Baptist Health eICU Care
Centimark Corporation
CertaPro Painters, LTD
Commerce Bank, N.A.
CoreSource, Inc.
Cornerstone Hospital of Little Rock
CR Crawford Construction, LLC
Crews & Associates, Inc.
Critical Alert Systems, Inc.
Cromwell Architects Engineers, Inc.
Curtis Stout
DataPath Administrative Services, Inc.
The Delta Companies
DocuVoice, LLC
Emergency Staffing Solutions
EMS, LLC
Evident, Inc.
Evo Business Environments
EZ Way, Inc.
Harding University MBA Program
Health eCareers
Healthcare Innovative Products, LLC
Healthcare Staffing Services, LLC
Heartland Medical Sales and Services, Inc.
Hewlett Packard Enterprise Services
Arkansas Medicaid
Hill-Rom
Hillyer Architectural Products
IMS - Integrated Medical Systems International, Inc.
Integrity Rehab Group
iVantage Health Analytics
Jackson & Coker
Jeron Electronic Systems, Inc.
JTS Financial Services, LLC
LaSalle Solutions
LHC Group, Inc.
Liberty Mutual Insurance
LifeShare Blood Centers
Masimo
Medical News, Inc.
MedPro Group
Mid-South Medical Imaging, LLC
Morgan Hunter HealthSearch, Inc.
Pension Consultants, Inc.
Perry Johnson & Associates, Inc.
Polk Stanley Wilcox Architects
Powers of Arkansas
Premier Care
ProAssurance Corp.
Professional Credit Management, Inc.
Publishing Concepts, Inc.
Quest Diagnostics
Randall Data Systems, Inc.
Razorback Air Filter, Inc.
Remi
Roof Connect
School & Office Products of Arkansas, Inc.
sComm
Southeast Imaging
Staples Business Advantage-Workplace Studio
The StayWell Company, LLC - Krames
Patient Education By StayWell
Tech Systems Inc.
TeleHealth Services
Therapy and Rehab Solutions, Inc.
ThyssenKrupp Elevator Americas
Today’s Office, Inc.
Triple-S Alarm Co., Inc.
UAMS Center for Distance Health
University of Arkansas, Little Rock
Weekend MBA Program
USDA Rural Development
Valley Services, Inc.
VersaSuite
Vision Service Plan
Voice Products, Inc.
WD & D Architects
Welch, Couch & Company, PA
Western Specialty Contractors
WorkSite Lighting
Zelis Healthcare

EDUCATIONAL EXHIBITORS

Arkansas Association for Healthcare Engineering
Arkansas Chapter HFMA
Healthy Active Arkansas
HomeCare Association of Arkansas
Riverview Behavioral Health
Society for Arkansas Healthcare Purchasing and Materials Management
UAMS College of Public Health Master of Health Administration
Community Connection

By David Rowlee, PhD, Integrated Healthcare Strategies, a division of Arthur J. Gallagher & Co.

Volunteers play a remarkably important role in today’s health care organizations. They frequently offer the first impression of a health care organization to patients, their families and visitors. They comfort patients and their loved ones during hospital stays, and they donate their talents and skills to enrich business operations.
Volunteers have been a long-standing curiosity of many psychologists. According to researchers, the very act of volunteering is somewhat opposite of most things we know about human behavior.

**So, Why Do People Volunteer?**

A classic definition of volunteering often entails a concept of people giving time, skills and effort without any form of compensation or reward in exchange. Although many of us like to imagine volunteering as a completely altruistic act – a selfless act of giving to improve the lives of others – researchers argue that to be truly motivated to volunteer, people must get something more from the experience rather than only feeling they have helped others.

A popular theory of volunteerism is often referred to as the Functionalist Theory of Volunteering. This theory suggests that there are six major categories which influence people to donate their time and skills without pay: values, understanding, enhancement, career, social and protective.

The higher the level of engagement among volunteers in hospitals, the higher the likelihood that patients will express better views of their care experience and the more likely hospitals are to be financially stable.

<table>
<thead>
<tr>
<th>VALUES</th>
<th>Help others in need</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNDERSTANDING</td>
<td>Learn and sharpen skills/abilities</td>
</tr>
<tr>
<td>ENHANCEMENT</td>
<td>Improve self-confidence/self-esteem</td>
</tr>
<tr>
<td>CAREER</td>
<td>Network professionally to increase job prospects</td>
</tr>
<tr>
<td>SOCIAL</td>
<td>Interact and build relationships with others</td>
</tr>
<tr>
<td>PROTECTIVE</td>
<td>Escape problems or reduce guilt</td>
</tr>
</tbody>
</table>

*Source: Houle, Sagarin, & Kaplan (2005); Clary and Snyder (1999); Clary et al. (1998)*

Of the six categories, only “values” represents a truly altruistic state in which individuals volunteer purely in the spirit of helping others. The remaining five categories all describe reasons for volunteering that may be considered self-enriching on the part of the volunteer – more aimed at improving self than helping others.

When focusing on volunteer engagement, it is important to note that researchers also find that individuals’ decisions to volunteer typically are multifaceted. That is, people tend to volunteer for a blend of motivating factors. For example, while most people select “values” as a key reason for volunteering, they also tend to simultaneously select self-enriching reasons. People often have numerous goals and objectives in mind as they enter the world of volunteering.

**How Should Engagement Be Measured Among Volunteers?**

Regardless of the reasons people volunteer, research shows that individuals will keep donating their time only if they sense that their volunteer experiences are enabling them to accomplish their personal goals – their reasons for volunteering. In other words, volunteers must be highly engaged by their experience.

We define “volunteer engagement” as a pronounced state of enthusiasm characterized by effort, pride and a sense of personal accomplishment. The importance of volunteer engagement cannot be overstated. For example, our most recent research has found noteworthy empirical linkages between the engagement level of volunteers and the patient experience ratings of health care organizations.

In addition, our studies have successfully linked the engagement levels of volunteers to other important outcomes including the financial performance of hospitals. The higher the level of engagement among volunteers in hospitals, the higher the likelihood that patients will express better views of their care experience and the more likely hospitals are to be financially stable.

For many years, we at Integrated Healthcare Strategies have been gathering feedback from hospital volunteers using our National Volunteer Engagement Survey. Our survey is specifically designed to measure volunteers’ engagement. It also measures their perceptions of day-to-day experiences which influence or “drive” volunteer engagement. Recently, we embarked on a large-scale analysis which considered input from thousands of individual volunteer respondents from our national volunteer database to identify the experiences that keep volunteers engaged.

The primary objective was to identify a narrow set of on-the-job experiences which exert a statistically significant influence on volunteer engagement. We also wanted to understand which of the six categories that most compel people to volunteer (as described by the Functionalist Theory of Volunteering table) are most represented by the drivers of volunteer engagement.

**What Keeps Health Care Volunteers Engaged?**

The analysis illuminated two very important findings. First, it confirmed that health care volunteers do have a variety of objectives and goals in mind which drive their engagement during their volunteer assignments. Returning to the six categories that influence volunteering, our results show that the “understanding” category plays a particularly important role in building, promoting and sustaining engagement among volunteers in the continued on page 12
health care sector. People want to learn and challenge themselves.

In fact, of ten significant survey items that drive health care volunteer engagement, half of the items represent the “understanding” category. This result is important for volunteer organizers. It suggests that individuals are, and will remain, most engaged when challenged to acquire and master new skills as well as have opportunities to sharpen existing skills.

driver analyses designed to evaluate the effect, if any, age may exert on the key drivers of volunteer engagement. In other words, should organizations consider different strategies to build engagement based on the generational groups of their volunteers – or is a one-size-fits-all approach appropriate?

Recall that our initial analysis based on all volunteers showed the most influential driver of volunteer engagement to be a “values” item, having a clear understanding of how their individual efforts contribute to the mission and goals of health care, reflecting a more altruistic notion of giving to help others.

The remaining drivers all represent pathways of self-enrichment whereby volunteers donate their efforts and skills in exchange for something to improve their situation. When the drivers of engagement were re-examined for different generational groups, some striking differences were noted.

Somewhat surprisingly, although the most different in age and arguably, attitude, the engagement level of both Traditionalists (oldest) and Millennials (youngest) is most influenced by the same identical item; having a clear understanding of how individual efforts contribute to exceptional care experiences for patients. This result confirms that the engagement levels of both the oldest and youngest volunteers, regardless of age, are greatly influenced by the altruistic nature of volunteerism – knowing their efforts are truly helping others.

Second and perhaps more importantly, while nine of ten key drivers of volunteer engagement are items indicating that volunteers desire self-enrichment while volunteering, “values” or altruism reigns as the most important factor among health care volunteers in building and sustaining their engagement. Our study confirms that the top-most predictor of volunteer engagement is having a clear understanding of how their individual efforts contribute to the mission and goals of health care – the ability to contribute to an exceptional care experience of patients.

In short, health care volunteers seek to fulfill self-enriching objectives through volunteering, especially building skills and abilities. However, first and foremost, health care volunteers are most enthusiastic about the idea of their efforts improving health care for others – a truly altruistic position. While the cultures vary widely among health care organizations, great enthusiasm characterized by extra effort, pride in their work and in the organization, and a genuine sense of personal accomplishment.

We have discussed “drivers” of engagement that most promote this sense of enthusiasm among volunteers nationwide. Working to improve these key drivers is an excellent starting point for building engagement among volunteers. However, there is something strikingly different about most health care volunteer populations compared to their employed counterparts – age diversity. Could this different age structure mean that different drivers may need to be applied to different generations to optimize engagement?

Unlike the paid health care workforce, volunteer teams are commonly over-represented by the oldest and youngest adult generations today. Millennials (born after 1980, also referred to as Generation Y) and the Traditionalist Generation (birth years 1925-1945) are both mainstays in many volunteer groups. This unique age structure among volunteer populations poses a fascinating management challenge for volunteer leaders. It forces leaders to simultaneously manage and build engagement among the oldest and youngest adult segments of our population.

Based on age, work and life experiences, and popular stereotypes, Traditionalist and Millennials represent the most dissimilar generations actively involved in volunteerism today.

Acknowledging the unique age structure of health care volunteer populations, we turned to a second series of key driver analyses designed to evaluate the effect, if any, age may exert on the key drivers of volunteer engagement. In other words, should organizations consider different strategies to build engagement based on the generational groups of their volunteers – or is a one-size-fits-all approach appropriate?

A highly engaged health care volunteer is quite easy to recognize; they display
having the ability to develop new and enhance existing friendships while volunteering at their organizations.

Considering the six reasons for volunteering, the Traditionalist key drivers of engagement are most strongly aligned with a “social” orientation for volunteerism. Therefore, to keep older volunteers highly engaged, health care organizations may be best served by structuring Traditionalist volunteer tasks and assignments in a way that enables a heightening of social interaction – especially placing Traditionalist volunteers with others who may also be seeking to develop and enhance friendships and social support.

In comparison, the youngest generation examined, Millennials or Generation Y, views the act of volunteering very differently. Rather than a social endeavor, the engagement level of Millennials is remarkably influenced by the presence of challenging tasks that allow this generation to build new skills, sharpen existing competencies and feel part of the team.

These key drivers of Millennials’ engagement are closely aligned with both the “understanding” and “enhancement” orientations of volunteering, as well as the one oriented toward “career.” This finding suggests that, unlike the older volunteers who appear to leverage volunteering as a mechanism for social interaction, the youngest volunteers are more likely donating their time and efforts as a way that enables a heightening of social interaction – especially placing Traditionalist volunteers with others who may also be seeking to develop and enhance friendships and social support.

Beyond this common driver, however, it is the age of volunteers – rather than their generational group – that most impacts the strategies organizations must pursue to maximize engagement.

It is important to draw distinctions between age and generational stereotypes, when considering meeting volunteers’ needs. Many popular articles focusing on identification of generational stereotypes alone rarely draw important distinctions between age and generational characteristics.

Generational characteristics are the easiest to understand – these are attitudes and behaviors that remain unchanged regardless of the age of the individual. A frequently cited example of this would be the tendency among Traditionalists to exhibit less risk-taking behavior when it comes to financial investments, likely due to their exposure to the Great Depression era.

