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A mother whose child breaks an arm on the playground wants it set in minutes by doctors and nurses known in her community. A stroke victim rushed to his local critical access hospital needs access to brain-saving treatment through telehealth connection partnerships. A farmer injured in an accident can be stabilized at his home hospital for transport to a higher level trauma center. For all of these people, having local access close to home is priceless.

Healthcare needs are not limited to urban settings. As former Centers for Disease Control and Prevention director Jeffrey Koplan, M.D., often noted, “Either we are all protected, or we are all at risk.”

In a predominantly rural state like Arkansas, the hospital industry recognizes the value of broad access to medical services. With more than 40 of Arkansas’s 104 hospitals designated as rural – 29 of those as critical access hospitals having 25 or fewer beds – our state has a great stake in the future of rural healthcare.

Our colleagues at the American Hospital Association have long recognized Arkansas’s valuable perspective in this arena. Recently, they named Ray Montgomery to head a newly formed Task Force on Ensuring Access in Vulnerable Communities. Ray, president and CEO of Unity Health White County Medical Center in Searcy, began work on the 30-member task force last fall. The group’s work is anticipated to conclude this spring and includes identifying strategies and federal policies to help ensure access to care in vulnerable rural and urban areas. Evaluation of emerging delivery and payment models for healthcare services is one focus of this work.

In addition to valuing strong leadership at the administrative level, the Arkansas hospital community recognizes the importance of volunteer leadership both within the state and nationally. Volunteers are key threads in the fabric of all hospitals, including those in our rural communities. For this reason, the President of the Arkansas Hospital Auxiliary Association (AHAA) has, for many years, been a voting member of our AHA Board of Directors.

At the national level, the American Hospital Association recently named former president of the AHAA, Lynn Smith, to chair its 2016 Committee on Volunteers. Lynn knows well the value small hospitals bring to their communities, and we know she will provide an excellent national voice for Arkansas’s hospitals.

Your voice as a representative of your hospital and your hometown counts at the national level, too. Attending the American Hospital Association’s annual meeting May 1-4 as a part of the Arkansas delegation gives you the opportunity to tell key congressional staffers and other national industry leaders how healthcare policy decisions play out at the local level.

In conjunction with the meeting, the Arkansas Hospital Association is sponsoring a May 3 luncheon where representatives from each of Arkansas’s six congressional offices will be in the room specifically to hear from you about the important issues facing the hospital industry across Arkansas. Part of that message will be a focus on access.

Access to healthcare is important no matter where a person lives; hospital access in our small towns is something we’re working together to maintain. We’re proud of the strong network of Arkansas hospitals providing high quality care to the diverse communities, large and small, within our state every day.

Bo Ryall
President and CEO
Arkansas Hospital Association
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EDITOR’S letter

HOMETOWN HEALTHCARE

Nothing replaces the “home” in hometown healthcare. We often think of rural and small town healthcare as part of the safety net, but it’s so much more than that.

For those of us who live in small town America, our local hospital often is the heart of the community, offering not only excellent services, but also warmth and compassion from the people we see each day while shopping in the grocery store or walking down the sidewalk.

I learned the importance of hometown healthcare firsthand in my early 20’s. Though I grew up in central Florida, I attended college at Arkansas State University in Jonesboro. I’d been away from home only three years when I was diagnosed with cancer during my senior year at ASU. Excellent treatment was available nearby, but I wanted home – my house, my bed, my local doctors and hospital, and most of all, my family and friends. So, I packed my bags, got in the car and drove 1,000 miles to stay with my parents and get treatment near the town where I grew up.

Even now, after being cancer free for more than two decades, I still believe my support system and familiar surroundings were critical components of my recovery. For me, having access to care in my home community was about more than convenience; it was about survival.

This issue of Arkansas Hospitals celebrates rural and small town healthcare. Our AHA member hospitals play a vital role in providing and supporting this care close to home.

Focusing not only on day-to-day medical services, these hospitals are implementing public health and community benefit initiatives, as well as supporting the local economy. Ask anyone in economic development, and they will tell you a strong hospital means a strong community.

Hometown healthcare offers opportunity for innovation, creative problem-solving and the satisfaction of serving neighbors well. To those on the front lines of local healthcare, we salute you. We thank you for continuing to welcome us home.

Elisa White, Editor-In-Chief

A 2016 Governor’s Quality Award Healthcare Seminar

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Calendar

April 1, Hot Springs
Arkansas Healthcare Human Resources Association (AHHRA) Spring Conference Clarion on the Lake

April 1, Little Rock
Arkansas Society for Directors of Volunteer Services (ASDVS) Spring Conference AHA Classroom

April 8, Little Rock
Arkansas Hospital Association Board Meeting AHA Boardroom

April 12, Webinar
CMS CoP Revised Interpretive Guidelines: What Every Hospital Needs to Know
Part 1 – CMS Patient Rights Standards: Keys to Ensuring Compliance *Part 2 – See April 26 face-to-face meeting.

April 12-13, Little Rock
2016 Hospital Emergency Preparedness Forum Crowne Plaza

April 13, Little Rock
Pharmacy Led Collaborative: Antimicrobial Stewardship/ADE Crowne Plaza

April 13, Hot Springs
Healthcare Financial Management Association (HFMA) – Arkansas Chapter Spring Conference Embassy Suites

April 21-22, Franklin, TN
Joint Commission Resources CSR Spring Workshop Embassy Suites

April 22, Little Rock
Arkansas Society for Healthcare Marketing and Public Relations (ASHMPR) Spring Conference AHA Classroom

2016 Hospital Emergency Preparedness Forum

By popular demand, Mitigation Dynamics, Inc. returns to Arkansas to present two compelling sessions: A Hospital Response to Civil Unrest and Domestic/Foreign Terrorism and Its Effects on Healthcare. This 2-day conference also includes an update and review of the Strategic National Stockpile CHEMPACK Facilities program; an overview of the Arkansas Crisis Response Team; and an up-close look at Alternate Care Site Requirements (including a tour of Arkansas’s mobile hospital). In addition, we will learn about the 189th Airlift Wing’s Rapid Augmentation Team and its Mobile Emergency Operations Center. Additional information is available from the AHA’s education team at 501.224.7878.
AHA Education Program information is available at www.arkhospitals.org/events.

April 22, Little Rock
AHA Workers’ Compensation
Self-Insured Trust Quarterly
Board Meeting
AHA Boardroom

April 26, Little Rock
CMS CoP Revised Interpretive Guidelines: What Every Hospital Needs to Know
Part 2 — The 2016 CMS Hospital CoPs: A Clear-Eyed Approach to Ensure Compliance
Hilton Garden Inn
*Part 1 — See April 12 webinar.

April 29, Little Rock
Arkansas Association for Medical Staff Services (ArkAMSS)
Spring Conference