Conversely, age characteristics change based on how old an individual is or what phase of life they have entered. An ideal example of age characteristics is visible in our research. Consider again our findings that Traditionalist volunteers (ages 71-91) are concerned with staying socially active while Millennials (under age 36) are interested in building business skills.

Over time, as Millennials continue to advance toward retirement age, it is almost a certainty that their drivers of engagement will reveal the newfound goal of attempting to remain socially active. We would thus argue that building business skills is not a generational characteristic; rather it is an age or life-stage objective.

Because the key drivers of volunteer engagement appear to be age-based rather than generationally-based, volunteer-engagement strategies will likely require constant adjustments and modifications as the age structure of your volunteer staff continues shifting across time. This is important to keep in mind as your organization continues to engage volunteers in the patient care process.

Since volunteers can positively or negatively affect both patient satisfaction levels and the hospital’s financial health, it truly pays to keep your volunteers highly engaged. Using the six key drivers and keeping age-directed objectives always in mind will help today’s hospitals build their most successful volunteer training and involvement programs – for the good of all.

**How Does Survey Data Help Us Sustain Engagement?**

These additional generational analyses of National Volunteer Engagement Survey data clearly reveal that, regardless of the age of the volunteer, organizations must make an effort to establish a clear connection between the volunteers’ assignments and the way their efforts directly influence the patients’ experiences. This is by far the strongest driver of engagement for both Traditionalist and Millennial volunteers alike.

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Arkansas’s Lynn Smith Chairing National Committee on Volunteers

Lynn Smith, longtime hospital auxilian at the Medical Center of South Arkansas in El Dorado and current auxilian at CHI St. Vincent Hot Springs, is making Arkansas proud as chair of the American Hospital Association’s (AHA) 2016 Committee on Volunteers.
The Committee on Volunteers (COV), a specialty committee of the AHA board, is concerned with the roles, responsibilities and services of organized volunteers and auxilians, as well as the community perspective they provide for the health care field.

Smith currently volunteers in the gift shop at CHI St. Vincent Hot Springs after recently moving to central Arkansas.

From October 2011 to October 2012, she served as president of the Arkansas Hospital Auxiliary Association (AHAA). In this role, Smith was instrumental in improving AHAA communications. Under Smith’s leadership, the organization established a website and completed a “go green” initiative by transforming its 20+ page bimonthly newsletter to a digital format and making all business forms available to members online.

While serving as AHAA president, Smith also served on the Arkansas Hospital Association Board of Directors where she offered valuable insight to hospital leaders about the patients and communities they serve.

Smith has a long history of service at the local and state levels. She began her volunteer career in 2001 at Medical Center of South Arkansas (MCSA) in El Dorado, where she was newsletter editor, secretary, vice president and president of the auxiliary. She also was appointed to the MCSA Auxiliary Board and served on both the Scholarship and Membership Committees.

At the state level, Smith served as editor of the AHAA’s statewide newsletter in 2008, and after her stint as president, was an active member of the organization’s Past Presidents Advisory Committee. Currently, she serves on the AHAA’s state Handbook Committee and continues to volunteer at her local hospital, CHI St. Vincent Hot Springs – all while serving in her national role with the AHA.

The Arkansas Hospital Association and its members congratulate Lynn Smith on this well-deserved recognition of her enthusiasm, energy and leadership. The American Hospital Association and its COV are lucky to have her as their chair.

Arkansas’s Lynn Smith represents hospital volunteers nationwide in Washington, D.C., with her duties as chair of the American Hospital Association’s Committee on Volunteers.

Committee on Volunteers Chair Lynn Smith (far left) and AHA Chairman-elect Eugene Woods (far right) flank representatives of the four 2016 Hospital Awards for Volunteer Excellence (HAVE) award-winning programs. From left, June Berlinger from Longmont United Hospital’s Storycatcher program, Longmont, Colorado; Molly James from Winona Health’s Health Coaches program, Winona, Minnesota; Karen Blandini from Vettes to Vets, Bedford VA Hospital, Bedford, Massachusetts; and Tina Lyon from Sutter Davis Hospital’s Volunteer Doula Program, Davis, California.
Similar to individual hospitals seeking guidance from patient and family advisory councils, the American Hospital Association (AHA) places a high value on input from patients and the community. While a representative group of volunteers and auxiliaries has been providing counsel to the AHA and its Board of Trustees dating back to 1948, the AHA officially introduced the Committee on Volunteers (COV), a specialty committee to the AHA board, in 1976.

The COV is comprised of 15 volunteers, auxiliaries, and directors of volunteers from around the country who are appointed by the AHA board. The committee focuses on the roles, responsibilities and services of organized volunteers and auxiliaries, as well as on the community perspective they provide for the health care field.

“Volunteers are often the first point of interaction for patients and families at a hospital, and some people will tell volunteers things they won’t tell their doctors or nurse,” says Kelley Boothby, COV member and director of volunteer services at Hartford Hospital in Hartford, Connecticut. “Executives and clinicians have a certain point of view, but when organizations like the AHA can also include what’s happening ‘on the ground’ as well, it’s very beneficial,” she adds.

The committee supports the AHA’s mission and goals by providing input to the policy development process. COV members participate in AHA grassroots advocacy and provide the association with the benefit of “eyes and ears on the ground” at the local health care level. “From the years I’ve served, I know the committee is important to the AHA,” says Barbara Muesing, COV immediate past-chair and auxilian and trustee at Essentia Health in Fosston, Minnesota. “We’re listened to as a real voice and a connection to the communities we serve.”

The COV provides input to the AHA Board of Trustees on topics at the top of the board’s and the nation’s agendas, whether it’s health care equity, workforce safety, hospital price transparency, quality, behavioral health or how hospitals are engaging with their communities.

Committee members are given assignments connected to specific agenda items and then report back on their findings. Examples are collecting anecdotes about how patients are dealing with high drug prices or describing how volunteers respond to the active shooter trainings being implemented at their own hospitals.

In addition to informing AHA policy, the COV also provides an opportunity for collaboration and idea-sharing around important health care topics. “We learn a lot about the hot button items for AHA in the field, and how we can help with our own volunteer programs on the local level,” says Vicki Holcombe, COV member and director of volunteer services for Baptist Hospitals of Southeast Texas in Beaumont. “Right now there’s a huge emphasis on community health, and we’re looking at how we can work with volunteers outside the walls of our hospitals.”

A major duty of the COV is to serve as the selection committee for the AHA’s Hospital Awards for Volunteer Excellence (HAVE Awards). Each year four competitive awards are presented by the AHA to hospitals around the country in the categories of community service, in-service hospital, fundraising and community outreach/collaboration.

The 2016 HAVE award winners were:

- Doula Volunteer Program, Sutter Davis Hospital/Sutter Health (Davis, California), which offers free non-clinical doula support to laboring or post-partum patients;
- Community Care Network Health Coaches, Winona Health (Winona, Minnesota), which provides home health coaching to chronic disease sufferers;
- Vettes to Vets, Bedford Veterans Hospital/VA New England Healthcare System (Bedford, Massachusetts), which raises money and resources for veterans at the hospital through an annual event that features a parade of Corvettes; and
- Storycatchers Program, Longmont United Hospital (Longmont, Colorado), in which volunteers interview patients and write their life stories as a meaningful gift.

“It’s been an honor to serve on this committee and to meet people from around the nation,” says Lynn Smith, current COV chair and auxilian at CHI St. Vincent Hot Springs in Hot Springs, Arkansas. “The best thing to me is seeing the different projects that hospital volunteers are doing across the nation. It’s just amazing what large, small and middle-sized volunteer programs are able to accomplish in each of our states.”
If you’ve ever served on the board of the Arkansas Hospital Auxiliary Association (AHAA), it’s likely you know Amber Estrada. Amber is the Arkansas Hospital Association’s (AHA) staff liaison with AHAA and is considered a valuable member of the affiliated group’s team.

“Even though Amber officially works for AHA, those of us on the AHAA Board feel she is one of us,” says Dorothy Berley, AHAA president. “Amber attends to so many of the important details that keep our meetings running smoothly; we are very appreciative of her.”

Last year, Berley’s husband, Jerry, became the first male to take on the role of AHAA president. “Amber jokingly called him the ‘First Dude,’ and the name stuck,” Berley recalls with a grin. “She makes time when we ask for something at the last minute, even though she may be busy with other duties. She always has a pleasant smile, and is truly a blessing to those of us at AHAA.”

Estrada has worked with AHAA leaders for the past seven years, since 2009. Her roles with the group include posting the AHAA newsletter archive to the AHA website, working with AHAA registration forms and posting them online and keeping convention information posted for members.

“These people inspire me,” Estrada says. “I’ve heard it said that in life, 20% of the people do 80% of the work. This is certainly true of the AHAA Board. These leaders volunteer time at their community hospitals, but also serve in other areas at the state level. They are selfless. Before I became their administrative liaison, I didn’t appreciate how much of a life force they are to our hospitals.”

She sees her work with AHAA as that of a helpmate, Estrada says. “I’m their go-to person at AHA, most often helping with software questions and technical assistance. The group is incredibly self-supporting.”

She also arranges for the bi-monthly AHAA Board meetings held at AHA headquarters, including multiple room arrangements, catering management and overseeing production of on-site meeting packets.

Though her work with AHAA is highlighted here, Estrada’s many roles at the AHA keep her plate full. She serves as the administrative assistant for president/CEO Bo Ryall, executive vice president Paul Cunningham, and vice president/governmental relations Jodiane Tritt. She is also the AHA webmaster and works as an in-house advisor on the association’s complex member database.

“As a whole, AHAA’s service to our hospitals through hours volunteered, funds raised in support of hospitals and scholarships and the powerful voice they bring to the political arena on behalf of our hospitals is incredibly impressive,” Estrada says.

“When the AHAA Board is meeting at the AHA, there’s a buzz in the building,” she says. “It’s a buzz of life, of laughter and of determination. They’re there to get things done, and they do! They’re go-getters, do-gooders and get-it-doners. They’re amazing, and I love them.”
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## Coming Together for Our Patients

We appreciate our hospital volunteers, and likewise the directors who support them! Two dynamic volunteer-centered groups are affiliated with and assisted by Arkansas Hospital Association staff.

Volunteering time, helping teens learn the gift of service, raising funds for their hometown hospitals and providing scholarships for those entering the health care field are the standard of the Arkansas Hospital Auxiliary Association (AHAA).

“In 2013, AHAA established an endowed scholarship in the amount of $25,000, to be shared equally by the College of Nursing and the College of Health Professions at UAMS,” says AHAA president Dorothy Berley. “This year, the board voted to establish an additional $25,000 endowed scholarship dedicated solely to the College of Health Professions at UAMS. This allows the first endowment to be dedicated solely to the College of Nursing, thus giving both colleges an endowment of $25,000 each. [Auxilians] are proud to be a part of an organization that makes it possible for deserving students to pursue their careers in the health care profession.” – AHAA President, Dorothy Berley

The Arkansas Society for Directors of Volunteer Services (ASDVS) is focused on professional development, supporting healthcare volunteerism and forging alliances to build healthier communities.

“ASDVS is designed to support hospital directors of volunteer service, and to share best practices so we can learn from each other,” says Holli Oliver, president of Arkansas’s chapter of the national organization. “We match the needs of our hospitals with the skills of our volunteers, bringing community support and expertise to our patients.”

“Hospitals benefit greatly from the work of their volunteers. Our role, as ASDVS directors, is to help volunteers accomplish their vision within each hospital while meeting our hospitals’ goals in the areas of patient service and patient satisfaction. Volunteers represent a true pocket of value to each hospital. It’s our honor to work with them on behalf of our hospitals.” – ASDVS President, Holli Oliver

The Arkansas Hospital Auxiliary Association seeks to improve patient care in Arkansas hospitals by assisting in the organization, promotion and coordination of local hospital auxiliaries and their members in hospitals throughout the state.

### ALL DISTRICTS

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</table>

Arkansas Hospitals | Fall 2016 | 19
Thank you to our hospital partners for providing high quality healthcare to Arkansans!

Arkansas Health & Wellness Solutions has earned its accreditation status from the National Committee for Quality Assurance (NCQA) for its Health Insurance Marketplace Exchange plan, Ambetter of Arkansas, for its service and clinical quality that have either met or exceeded NCQA's rigorous requirements for consumer protection and quality improvement.

“Earning accreditation reflects a health plan’s ability to work with its members’ physicians to improve the quality of clinical care,” said Margaret E. O’Kane, NCQA Marketing President. “It shows that the plan is building the kinds of partnerships that are critical to delivering great care and great service.”

“NCQA Health Plan Accreditation evaluates the quality of healthcare that plans provide to their members,” said Arkansas Health & Wellness Solutions’ President and CEO John Ryan. “We are honored to receive accreditation from NCQA. To have our unrelenting commitment to the highest quality of care for our members recognized by such an esteemed organization is a powerful affirmation.”

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The CDC has just released a new edition of its publication, *Vital Signs*, dedicated to sepsis, emphasizing the importance of prevention and early recognition. In addition, a host of downloadable infographics, sepsis education resources and checklists for health care providers and administrators are available at www.cdc.gov/vitalsigns/sepsis.

The American Hospital Association’s strategic performance improvement platform, Hospitals in Pursuit of Excellence (HPOE), with support from the Robert Wood Johnson Foundation, recently released the guide “Creating Effective Hospital-Community Partnerships to Build a Culture of Health.” Focusing on the ways hospitals and communities can develop and sustain partnerships, it shares lessons from 50 interviews conducted with hospital, health system and community leaders in 25 diverse communities. The free guide is available on the HPOE website at www.hpoe.org/effectivepartnerships.


The American Hospital Association’s Physician Leadership Forum and HPOE have released a new compendium to help hospitals, in partnership with their clinical staff and patients, closely examine the appropriate use of medical resources for five hospital-based procedures or interventions. The compendium offers a toolkit on each of these five areas:
- blood management;
- antimicrobial stewardship;
- ambulatory care sensitive conditions;
- elective percutaneous coronary intervention; and
- aligning treatment with patient priorities for use of the ICU.

To learn more about the compendium or to download the complete document visit www.aha.org/appropriateuse.

The American Hospital Association and the Institute for Diversity in Health Management now offer a toolkit supporting the #123forEquity Pledge to Eliminate Health Care Disparities. The toolkit contains resources that can assist all hospitals – whether an organization is just beginning the equity of care journey or is already deeply ingrained in this work. Find the toolkit at www.equityofcare.org.
QUALITY AND PATIENT SAFETY

Caregiver Training Leads to Better Care at Home

A Schmieding instructor leads a class on caregiving for patients with dementia.

By Robin McAtee, PhD, RN, FACHE, University of Arkansas for Medical Sciences

Many older Arkansans are able to function well and continue living at home with the help and guidance of caregivers. Whether they are family members or service providers, caregivers play a crucial role in helping older Arkansans age in place, living independently in their own homes and communities — where they want to be. Caregiving is a labor of love, and often more than a full-time job.
To help Arkansas caregivers attain the skills they need, the University of Arkansas for Medical Sciences (UAMS) Schmieding Home Caregiver Training Program offers evidence-based instruction taught through its seven locations around the state.

**Reducing Readmissions**

Not just important to everyday life, such assistance has been shown to lower readmissions after hospitalization, helping patients recover well at home. This is good not only for patients, but also for hospitals; expenses for each are avoided and hospital penalties resulting from readmissions are averted.

Readmission costs to hospitals can be high. The Centers for Medicare & Medicaid Services (CMS) in Fiscal Year 2015 penalized more than 2,600 hospitals $428 million for excessive readmissions. Hospitals nationwide are working diligently to reduce 30-day readmissions. One way to help this effort is to be certain caregivers who will assist patients returning home have the knowledge and resources necessary to keep their patient recovering in the home setting.

In September 2015, the Arkansas Lay Caregiver Act went into effect and made cooperation between hospitals and caregivers more important than ever before. The law requires hospitals to provide a patient, or the patient’s legal guardian, the chance to designate a caregiver, notify the caregiver in advance of a patient’s transfer or discharge, consult with the caregiver about the patient’s aftercare needs and, if necessary, demonstrate tasks to the caregiver needed for good aftercare.

Trained caregivers, whether they are a patient’s unpaid family members or paid professionals, can help ensure that the transition of patients from acute care in hospitals to recovery care at home is smooth and safe. Once a patient is home, their caregiver can see, for example, that a diabetic patient adheres to a diet plan or a dementia patient takes medication necessary for quality of life.

**Unsung Heroes**

Caregivers who see their patients or loved ones daily (or several times a week) are often the only contacts who help manage chronic health conditions like diabetes or emphysema.

About 452,000 family caregivers in Arkansas provide an estimated $4.7 billion in unpaid care each year, helping their loved ones with bathing and dressing, meal preparation, transportation, finances, and even with complex medical tasks like wound care and injections.

Sue Carter of Elkins, a home caregiver for 15 years, makes her living as a caregiver, but she has also been an unpaid caregiver for older members of her own family.

Knowing Sue’s passion for caregiving, a relative encouraged her to enroll in classes at the UAMS Schmieding Center in Springdale.

The Schmieding Home Caregiver Training Program gave Sue the tools she needed to enhance her knowledge and help her better care for her clients.

Sue says she learned, for example, skills many don’t realize are significant in caring for clients with dementia. More than five million people in the U.S. are living with some form of dementia, including Alzheimer’s, and that number is on the rise.

**Certified Home Caregiver Training**

The Schmieding Certified Home Caregiver Training is a unique program designed to teach how to care for an older adult in the home. Training is divided into four courses, each enabling the student to advance their caregiving skills and competency. Courses are taught by nurses and other health care professionals. The Schmieding curriculum fulfills training requirements of the Arkansas Medicaid Personal Care Training Program and other regulating entities.

Certified Nursing Assistant training and certification are available through Schmieding, as are In-Home Assistant (IHA) and Advanced IHA courses.

**Caregiver Training: Proven Results**

A new report from the University of California, San Francisco (UCSF) says elderly and disabled adults are less likely to go to the emergency room or be hospitalized if their in-home caregivers participate in an intensive training program, such as the Schmieding Home Caregiver Training program at UAMS.

The rate of repeated emergency room visits by a study group of elderly or disabled adults cared for by in-home caregivers dropped by 24%, on average, in the first year after caregivers were trained, and by 41% in the second year, according to UCSF.

Also, caregivers who received training told UCSF researchers they felt better equipped to do their jobs and to communicate with clients and their doctors. The study results demonstrate that trained caregivers play a pivotal role in helping this key group of patients avoid unnecessary hospital admissions.
IHA course satisfies training required by Arkansas law for caregivers who are paid to provide care in the home of a person who is 50 years of age or older.

Schmieding also offers classes specifically focused on dementia, incorporating roleplaying to demonstrate to students how to cope with a patient’s short-term memory problems. Knowing how to deal with the emotional episodes of dementia can reduce stress on the caregiver and the patient, alike.

**Family Caregiver Workshops**

The Schmieding Center’s family caregiver workshops are designed to increase family members’ knowledge of basic caregiving topics and introduce them to basic caregiving skills needed to care for an older adult in the home.

Helping another to manage adult daily living skills can be very challenging. It is important for family caregivers to learn special strategies to help them provide assistance to loved ones in both a safe and efficient manner. The family caregiver program presents an overview of information on caregiving for anyone helping to provide unpaid care for an older adult at home.

Topics covered include:
- Body mechanics;
- Transferring;
- Mobility;
- Infection control;
- Skin care;
- Incontinence management;
- Nutrition;
- Range of motion;
- Wheelchair use;
- Caregiver stress;
- Home safety;
- Bathing;
- Dressing; and
- Local resources and reference materials

Special workshops are offered for those caring for a person with dementia. This type of care poses many challenges for families and caregivers. Without proper understanding of the disease, it is very easy for family members to give way to feelings of frustration, which often leads to burn out.

The workshop for family members caring for a person with dementia equips family caregivers with the knowledge and information they need to assist a loved one suffering from Alzheimer’s, dementia or other memory disorders.

Topics include:
- Communication;
- Understanding behaviors;
- Activities;
- Caregiver stress;
- Home safety;
- Personal care skills;
- Nutrition;
- Skin care;
- Incontinence management;
- Body mechanics;
- Activities of daily living; and
- Local resources and reference materials

**Thousands Educated Thus Far**

Nearly 2,000 family members have attended family caregiver workshops since the Schmieding program’s start, and those classes are growing in popularity. Almost
6,000 have attended Schmieding Certified Home Caregiver Training classes, about half graduating with certificates.

While UAMS is at the forefront of training the home care workforce, it is also working to create a statewide network of support and educational programs to help communities and families learn about elder caregiving. Caregivers are uniquely suited to advocate for their loved ones and make informed choices about care in the home.

The caregiver’s role must be sustainable, too. The mental, physical and financial toll experienced by family caregivers is gaining national attention. In one study, 17% of caregivers surveyed said they had to leave their jobs so they could concentrate on providing care to a loved one. Keeping older Arkansans from returning to hospitals also means making sure their caregivers don’t give up in exhaustion.

**A Phone Call Away**

Finally, partnering is a critical part of this training. In a recent partnership with the Arkansas Division of Aging Services, UAMS/Schmieding staff provided free training for volunteers who provide respite or temporary relief to a permanent caregiver. In support and continuation of this effort, a statewide respite conference is planned for October 21 at the Reynolds Institute on Aging in Little Rock.

If your organization is interested in hosting a family workshop, needs training for direct care workers or would like more information on the UAMS Schmieding Home Caregiver Training programs and partnership opportunities, please contact project director Sherry White at 479.445.9542. You may also visit the Schmieding website, www.uamscaregiving.org, for a list of available classes or to access the caregiver directory.

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Robin E. McAtee, PhD, RN, FACHE, is the Schmieding Home Caregiving Grant primary investigator and the associate director of the Arkansas Aging Initiative in the University of Arkansas for Medical Sciences Donald W. Reynolds Institute on Aging.

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Engaging the Community to Fight Diabetes

By Julia Kettlewell, MPH, BSN, RNP, Arkansas Foundation for Medical Care

Being diagnosed with diabetes is a life-changing event, regardless of age, gender, ethnicity or financial status. With that diagnosis, a host of potential complications, including heart disease, stroke, vision problems, kidney failure and amputations, come into the picture. Patients need help in learning how best to avoid these complications and how to keep their own diabetes under control.

The Arkansas Foundation for Medical Care (AFMC) team is a part of the TMF Health Quality Institute (TMF), the Quality Innovation Network-Quality Improvement Organization serving our region under a contract with the Centers for Medicare and Medicaid Services. TMF works with other experienced quality improvement partners, including AFMC, to provide expert technical assistance and quality improvement support to participating providers across a region encompassing Arkansas, Texas, Missouri, Puerto Rico and Oklahoma.

As one of its projects, TMF is tasked with improving health outcomes and reducing issues related to health disparities among people with diabetes. The project is two-fold:

- Expand the reach of diabetes education and self-management programs in Arkansas; and
- Work with health care providers to make diabetes screening a routine process.

As the number of Arkansans with diabetes increases, this work becomes even more important.

The incidence of diabetes among Arkansans increased from 5.3% in 2004 to 11.5% in 2014 – a 217% increase in just 10 years. In 2014, there were 53,973 Arkansas Medicare beneficiaries with diabetes.

Nationally, nearly 13% of adults aged 20 and over have diabetes, according to the most recent data available from the National Institutes of Health and the Centers for Disease Control and Prevention. Nearly one-third of persons 65 years and older have diabetes.

Type 2 diabetes accounts for up to 95% of all diabetes cases and virtually...
all undiagnosed diabetes. The CDC reports that each year, 1.3 million people over age 20 are newly diagnosed with diabetes.

AFMC promotes diabetes self-management education (DSME), a proven intervention to empower those with diabetes to take an active role in controlling their disease. DSME provides the knowledge and skills necessary to improve the quality of diabetics’ lives, by preventing or lessening the severity of their diabetes complications.

To effectively reach the Medicare population, AFMC recognizes the importance of interacting with those Arkansas communities where the highest numbers of diabetic Medicare patients live.

By working with subcontractors and community organizations having similar goals, AFMC aligns its support to educate the growing number of persons with diabetes in Arkansas. Organizational partners include health ministries, hospital-based programs, pharmacies, senior housing programs and grassroots organizations.

Beneficiary education is provided by peer educators who have successfully completed a three-day training program and received certification to teach DSME classes. Classes are held weekly over a six-week period, each session lasting about 90 minutes. The goal of peer education is to effectively connect with participants and provide an interactive curriculum that results in behavior change over the long term.

AFMC is improving access to DSME by:
• Training community educators to provide community, peer-led DSME classes through partnerships with community organizations;
• Providing technical assistance to DSME programs moving toward becoming accredited/recognized DSME sites; and
• Increasing the number of certified diabetes educators (CDE®) in the region by facilitating virtual CDE study workshops.

Hospitals are some of the best partners in this work. For example, AFMC has been working closely with Arkansas Heart Hospital's foundation arm, The Arkansas Heart Foundation,
over the past few months to improve access to DSME. The foundation has facilitated one-day Diabetes Boot Camps across the state.

After completing the boot camp, participants are referred by the hospital to the free DSME classes. So far, boot camp referral classes have been held in Danville, Hot Springs, El Dorado and Little Rock. There are boot camps scheduled through November in other Arkansas communities.

Another successful partnership is with the Greater Delta Alliance for Health, Inc. (GDAH), a nonprofit, horizontal hospital network governed by the chief executive officers of 10 hospitals in the southeast quadrant of Arkansas.

This unique network is the largest health care service provider in the area with participating sites located in Arkansas, Ashley, Bradley, Chicot, Dallas, Desha, Drew and Jefferson counties. GDAH has been both a partner and a subcontractor with TMF in providing DSME classes to patients with diabetes. The program has 17 trained peer educators providing DSME classes to residents of the eight-county area.

During the DSME project, which ends July 31, 2019, Arkansas’s goals are to:
• Graduate 1,724 diabetic Medicare beneficiaries from DSME classes; and
• Engage 50 primary care practices in increasing screenings and improving outcomes for diabetic patients.

For more information about becoming a diabetes community partner or to locate DSME classes being held near you, contact Julia Kettlewell at jkettlewell@afmc.org.

Julia Kettlewell is director of outreach quality for AFMC.
Where We Began...

The Arkansas Hospital Association’s (AHA) specific focus on hospital quality began, as did that of many state associations, with the Institute of Healthcare Improvement’s (IHI) invitation to join the 100,000 Lives Campaign, and later, the 5 Million Lives Campaign, each developed to protect patients from incidents of injury and harm related to the medical care they receive.

As these campaigns progressed, we also worked our way through the standardization of wristbands to the earliest days of the Comprehensive Unit-Based Safety Program model of reducing catheter-acquired bloodstream infections. Led by Elisa White, the AHA’s vice president and general counsel with a gift for leadership and communication, the programs were not only successful, but eye-opening. The national trend for data-based, measureable patient care improvements was burgeoning. It was time for the AHA to establish its own, dedicated Quality and Patient Safety Program.

Pamela Brown, RN, BSN, CPHQ launched the AHA Quality Program in early 2012, with Arkansas hospitals’ participation in the first Hospital Engagement Network (HEN) program. More than half of the AHA’s member hospitals participated in our first HEN initiative, which was completed as a part of a multi-state partnership through the American Hospital Association’s Health Research and Educational Trust (HRET).

The initial HEN project led to a second HEN initiative. From “HEN 2.0,” to Stop BSI, Stop CAUTI, Stop EED and more ... the programs continue, our hospitals participate, and new patient safety techniques become standards of care. Hospitals share best practices, and patient safety and quality improve exponentially. Most importantly, patients’ lives are saved.

With this guide, we take a look at the remarkable results Arkansas hospitals have achieved in the areas of quality and patient safety programming and offer it as a salute to hospital quality and to all of our dedicated hospital quality teams.
HEN 2.0 – 48 Arkansas Hospitals Participating

- Arkansas Methodist Medical Center
- Baxter Regional Medical Center
- Bradley County Medical Center
- CHI St. Vincent Hot Springs
- CHI St. Vincent Infirmary
- CHI St. Vincent Morrilton
- CHI St. Vincent North
- Chicot Memorial Medical Center
- Community Medical Center of Izard County
- Conway Regional Medical Center
- CrossRidge Community Hospital
- Delta Memorial Hospital
- DeWitt Hospital
- Drew Memorial Hospital
- Eureka Springs Hospital
- Forrest City Medical Center
- Fulton County Hospital
- Helena Regional Medical Center
- Howard Memorial Hospital
- Jefferson Regional Medical Center
- Johnson Regional Medical Center
- Lawrence Memorial Hospital
- Little River Memorial Hospital
- Magnolia Regional Medical Center
- Medical Center of South Arkansas
- Mena Regional Health System
- Mercy Hospital Fort Smith
- Mercy Hospital Northwest Arkansas
- National Park Medical Center
- North Arkansas Regional Medical Center
- North Metro Medical Center
- Northwest Medical Center-Bentonville
- Northwest Medical Center-Springdale
- Ouachita County Medical Center
- Ozarks Community Hospital
- Piggott Community Hospital
- Pinnacle Point Behavioral Health Services
- River Valley Medical Center
- Saint Mary’s Regional Medical Center
- Saline Memorial Hospital
- Siloam Springs Regional Hospital
- Sparks Regional Medical Center
- Sparks Medical Center-Van Buren
- Stone County Medical Center
- UAMS Medical Center
- Unity Health-Harris Medical Center
- Unity Health-White County Medical Center
- Willow Creek Women’s Hospital

HEN 2.0 Improvement Topics

- Adverse Drug Events (ADE)
- Airway Safety
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Central Line-Associated Bloodstream Infection (CLABSI)
- Clostridium difficile Infection (CDI)
- Culture of Safety
- Early Elective Delivery (EED)
- Failure to Rescue
- Health Care Disparities
- Iatrogenic Delirium
- Injuries from Falls and Immobility
- Obstetrical Adverse Events
- Patient & Family Engagement
- Pressure Ulcers
- Radiation Exposure
- Readmissions
- Sepsis
- Surgical Site Infection (SSI)
- Venous Thromboembolism (VTE)
- Ventilator-Associated Event (VAE)

Results are a cumulative effort but have been spurred in part by Medicare payment incentives and catalyzed by the Partnership for Patients (PfP) initiative.

AHA HEN Benefits of Participation

- In-person and virtual networking opportunities to gain from national experts and peers.
- Benchmark data to compare progress and identify areas for improvement.
- Opportunities to mentor peers.
- Opportunities to share best practices in a variety of ways, such as national websites, national calls and national meetings.
- Tools and expert resources related to HEN topics.
Formation of separate, multi-departmental teams for each HEN topic, each meeting bimonthly to strategize plans and track progress, has led to practice improvements. The SSI Prevention Team has achieved 0% rates for surgical site infections in colon surgeries. This hospital was chosen by HRET to complete a national case study on SSI Prevention. During both the original HEN initiative and HEN 2.0, this hospital was selected by HRET for a national high-performing hospital video.

Conway Regional Medical Center

Redesigning its discharge process using the Re-Engineered Discharge (RED) toolkit and instituting a 6-month pilot on the high risk/high return unit, the quality team decreased the hospital’s telemetry unit readmission rate by 31%, from 18.6% to 10.81%, producing a cost savings of $489,600 resulting from 51 fewer readmissions.

Chicot Memorial Medical Center

Expanding their team approach to reducing incidents of hyperglycemia in hospitalized patients, protocols for blood sugar analysis were changed. The lab now sends blood sugar results to the pharmacy and quality departments, which analyze results; accurate charting of intake (meal consumption) allows for appropriate medication adjustments. In-hospital hyperglycemia incidents are now significantly reduced.

CrossRidge Community Hospital

Implementing protocols/processes to reduce the risk of hypoglycemia in hospitalized patients receiving insulin, the quality team initiated new practices, including coordination of meal delivery with insulin administration and improvement of diabetic snacks to make them more appealing.

Howard Memorial Hospital

The quality team set out to target zero CAUTIs, realizing this infection is the most common and most preventable in the realm of hospital-acquired infections. Over the first six months, there was a decrease in Foley days from 102 down to 52, and the team’s work has led to a sustained CAUTI rate of zero. In recognition of their fine work, this hospital was chosen by the American Hospital Association’s Health Research and Educational Trust (HRET) for a spotlight video soon to be completed and circulated nationwide.
North Arkansas Regional Medical Center

Focusing on urinary catheter removal within 48 hours of placement, unless there was a documented reason for retaining the catheter, led the CAUTI rate to drop – and stay – at nearly 0.

Targeting patient falls, the quality team established a fall prevention contract, which was signed by patients assessed as having high risk for fall, and implemented use of Patient Safety Companions for confused patients. The hospital’s falls rate declined by 51%.

Saint Mary’s Regional Medical Center

Targeting antimicrobial stewardship to improve patient care, the hospital formed an Antimicrobial Stewardship Committee through membership in the AHA’s Pharmacist-Led Collaborative project. Because of real time data review and prompt feedback to clinicians, unnecessary treatment of positive urine cultures dropped from 23.27% to 4.87%.

Saline Memorial Hospital

The quality team introduced pharmacy review of every readmission, as well as patient conversations related to successful home recovery. The hospital’s transitional care program, citing changes to routine practices, has been featured on the HRET Huddle for Care website, www.huddleforcare.org.

Siloam Springs Regional Hospital

Implementing a pre-Oxytocin checklist which includes evaluation of gestational age and the ongoing commitment of staff and physicians to evidence-based practices has led to a sustained 0% rate for Early Elective Deliveries.

Sparks Regional Medical Center

The hospital developed a multi-disciplinary falls team amid a company-wide falls collaborative. Recognizing that improved communication among staff would be an important element in the effort’s success, the team put in place fall communication boards in each unit, and communicates current fall metrics at unit conferences and through daily emails.

University of Arkansas for Medical Sciences (UAMS)

Among many other initiatives, the hospital focused on improvement of perinatal care through its inter-disciplinary team’s use of Comprehensive Unit-based Safety Program (CUSP) methods as part of an AHRQ-sponsored national project. The team presented their work and success in reducing perinatal harm at the American Hospital Association’s 2016 Leadership Summit in San Diego.

Unity Health–White County Medical Center

The quality team implemented a new strategy of having unit directors research each fall and develop fall prevention plans unique to their unit’s patient population. Shift huddles identify at-risk patients, for whom targeted approaches are put in place. Lessons learned are shared with all units at team meetings to spread successes throughout the facility. The team reached its falls reduction goal within the first month of the project and sustained it throughout.

Ouachita County Medical Center

Taking both internal and external approaches to reducing readmissions, the hospital formed an in-house interdisciplinary team that reviews all readmissions and identifies areas for improvement. These cases are then reviewed at regular community meetings with nursing home representatives and other outside entities, where cooperative improvement opportunities are identified. Preventable readmissions are thereby reduced.
Arkansas Hospitals Gain Attention for Quality

As part of the Hospital Engagement Network (HEN) in which the Arkansas Hospital Association (AHA) participates under the umbrella of the American Hospital Association’s Health Research & Educational Trust (HRET) HEN Programs, participating hospitals are able to accomplish great things. One of the best benefits of the program has been the sharing of best practices and strategies among their peers by these hospitals who are leading change.

In recent months, leaders of the HRET HEN have had under review the successes throughout the country resulting from this sharing. Earlier this month, HRET released Case Studies on 11 of their 1,500 participating hospitals. The AHA is proud to announce that five of the 11 studies, more than 45%, focused on Arkansas hospitals.

Specifically, the case studies recognize Baxter Regional Medical Center for its work on reducing Central Line Associated Blood Stream Infections; Chicot Memorial Medical Center for its work on reducing Adverse Drug Events; Jefferson Regional Medical Center for its work in reducing Surgical Site Infections; Ouachita County Medical Center and Medical Center of South Arkansas for their work in reducing readmissions.

These successes are leadership-driven and organizationally embraced for the benefit of the hospitals’ patients and communities.

Congratulations to each of these hospitals for being leaders and mentors through the sharing of successes with peers across the country, and to the AHA’s vice president of quality and patient safety, Pam Brown, and her outstanding team of professionals who have worked closely with the state’s hospitals over the years to improve hospitals’ quality performance.

Nancy Godsey, RN, CPHQ, Nikki Wallace, RN and Cindy Harris – led by Pam — your team daily makes overwhelmingly positive differences in the lives of our hospital quality teams and patients across Arkansas!

To read about the various strategies for success and results, visit: www.hrethen.org/resources/castudies/casestudies.shtml. Be watching over the coming weeks for the release of more case studies from Arkansas.

More than the HEN...
Other AHA Quality Projects

Reducing Infections in the ICU

Health care-associated infections, or HAIs, are among the most common preventable causes of mortality in the United States, affecting one out of every 25 hospitalized patients. They are a significant cause of illness, death and excess cost in all health care settings.

Catheter Associated Urinary Tract Infections: affects roughly 290,000 hospital patients each year.

Central Line Associated Blood Stream Infections: approximately 31,000 cases occur annually with a mortality rate from 12 to 25 percent.

Through this project, participating hospitals target HAIs in the ICU by using the Comprehensive Unit-based Safety Program (CUSP) to focus on infection prevention at the unit level and improvement of the hospital’s overall safety culture.

Cohort 1 began in January 2016, and the AHA Quality Team is recruiting for Cohort 2 to begin soon!

Partnering to Reduce Readmissions

Part of the AHA’s quality commitment is to work with stakeholders across the state to equalize resources for improvement and avoid duplication of efforts.

Care across the continuum in communities is what it takes to reduce readmissions. This includes a holistic approach including not only the hospital, but also nursing homes, home health agencies, home caregivers and others to support patients’ successful recovery at home and prevent a return to the hospital.

The Arkansas Hospital Association (AHA) began partnering with the Arkansas Foundation for Medical Care in its work (under the QIO/QIN contract with TMF for the 11th Scope of Work) supporting community coalitions. In 2016, the AHA hosted two in-person meetings – Care Transitions-Care Across the Continuum – to introduce expert insight, resources and networking opportunities for providers across all community health care settings.
Sometimes, it is done for the convenience of the parents. Sometimes, so that a particular physician can attend the delivery. Whatever the case, early elective delivery (EED) is just that...early and elective, performed for a non-medical reason. Why is it important to stop the practice of “scheduling” delivery of babies a couple of weeks early?

It was once thought that babies born a few weeks early – between 37 and 39 weeks of gestation – were just as healthy as babies born after 39 weeks. Experts now know that babies grow throughout the entire 40 weeks of pregnancy, and particularly, their brains grow significantly in these last important weeks of gestation. The brain grows by one third just between week 35 and week 39. Electing to deliver a baby early, without a medical reason, compromises both the development and the health of the newborn infant.

AHA and its quality team are partnering with The March of Dimes to recognize hospitals that are preventing early elective delivery by implementing a “hard stop” policy and achieving a rate of early elective deliveries at 5% or below. (Hard stop policies eliminate scheduled deliveries performed without a valid medical indication prior to 39 weeks gestation.)

Hospitals Achieving this Recognition Include:
- Baptist Health Medical Center-Arkadelphia
- Baptist Health Medical Center-Little Rock
- Baptist Health Medical Center-North Little Rock
- CHI St. Vincent Hot Springs
- Conway Regional Medical Center
- Delta Memorial Hospital, Dumas
- Jefferson Regional Medical Center, Pine Bluff
- Medical Center of South Arkansas, El Dorado
- Mena Regional Health System
- Mercy Hospital Fort Smith
- Mercy Hospital Northwest Arkansas, Rogers
- Northwest Medical Center-Bentonville
- North Arkansas Regional Medical Center, Harrison
- Ouachita County Medical Center, Camden
- Saline Memorial Hospital, Benton
- St. Bernards Medical Center, Jonesboro
- Saint Mary’s Regional Medical Center, Russellville
- UAMS, Little Rock
- Washington Regional Medical Center, Fayetteville
- Willow Creek Women’s Hospital, Springdale

When the Arkansas Association of Health-System Pharmacists (AAHP) and the Arkansas Hospital Association (AHA) joined forces in January 2014, no one could anticipate the incalculable life-saving achievements this highly-charged collaborative would deliver. Nor that those results would blossom with a broadened focus, resulting in the development of new processes, bringing down hospital costs, while saving countless lives now and into the future.

The first year, the collaborative focused on reducing adverse drug events and sharing patient safety improvement methods across the state. The goal was to work together to solve problems that no one hospital can solve alone. Developed were processes, policies and procedures, order sets and protocols, educational materials, consistent methods of data collection and ways to coordinate processes through each hospital’s use of its electronic medical records.

In year two, Antimicrobial Stewardship became the focus. AHA and AAHP were joined by the Arkansas Department of Health, Arkansas Foundation for Medical Care, UAMS and the Centers for Disease Control and Prevention (CDC).

The goal was to increase the implementation of Antimicrobial Stewardship programs in our hospitals. From 2014 to 2015, 33 Arkansas hospitals showed an increase in implementation of the CDC core components of Antimicrobial Stewardship according to the annual CDC assessment. The collaborative also continued its focus on reducing Adverse Drug Events such as those associated with Warfarin, Insulin and Opioids.
Encouraging Hospitals to Achieve “Safe Sleep Certification” for Newborns

The Arkansas Hospital Association is partnering with the Arkansas Department of Health in promoting “Safe Sleep Certification” in hospitals with obstetric and newborn services through a program developed by Cribs for Kids®. Recognition is achievable at the gold, silver and bronze levels.

The National Safe Sleep Hospital Certification Program’s goal is to award recognition to hospitals that demonstrate a commitment to community leadership for best practices and education in infant sleep safety. By becoming certified, a hospital is demonstrating that it is committed to the mission of making babies as safe as possible in their sleep environment and eliminating as many sleep-related deaths as possible.

Six Arkansas hospitals have achieved certification through our partnership efforts. They are:

- UAMS (Gold Level) – Certified Safe Sleep Champion
- Arkansas Children’s Hospital (Silver Level) – Certified Safe Sleep Leader
- Ashley County Medical Center (Silver Level) – Certified Safe Sleep Leader
- Mercy Hospital Northwest Arkansas (Silver Level) – Certified Safe Sleep Leader
- Willow Creek Women’s Hospital (Silver Level) – Certified Safe Sleep Leader
- Delta Memorial Hospital (Bronze Level) – Certified Safe Sleep Hospital

Promoting Equity of Care and the Elimination of Disparities

Universal and rapid progress in ensuring that every patient receives the highest quality of care is essential to our efforts to meet the changing needs of our communities. As our nation makes the demographic shift toward a minority-majority balance, the need to identify and address disparities in care is increasing. So is the need to increase diversity in hospital leadership and governance.

But our consensus about the need to address these issues is not currently matched by a level and pace of action that will ensure success. That’s why the American Hospital Association is a partner in the National Call to Action to Eliminate Health Care Disparities, along with the American College of Healthcare Executives, America’s Essential Hospitals, the Association of American Medical Colleges and the Catholic Health Association of the United States.

This group is focused on making progress in three areas we believe provide the greatest opportunities for hospitals to increase the equity of the care they deliver: 1) Increase the collection and use of race, ethnicity and language preference data; 2) Increase cultural competency training; and 3) Increase diversity in leadership and governance.

Arkansas Pledged Organizations are:

- Arkansas Hospital Association
- Baptist Health
- Baptist Health Extended Care Hospital
- Baptist Health Medical Center-North Little Rock
- Baptist Health Medical Center-Arkadelphia
- Baptist Health Medical Center-Heber Springs
- Baptist Health Medical Center-Hot Spring County
- Baptist Health Medical Center-Little Rock
- St. Bernard’s Health System
-Ү

#123forEquity PledgeToAct
Organizations Pledged: 1,278
State Hospital Associations Pledged: 48
Metropolitan Hospital Associations Pledged: 10
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For voice callers who initiate calls to a person who has a hearing loss or a speech disability
arkansasrelay.com/voice

SPEECH-TO-SPEECH
For callers who have a speech disability and prefer to speak over the phone
arkansasrelay.com/sts

VOICE CARRY-OVER
For callers who have a hearing loss and prefer to speak over the phone
arkansasrelay.com/vco

SPANISH RELAY
For callers who wish to speak or type in Spanish
arkansasrelay.com/espanol

HEARING CARRY-OVER
For callers who are unable to speak and use a TTY
arkansasrelay.com/hco

CAPTEL
For callers who have a hearing loss and wish to speak and read on the phone
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888-269-7477 (CapTel - Español)
**THE COACH’S PLAYBOOK**

**Doing Well by Doing Good**

**By Kay Kendall**

As CEO and Principal of BaldrigeCoach, Kay Kendall coaches organizations on their paths to performance excellence using the Malcolm Baldrige National Quality Award criteria as a framework. In each edition of Arkansas Hospitals, Kay offers readers quality improvement tips from her coaching playbook. Contact Kay at 972.489.3611 or Kay@Baldrige-Coach.com.

The benefits of an engaged workforce are well-documented. These include higher customer loyalty, higher shareholder returns and higher productivity, along with lower employee turnover and decreased safety incidents.

It’s very interesting to me that recent studies from the past five or six years have demonstrated the statistically significant relationship between an organization’s commitment to societal responsibility (sometimes referred to as corporate citizenship) and employee engagement.

Societal responsibility indicates support of environmental, social and local economic systems and is demonstrated through contributions of money, other donations and volunteer efforts.

In excellent organizations, these contributions are given strategically to leverage core competencies, as opposed to merely writing a check for a disconnected, “feel good” opportunity to throw money at a cause.

In one study conducted by Northwestern University, employees working for organizations that invest in corporate citizenship were found to be significantly more engaged than employees who work for organizations that don’t contribute to societal responsibility. In addition, findings also show that the broader the opportunities for employees to participate in these activities, the higher the employee engagement scores.

Another study conducted by Boston College’s Center for Corporate Citizenship found that “the kind of employee engagement companies reap from community volunteer programs leads to workers having a deeper interest in the company’s overall goals and strategies.” In the same study, more than 90% of the companies surveyed listed improved employee engagement among the top three benefits of an employee volunteer program.

Many years ago, I served as the Leadership Team Champion for the Community Involvement Committee at the division where I worked in Tucson, Arizona. There, I saw firsthand the passion of our employees in making a difference in so many ways in our local community. We were the largest corporate contributor to the annual Diaper Drive for La Casa de Los Niños, a local not-for-profit organization that promotes child well-being and family stability, and the prevention of child abuse and neglect. I also recruited and led a team of our employees for the first all-women’s build for the Tucson Habitat for Humanity. We were not the largest employer—by far—in the area, but we were among the most recognized for our efforts in supporting our local community, and our employees took great pride in that.

The Baldrige Excellence Framework’s Core Values and Concepts include Societal Responsibility. For the health care version, that also includes Community Health. We see incredible examples from recent health care recipients of the Baldrige Award that support the findings that a strong focus on community involvement correlates with employee engagement. Here are a few:

- **North Mississippi Health Services (NMHS)** (2006 and 2012 Baldrige Award) – NMHS is located in what has been called the “epicenter of poverty,” and it provides high levels of charity care with $80 million worth provided in 2010 and 2011. The organization’s regional outreach includes obesity prevention services, school health centers that provide nurses...
to 22 schools in six counties, a free Nurse Link Call Center, and free fairs for preventive screenings and health care promotion. Does this societal responsibility resonate with the workforce? NMHS’s employee retention rate has been at or above 90% since FY07 and exceeds the U.S. Bureau of Labor Statistics benchmark for health care organizations by 10%.

- St. David’s HealthCare (SDH) (2014 Baldrige Award) – Since 2008, SDH has provided more than $1 billion in uncompensated care. It also provides preventive and restorative dental care to children and adults who would otherwise be unable to get treatment. The senior leaders encourage workforce involvement by asking employees and physicians annually to identify community involvement areas to support with volunteer hours.

And SDH’s employee engagement? It was the first health system in Texas to be named “Texas Employer of the Year” by the Texas Workforce Commission and has also been recognized as one of the “top 100 best places to work” by Modern Healthcare magazine. Physician engagement at SDH is in the top 10% nationally in six of nine factors and in the top 20% for the other three.

- Hill Country Memorial (HCM) (2014 Baldrige Award) – This 86-bed community hospital has provided more than $42 million in charity care since 2005. This includes discounting up to 90% of its fees to meet the needs of patients without health insurance or those without the means to obtain it. HCM also hosts “Good Health Schools” and community health screenings, offering osteoporosis information and bone density scans, hearing tests, and education on the importance of colonoscopies, vascular health and other relevant topics. Its “Transitions” program helps patients with chronic disease management.

What about HCM’s workforce engagement? Employee satisfaction and engagement scores, as well as those for employed and independent physicians, rank HCM in the top 10% nationally.

What these studies and examples show is that organizations can “do well by doing good.” An intentional process of understanding the needs of the local community and aligning those needs with the interests and passions of the workforce yields at least twice the impact. How can your organization maximize its contribution to societal responsibility while increasing workforce engagement?

Kay Kendall’s latest book, Leading the Malcolm Baldrige Way: How World-Class Leaders Align Their Organizations to Achieve Exceptional Results, can be pre-ordered at Amazon.com and BarnesandNoble.com.
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The Food and Drug Administration will require its strongest warning on nearly 400 opioid painkillers and benzodiazepines in order to educate more people about the risks of mixing the two types of drugs. The number of patients prescribed both types of drugs increased by an astounding 41% between 2002 and 2014. — The Washington Post

A new analysis based on data from seven countries hit hard by the Zika virus found a strong link between Zika infection and Guillain-Barre syndrome (GBS), a complication marked by numbness, weakness and sometimes paralysis of the limbs. The analysis reviews Zika and GBS patterns in seven countries: Brazil, Colombia, the Dominican Republic, El Salvador, Honduras, Suriname and Venezuela. Authors include health ministry officials and experts from the World Health Organization and its Pan American Health Organization. — Center for Infectious Disease and Policy

The Kaiser Family Foundation has released a new study titled “Disparities in Health and Health Care: Five Key Questions and Answers.” The study examines why some groups receive less and lower quality health care than others and offers an introductory overview of health and health care disparities, including what disparities are and why they matter, the status of disparities today, and key efforts to address disparities, including provisions in the Affordable Care Act and their impact on health coverage disparities. Find the study at www.kff.org/disparities-policy.

The Centers for Medicare and Medicaid Services has issued proposed rules to amend the Affordable Care Act’s permanent risk adjustment program, which was created to compensate plans for taking on sicker enrollees who have higher healthcare costs. If the rules are finalized, the program will consider prescription drug data related to the regular conditions factored into a patient’s risk score beginning in 2018. The proposed changes also would account for the risk to insurers associated with individuals who enroll outside of the open enrollment period. — Modern Healthcare
THE CALL BEFORE THE 9-1-1 CALL

Community Paramedics Provide More Than Transport

By Ed Gilbertson, Program Director, MEMS Community Paramedicine

The alarm sounds. An ambulance engine roars; lights and siren demand clear passage to the side of a suffering patient. We are on our way to save a life! That’s how you’d describe the excitement and drama of the paramedic profession, right?

You might be surprised to learn there’s a new response mode Metropolitan Emergency Medical Services (MEMS) paramedics in Central Arkansas are adding these days. We call it, “the call before the 911 call.” And we paramedics are the ones who will make them!
Answering a Need

Reducing readmission rates, addressing the overcrowding of ERs and meeting goals of the Triple Aim are standing agenda items in most hospital meetings. When digging through the toolbox searching for ways to address these concerns, sometimes a bigger hammer is not the best option. Something more subtle and personal may be the tool that gets the results you need. Enter the Community Paramedic (CP).

Community Paramedicine expands the role of EMS personnel to serve communities more broadly in the areas of primary care, public health, disease management, disease prevention and wellness, mental health, and oral health. CPs receive advanced training through an intensive standardized curriculum, allowing them to adapt to specific roles needed in their locales.

Community Paramedicine helps hospitals by keeping non-emergent patients out of the ER, helping discharged patients recover well at home instead of returning to the hospital, and encouraging population health while keeping costs down.

For the CP, the patient who, last month, was calling for ambulance service weekly with an emergency is now the client we are having coffee with, while gathering in-depth information on health history, social support structure, economic resources and education levels.

A part of the CP’s work is conducting an extensive physical exam of the client, as well as assessing their home to evaluate safety of living conditions, how well-stocked the pantry is, how medications are stored and dispensed, and other variables that can’t be determined during an emergent 911 response.

These assessments and histories are the detective work that leads the paramedic to underlying reasons for repeated 911 calls. For example, a patient will never reveal during an ambulance run that they are food insecure, and that if they go to the ED, they will get one or two meals during their stay before being discharged.

Or, the fact that they don’t understand their hospital discharge orders, and they aren’t sure how to proceed in getting help...this doesn’t readily pour out of a client. But these are the types of things that are revealed during an extended “visit” with the CP.

As ambulance paramedics, we have little option but to transport if the patient or family so requests. But once a hospice patient is readmitted to the hospital, revocation of hospice services usually follows.

The CP program can help these patients and their families think through their options, along with the hospice team, ahead of time, so that when symptoms worsen, a care plan is already in place. If a hospice nurse can’t respond quickly in an emergency, a CP can respond and release the 911 crew, staying with the patient and family until the hospice nurse can take over. Revocation of hospice services is thus avoided.

Some HUG consumers are diabetic or Congestive Heart Failure patients who have problems balancing diet and medicines. Some are elderly patients who fall often, and who need help getting up from the floor. Others are patients who don’t manage their medical conditions properly because they simply don’t know how. In each of these instances, CPs are on-scene providers who can assess the situation, offer immediate help, then assist in navigating the health care system to match the patient with existing resources.

Community Paramedicine also works well for patients discharged from the hospital with an increased likelihood of readmission, perhaps due to a lack of...

Community Paramedicine’s Clients

This new and emerging form of “out-of-hospital” care has developed in response to needs of patients who slip through the gaps in our current health care system. These patients frequently call 911 to handle non-emergent issues. In paramedicine, we call them our High Utilizer Group, affectionately known as HUG.

Some are hospice patients or families who call 911 when symptoms worsen.
around the country simply adapted paramedic interactions with patients in response to community needs.

With its own label today, response to community need is still the name of the game, and no two programs are exactly alike.

Community Paramedicine works in remote locales where the nearest definitive care is 200 miles away, and paramedics are essentially used for preventive and primary care.

It works in urban communities where people dial 911 for a variety of non-emergent problems when they aren’t sure what else to do.

It works anywhere patients are slipping through gaps in the system, addressing specific local problems by connecting patients with appropriate local resources.

To become a CP in Arkansas, the medic must have at least two years of field experience (each medic in the MEMS program has at least 10). They must also attend advanced training above and beyond their paramedic licensure.

This training is 300 hours, of which 200 is in the clinical setting working with home health and hospice nurses, case managers, physical therapists, primary care clinics, public health units, and additional ER experience on in-depth exam and history taking. They must then pass a National Certification Exam.

**Ambulance or Community Paramedic Response?**

When an ambulance call comes in, paramedics are obligated to respond. If the patient wants to be transported, they cannot be refused. The most a paramedic can do to redirect patients to more appropriate resources is explain their exam findings, and hope the patient will choose to be treated in a more appropriate way (that doesn’t tie up an ambulance and an ER bed).

The first officially recognized program in the state is run by Baxter Regional Medical Center in Mountain Home. Gerald Cantrell, RN/Paramedic, and Dan Snyder, Nationally Registered Paramedic, built and are running the program with five staff medics who cover day shifts Monday through Friday and are on call after hours and on weekends.

It’s a pilot program launched in March 2013. They saw 102 patients total that first year (each patient could receive multiple visits). This year, they have seen 197 patients so far and typically see 30-40 patients per month, with 173 patient visits in July alone.

Patient health goals are achieved through one or more community paramedic visits. “We get our referrals through the hospital’s case management office,” Cantrell explains. “We’re asked to follow up on patients who miss appointments or need some other follow up to ensure positive continuity of care.”

Some cardiologists have initiated a follow-up order for post-bypass patients to be seen by Community Paramedicine.

Snyder and Cantrell report that patient satisfaction rates stay consistently in the 95% range, as reported by post-care surveys. This satisfaction reflects well on the hospital, which arranges the follow ups.

As with every community paramedicine program in the country, services offered are shaped by both community needs and provider solutions in those communities.

**Some Statistics**

One program run by a company similar to MEMS is in Ft. Worth, Texas at MedStar Mobile Healthcare. They have been running their program for over six years and collecting data on cost savings since October 1, 2010.

Using CMS tables and charges, in the past six years they have recorded a total cost avoidance of $8,285,689 on high utilizer patients alone.

With 104 patients enrolled in their Readmission Prevention Program, 30-day readmissions have been reduced by 63.5%, resulting in a savings of $693,000 in direct costs.

Prevented penalties for Center for Medicare and Medicaid Services (CMS) 30-day readmissions were not figured into the savings, but, of course, penalties are potentially reduced with every prevented 30-day readmission. Arkansas has the second-highest readmission penalty rate.
The Right Thing to Do

Under the fee-for-service model, the service that ambulance services provide is “transport.” There is little to no reimbursement for the medical care that takes place in the patient’s home or in the ambulance.

So you might ask why a company whose financial lifeline depends on transportation is building a division to help prevent transportation. The answer is pretty simple. It’s the right thing to do.

Our health care system is overburdened with avoidable visits and admissions to the hospital. It costs everyone. When a patient doesn’t have the right follow-up or preventive care, it impacts their quality of life. Too often, people access care inappropriately, and more expensive care solutions are put into play when less expensive solutions were available. Proper utilization of care solutions – like calling on CPs – can leave ambulances, ED beds and in-patient hospital beds available for those who really need them.

As Jon Swanson, Executive Director of MEMS in Central Arkansas puts it, “We recognize that health care is undergoing a major transition in both how care is provided and how it is reimbursed. While MEMS continues its commitment to our core mission of pre-hospital care, we also believe that EMS generally, and MEMS specifically, is in a unique position to offer valuable services to our hospitals and patients through our community paramedic/mobile integrated health program to improve patient outcomes and reduce readmission rates in a very cost-effective manner.”

For more information on the MEMS Community Paramedicine program, contact Program Director Ed Gilbertson, RN, BSN. You can reach Ed at 501.301.1404 or egilbertson@metroems.com.
A Tale of Two Hospitals...and One Dedicated Administrator

Gary Sparks, CrossRidge Community Hospital and Lawrence Memorial Hospital

By Nancy Robertson Cook

Gary Sparks does not like attention. In fact, it’s hard to get him to talk about himself, but ask about the two hospitals he serves, and he opens right up. Gary is the administrator of CrossRidge Community Hospital in Wynne and Lawrence Memorial Hospital in Walnut Ridge. Located about an hour and 15 minutes apart, the hospitals share his time equally.

Both hospitals are connected with the St. Bernards system, which is headquartered in Jonesboro. CrossRidge is owned by St. Bernards, while Lawrence Memorial maintains its county-owned status but has been managed by the St. Bernards system for many years.

Log on to CrossRidge’s Facebook page, and you’ll see the words “Community” and “Thank You” often. The hospital thanks towns, schools, students, fire stations and others for hosting and participating in Kids Farmers Market and Heart Health events. It thanks auxilians for their time and service, physicians and nurses for their care and expertise, this employee and that employee for jobs well done. But what comes across loud and clear through these posts is the vast array of community service and outreach events the hospital provides. It’s an attitude of giving that prevails.

The same is clear at Lawrence Memorial. Take a look at the hospital’s web page, and you’ll find flyers for all kinds of upcoming events, from a Kids Health Fair and Carnival to upcoming blood drives to free prostate cancer screenings available at a community Prostate Cancer Awareness event.

The message is clear. Community outreach matters, and these two hospitals, under the leadership of Gary Sparks, have it going in spades.

“One of the advantages of a small town hospital is its ability to create close interactions with our citizens,” Sparks says. “For example, at CrossRidge, we focus a lot of outreach attention on our younger folks. We’re involved with the school system’s health and nutrition programming. We believe this can really make a difference to the health of tomorrow’s adults.”
• WHAT BRINGS YOU JOY?
Family! My wife, Carol, and I have a son and a daughter, and we have three granddaughters under the age of 2½. They’re close by in Memphis and Searcy, for which we’re very grateful.

• WHAT’S THE BEST ADVICE YOU EVER RECEIVED?
It came from my mother, who urged me to always speak to everyone and to be friendly to all. Particularly as we work in our hospitals, it’s important to be approachable. Her advice has served me well.

• WHAT ARE YOU READING?
Right now, two books. *Thinking Fast and Slow* is by Daniel Kahneman, a Nobel prize-winning economist, who explains how we think and come to make decisions. I’m also reading John MacArthur’s *Parables: the Mysteries of God’s Kingdom Revealed through the Stories Jesus Told*. I like reading anything in the human interest/biographical areas, and I am a regular reader of financial periodicals and a number of national and area newspapers.

• WHAT’S SOMETHING ABOUT YOU THAT PEOPLE DON’T KNOW?
I’m a longtime NASCAR fan. In our early 30s, my wife and I, along with several of our couples friends in Dyersburg, Tennessee, followed NASCAR and went every year to the two races at Bristol, Tennessee. I’m still following the sport all these years later.
Other CrossRidge programming includes county-wide blood drives, health career programs for high school students, heart health screenings, prostate health screenings, breast cancer awareness events and safe trick-or-treating for kids on Halloween.

Both hospitals have deep commitments to their communities and to quality of care. Both are financially stable...a difficult position for any hospital, particularly small, rural hospitals, in these times of severe federal budget cuts to Medicare.

“At CrossRidge, the Private Option has made a positive difference for our hospital’s financial status,” Sparks says. “Hospitals, particularly smaller hospitals, are in a difficult payment environment due to unintended consequences associated with cuts to Medicare reimbursement and changes in Medicaid policy. We’re very grateful to the legislature and our governor for seeing that the Private Option, soon to transition to Arkansas Works, is re-appropriated each year.” The Arkansas Hospital Association-engineered Medicaid provider assessment is also beneficial, he notes.

Lawrence Memorial’s financial stability is greatly helped by its Nursing Home and Durable Medical Equipment operations, he says. “Because it is a county-owned hospital, Lawrence isn’t eligible for participation in the provider tax program,” he adds.

Both hospitals are supported by 1-cent county-wide sales taxes, which have been renewed each time they sunset. “We are extremely humbled by the support of the citizens of Lawrence and Cross Counties,” Sparks says. “This year, the tax to support CrossRidge passed with 93% of the vote. Lawrence countians’ last hospital tax proposal passed with 75% of the vote. We feel these are votes of overwhelming confidence in our hospitals, and this drives us to do our best every day.”

Sparks holds an MBA, but earned his undergraduate degree in accounting. His health care career began with the Methodist hospital system in Memphis working at Methodist Central (now Methodist University Hospital) in Memphis, Tennessee. “In those days, Methodist Central was known as ‘the big house,’” he says. “It was one of the 10 largest private, church-related hospitals in the country.”

His first move was within the Methodist system, to the controller position at Biloxi Regional Medical Center. “I took a big chance agreeing to that one,” he smiles. “Not because of the position, but because I accepted it a few weeks before my wedding and didn’t have a chance to thoroughly discuss it with my future wife before accepting the job. Thankfully, she agreed!”

After 21 years in the Methodist system in roles including controller and, later, administrator, he heard about the administrative opportunity at Wynne through a friend. “Methodist was preparing to sell the hospital in Jackson, Mississippi, where I was serving,” he says. “I was a Harding College graduate and had family ties in Wynne. My parents still lived in the Memphis area, and our kids were going into the 6th and 8th grades. It was a good time to make a move.” Seventeen years later, he’s still glad they came home to Arkansas.
“Early on, I knew that I am most suited to life in smaller, more closely knit communities,” he says. “My accounting background has been a good foundation for meeting the challenges smaller hospitals face.”

As in every hospital today, hospital quality is front and center as a major focus at both facilities Sparks leads. “Regardless of its size, every hospital must meet expectations when it comes to quality of care,” Sparks says. “We’re proud that CrossRidge Community Hospital and Lawrence Memorial Hospital both consistently rank in the top four of 29 critical access hospitals (CAH) in the state for core measures. Many quarters, we’re either tied for first, or one or the other of the two is ranked first. The citizens support us with their tax dollars; they expect us to perform at a high level, and both hospital staffs work very hard to meet these expectations in the area of quality.”

Lawrence has received a top 20 CAH national quality award from the National Rural Health Association the last two years. CrossRidge received a 4-star ranking in the recent Hospital Compare ratings.

The hospitals’ successes can also be tied to leadership strength and administrative culture. “I am very lucky that in both hospitals, we have leadership teams that have been in place for more than 10 years,” Sparks says. “There’s no way to manage the dual administrative role without these teams and today’s communication technology!”

He sees hospital culture most strongly tied to the small things its leaders do. “Explaining a hospital’s culture can be an elusive goal,” he says, “but I think it’s the little decisions, day in and day out, that create the hospital’s atmosphere. What we emphasize at work, in our personal lives, in our communities matters!”

Two rural communities, two dynamic critical access hospitals, one dedicated administrator – Gary Sparks values the service opportunities particular to small town hospitals and is grateful for the very personal connections with Northeast Arkansas communities his role provides.
Smoking Cessation in Arkansas: Hospitals’ Duty of Care

Submitted by the Tobacco Prevention and Cessation Program, Arkansas Department of Health

Tobacco use impacts patient treatment and recovery from a variety of acute and chronic conditions. In Arkansas, health systems are encouraged to institutionalize cessation into routine clinical care. This includes screening patients for tobacco use and providing an intervention with every health care visit.

Systematically establishing electronic health record interventions increases the likelihood that healthcare providers will screen and intervene with patients who use tobacco. These tobacco cessation interventions will help reduce hospital readmissions for smoking-related diseases and improve patient outcomes.

Each year, 5,800 Arkansans die prematurely from tobacco-related diseases. Hospitals are foundational institutions in the fight against tobacco. They engage local communities in numerous ways beyond providing direct medical care. Hospitals and their clinics are credible voices for healthy changes and have a critical role in decreasing the lives lost to tobacco use in Arkansas.

The promotion of cessation efforts is the primary way in which Arkansas hospitals and health systems can play a role in the reduction of tobacco use. Since 2000, the United States Preventive Services Task Force (USPSTF) has recommended that clinicians ask all patients about tobacco use during every encounter and provide tobacco cessation interventions for those who use tobacco products.

There are numerous ways to provide or connect patients with appropriate treatment. Good communication with patients and their families is the key. By ASKING about tobacco use at every visit, ADVISING patients to quit and REFERRING patients to the Arkansas Tobacco Quitline (ATQ), hospitals will create a culture of health. This approach saves lives.

The ATQ is a confidential tobacco cessation counseling service that offers one, five, or ten call sessions combined with nicotine replacement therapy (NRT) and is free to any Arkansas resident. The quit counselor assists the tobacco user in developing a personalized quit plan and provides guidance through altruistic support and proven clinical methods.

In addition to the conventional phone-based services and NRT provided through the ATQ, services also include:
- Web-based tobacco cessation counseling;
- Text messaging for both phone and web enrollees;
- Online community forums to share and support those trying to quit; and
- Dedicated coaches for pregnant women.

Referring providers receive notifications when fax referrals or electronic referrals are received, when a patient enrolls or declines services, when a patient cannot be reached after five attempts, if NRT was shipped, and when the participant’s program is completed.

Research shows that tobacco users who use quitline services are more likely to successfully quit than tobacco users who try to quit on their own. Those individuals referred by their doctors are four to five times more likely to make an attempt to quit using tobacco. In fact, more than 80% of smokers see a physician at least once a year; of those, a majority show receptivity to their physician’s advice on tobacco cessation.
According to the National Institute for Health and Care Excellence, patients who remain smoke-free during a stay in the hospital heal more quickly and are less likely to be readmitted. Additionally, patients are more receptive to smoking cessation support while in a hospital, and are often more motivated to stop smoking following admission.

Recently, the United States Surgeon General reported that one out of five deaths in the United States is attributable to tobacco use. Therefore, hospitals should make tobacco cessation a priority in their operations.

**Making Tobacco Cessation a Priority in Your Hospital**

- Designate a staff member to coordinate tobacco dependence treatments.
- Enforce Act 975 of 2013 which requires indoor and outdoor smoke-free campuses to protect patients and staff from secondhand smoke.
- Create decision support tools and develop clinical workflows to modify electronic health records (EHRs), ensuring every patient’s tobacco use status is queried and documented at every visit.
- Integrate care with the Arkansas Tobacco Quitline (ATQ) and establish capacity for bi-directional data exchange and reporting so physicians can receive reports on services provided by the ATQ to their patients, and doctors and professional staff can monitor patient outcomes.
- Promote continuing education opportunities offered by the Arkansas Department of Health on tobacco dependence treatments.
- Communicate to all staff the importance of intervening with tobacco users, ensuring that healthcare providers within your hospital implement the brief tobacco intervention (Ask, Advise, Refer) at every patient visit.
- Educate your physicians about referring patients who use tobacco to the Arkansas Tobacco Quitline for free help at 1.800.QUIT.NOW (1-800-784-8669) or 1-855-DEJELO-YA (1-855-335-3569 for Spanish speakers).
- Order free educational materials with quitline information from stampoutsmoking.com to use in your hospital.
- Provide feedback to clinicians about their performance in patient screenings, drawing on data from electronic medical records.
- Choose tobacco Ask, Advise, and Refer measures Accountable Care Organization (ACO) #17, Center for Medicare and Medicaid Services (CMS) Clinical Quality Measures, or Joint Commission Core Measure Set and apply to hospital operations and clinics.
- For assistance in implementing electronic referrals, conducting brief tobacco intervention trainings, and ordering free educational materials for your patients, please contact Debbie Rushing or Shelia Garrett at the Arkansas Department of Health, 501-661-2953.

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tobacco use. The five leading causes of death in Arkansas are heart disease, cancer, stroke, diabetes and chronic lower respiratory disease — each of which can be related to tobacco use.

Smokers with a chronic disease are especially vulnerable to the health effects of tobacco, and they can experience longer hospitalization times, complications, and increased risk of death. In addition to the impact that smoking has on health and well-being, the healthcare costs in Arkansas directly caused by smoking amount to $1.2 billion annually.

“Hospitals are part of a broad health network,” says Dr. Gary Wheeler, Chief Medical Officer of the Arkansas Department of Health. “Our health networks must address tobacco use, our number one reversible behavior, which contributes to great human and financial losses for our state.”

He urges hospitals forward in the fight against tobacco use. “Hospitals can be significant allies to help reduce tobacco use and its negative effects among patients and workers,” Wheeler says. “They can be a powerful voice for healthy changes by making tobacco dependence treatment the standard of care.”

REFERENCES:
Dedicated hospital volunteers deserve to be protected while they are serving our hospitals and patients. Because they are not paid for their services, however, there often is no coverage available for an injured volunteer worker. Does your hospital have insurance to cover hospital volunteers? AHA Services, Inc. and the American Hospital Association endorse the AHA Volunteer Plan for the protection of hospitals and those generous individuals who donate their time to our facilities.

There is a group plan available for Arkansas Hospital Association members, or hospitals can take out individual plans, if desired.

“In absence of any coverage, an injured volunteer could file a general liability claim to have their injury/medical bills paid,” says Tina Creel, vice president of AHA Services, Inc. “This would go against the facility’s loss experience with their liability carrier. Volunteers injured while at the hospital facility are not covered by Workers’ Compensation coverage; therefore it makes sense that health care facilities would rather provide some level of coverage for injured volunteers, such as this plan co-endorsed by the American Hospital Association.”

The AHA Volunteer Plan was developed in collaboration with the American Hospital Association and AXIS Accident & Health, and it is a cost-effective option for insuring hospital volunteers, whether on or off your hospital’s premises. The program offers flexible benefit levels and premiums that meet the specific needs of each health care organization, without deductibles or co-payments.

The benefits offered under each plan include:

- Coverage of medical expenses that result from covered accidental injuries;
- Coverage for accidental death and dismemberment;
- Coverage for dental expenses resulting from accidental injuries; and
- No deductibles.

For more information on the plan or assistance with plan enrollment, please contact Tina Creel, 501.224.7878 or tcreel@arkhospitals.org.
In the current legal and regulatory environment, it is not a question of “if” but “when” your organization will be audited by a state or federal agency. And based on the results of these audits, you may be expected to demonstrate the effectiveness of your compliance program.

This is the second in a series of Compliance Counselor columns that will help you design hospital compliance programs and policies to keep you constantly ready for the auditing process.

Audits typically focus on compliance-related activities such as coding, billing, medical necessity documentation, privacy and security, anti-kickback or Stark considerations, cost reporting, conflicts of interest and EMTALA. Demonstration of the effectiveness of your program will be assessed based on the seven Compliance Program Elements listed in the 1998 Compliance Program Guidance for Hospitals, (63 Fed. Reg. 8987; Feb. 23, 1998) and supplemental guidance issued in 2005 (70 Fed. Reg. 4858; Jan. 31, 2005).

In our inaugural column, the Compliance Counselor listed these seven compliance program elements. As a reminder, they include:

- **Element 1** – development of written standards of conduct, as well as written policies and procedures that promote the hospital’s commitment to compliance;
- **Element 2** – designation of a chief compliance officer and compliance committee;
- **Element 3** – development and implementation of regular, effective education and training programs;
- **Element 4** – maintenance of a process, such as a hotline, to receive and track complaints;
- **Element 5** – development of a system to respond to allegations of improper or illegal activities;
- **Element 6** – use of audits and other techniques to monitor compliance with state and federal regulations; and
- **Element 7** – investigation and remediation of systemic problems.

Element 1 – development and distribution of written standards of conduct, as well as written policies and procedures that promote the hospital’s commitment to compliance and that address specific areas of potential fraud, was discussed in detail in that initial column (Arkansas Hospitals, Summer 2016).

This column addresses the requirements for satisfying Elements 2 and 3: Designation of a Compliance Officer and Compliance Committee, and Development of Education and Training Programs.

### Designation of a Compliance Officer

Each hospital should have an appointed compliance officer. Depending upon the size of the hospital, the person may have other duties; however, they should have sufficient resources (time, budget and personnel) to ensure that day-to-day operations of the compliance program are effective.

The compliance officer should report directly to the Chief Executive Officer and make regular reports regarding compliance directly to the hospital’s...
governing body (board). The compliance officer should maintain records of these reports.

The Office of Inspector General’s voluntary program guidance, as well as its formal directives issued in most Corporate Integrity Agreements, indicate that the compliance officer should not report to the General Counsel or Chief Financial Officer.

**Establishment of a Compliance Committee**

A compliance committee should be established with the compliance officer serving as chair. The committee should meet regularly (at a minimum, quarterly) and should include high-level executives of relevant departments such as finance, revenue cycle, human resources, medical staff, nursing, privacy/security, information technology and operations.

If the committee represents a hospital system, the committee should also include leaders of the other entities (e.g., home health, therapy clinics, physician practices, long term care units, etc.). Committee members are expected to attend each meeting, and minutes of the meetings should be maintained.

Committee members support the compliance officer in the analysis of risk areas, review of internal and external audits and investigations, establishment of education plans, review of industry updates and the development of compliance-related policies and procedures. They are also involved in an annual review of those policies, as well as the code of conduct.

**Compliance Training and Education**

Each hospital should, as a part of its Annual Implementation Plan, identify the training and education programs that will be provided. It is expected that all employees receive annual compliance training, including information about federal and state laws relating to health care benefit programs. This training should also address some, if not all, aspects of the code of conduct.

In addition to annual education of all employees, it is expected that the
compliance officer will provide education for the board. This can be provided through various media, including lecture, compact disc, written materials (such as newsletters) or computer-based training.

**Specialized Training**

An important part of any education and training program is information provided as part of new employee orientation. Employees should be introduced to the seven elements of an effective compliance program, information about privacy and security, as well as the code of conduct. Employees should receive this training within 30 days of their employment.

It is also recommended that high risk areas within the hospital, such as finance, health information management, billing, human resources, admissions and marketing, receive annual specialized training focusing on specific federal and state health care program requirements, as well as hospital-specific policies that pertain to their area of performance. All training materials and tracking records (sign in sheets/computer-based learning reports) should be maintained.

**Training after an Audit**

In addition to annual training, it is important that follow-up training related to findings of any audits or investigations be provided, as indicated. This training would be documented as an action item in the audit or investigative report. Any material revision to the code of conduct or compliance-related policies should be communicated to all employees at the time the changes are made.

In summary, one of the most important keys to an effective compliance program is the appointment of a qualified, designated compliance officer who has the resources necessary to manage the program. As a member of senior leadership, the compliance officer should report directly to the CEO and the board, as well as chair the compliance committee. Another key is a regular and comprehensive education and training program. With these elements in place, you are off to a good start... because ready or not, here they come!
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Voting for Health Care

By Jodiane Tritt, Vice President of Government Relations, Arkansas Hospital Association

In addition to hospital staff and physicians, our Arkansas volunteers are an integral part of the health care team. These dedicated individuals assist with mealtimes, provide support for bereaved families, help patients navigate complex building designs, raise critical funds and much, much more.

Volunteers in local communities are trusted and possess the understanding needed to engage people, too. In addition to all of the quiet, intimate tasks that volunteers selflessly accomplish within the walls of hospitals and other health care settings, they have a very important role in helping to transform health and social care services and bring about real improvement for patients and the general public.

All of those involved with Arkansas hospitals, including volunteers, have the ability to engage in the political process to ensure that candidates seeking elected positions are educated on community health care needs. They can relay accurate and helpful information to the public about which candidates are supportive of various mechanisms to continue to improve our health care system.

Health care has a lot at stake in November’s elections. At every level of government – federal, state, county and community – the people elected will have Arkansas health care’s future resting in their hands.

Arkansas now has more than 307,800 citizens who have completed the enrollment process and are receiving health insurance through the Private Option. With the backing of Governor Asa Hutchinson and our state legislature, the Private Option will end on December 31, 2016, and coverage for Arkansans whose incomes are at or below 138% of the federal poverty level (a yearly income of $16,242 for an individual or $33,465 annual household income for a family of four) will be transitioned to a new program, called “Arkansas Works,” on January 1, 2017. This health insurance helps our fellow Arkansans achieve and maintain better health.

Arkansas hospitals also benefit and become more financially stable as more Arkansans acquire health insurance. Since the Private Option’s inception in 2013, the rate of uninsured Arkansans has dropped more than that of any other
state except Kentucky. Unreimbursed visits to the emergency room are down, and uncompensated care costs for uninsured individuals – though they may never be fully eliminated – have dropped dramatically.

**Your Vote Matters**

Decisions made on the health care front in Washington, D.C. impact both state policy and financial decisions. Those decisions, in turn, affect every Arkansan, whether as citizens seeking health care, providing health care, overseeing health care, or monitoring the health of our citizens. Electing people who will work together to keep health care accessible and affordable helps keep our nation, and our state, healthy and productive.

Although Arkansas’s economy is improving, we are still a poor state. But Arkansas’s citizens have shown that we can do more with less, and that we are rigorous in the application of federal health care funding that comes our way.

Out of each Arkansas tax payer dollar, 44 cents is designated for kindergarten through 12th grade education; 27 cents for the Department of Human Services and the Department of Health – of which a portion is Medicaid funding; 14 cents is provided to higher education institutions; 8 cents is allocated for the Department of Corrections and the Department of Community Corrections; and the last 7 cents is dedicated to general government and local aid.

Of Arkansas’s $35 billion budget, only about $6 billion is state funds. The $6 billion is collected through Arkansas income taxes (56.2%); sales/use tax (36.0%); luxury tax (5.1%); insurance tax (1.5%); and other fees and taxes (1.2%).

The mechanics of the interplay between state and federal health care funding sources draws extra attention
with every presidential election. The person we elect can have a profound effect on how funding sources are managed, which, in turn, affects health care policy. In looking at just the 2015 Medicaid budget, only $898 million of the total $6.3 billion program came from state general revenue. New presidential priorities can modify how federal dollars are allocated to states and can dictate how states can use those dollars.

**Federal Matching Amounts**
Perhaps one of the biggest examples of this funding interplay occurs in policy decisions based around the state’s FMAP, which stands for Federal Medical Assistance Percentages. It’s the formula by which the percentage of federal matching funds for state expenditures toward state medical, medical insurance and certain social services assistance payments is calculated. Calculated FMAP rates are used by the United States Department of Health and Human Services to determine the amount of federal matching for state medical assistance (Medicaid), Temporary Assistance for Needy Families (TANF) Contingency Funds, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, and the enhanced FMAP rates for the ARKids program (federally called the Children’s Health Insurance Program [CHIP]) expenditures, among others.

FMAPs are determined and published each year by the U.S. Secretary of Health and Human Services. Poorer states, like Arkansas, have higher FMAPs, so our state receives more in federal matching funds on approved programs than would a more affluent state.

The current FMAP for Arkansas is just under 70% (69.69%, to be exact). This means out of every dollar spent in the state medical insurance and designated social services assistance arenas, only a little more than 30 cents comes from Arkansas tax dollars. The rest – about 70 cents of every dollar – comes from federal tax funds.

**Federal/State Partnership Imperative**
Keep in mind that it takes a state-federal partnership in order to utilize the FMAP funding formula. If the state proposes a policy that the federal government refuses to fund, the state would not have the advantage of utilizing federal dollars to offset expenses. By the same token, the federal administration can present a huge incentive to states to implement a policy by paying MORE than the FMAP’s share to a state. That is one reason that the federal elected officials and the state elected officials must work together, and why we must elect officials who are diligent in their efforts to improve our health care system in the most efficient, effective way.

Using some provisions of the federal Patient Protection and Affordable Care Act of 2010 and granted waivers from the Centers for Medicare and Medicaid within the federal Department of Health and Human Services, the Arkansas Works program will take advantage of an enhanced match rate. Instead of 30 cents of each dollar coming from state revenues, only 5 cents will be needed (95 cents will come from federal sources). In calendar year 2018, 6 cents of each dollar will be from state revenues;
7 cents in 2019; and 10 cents in calendar years 2020 and beyond.

This plan bodes well for the continuation of health insurance coverage for the previously uninsured, and it invites others still uninsured to seek health insurance, as well.

The Importance of Citizen Participation

Just as your vote is important for Arkansas health care, so is your voice. This issue of Arkansas Hospitals celebrates our hospital volunteers, whose voices carry a mighty weight with Arkansas’s elected officials.

Having health care as part of an election platform is defining for candidates at all levels. Gone are the days when we, as citizens, leave decisions about our health and our health care to others. Taking interest in health care issues, studying candidates’ health care positions, being involved in health care governance discussions and carrying the Arkansas health care message forward are all things you can do as election year rhetoric heats up.

More importantly, your being heard as a voice of reason in the midst of heated rhetoric speaks volumes. Whether you are talking with friends, thinking things over with family, discussing issues with your church group, or shooting the breeze at the barber shop, never underestimate the importance of your voice to the health care dialogue. Being informed on how candidates’ views may impact each Arkansan’s health care is important, and drawing attention to their views may just be the impetus needed to encourage our elected officials’ steadfast support of improving our health care system.

If we at the Arkansas Hospital Association can assist and connect you with information on how individual candidates stand on health care, we would be glad to do so. You may contact me directly at 501.224.7878.

Your voice counts. Your vote counts.

No matter who you support, please exercise your right to vote November 8. It’s a precious right, admired and desired by so many in other nations. Here’s to Election Day, and to good decisions to come from those we choose to lead us.

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- Saline Memorial Hospital
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- Bradley County Medical Center
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Learn more at afmc.org/breastfeeding. Breastfeeding is the healthiest choice for mom and baby.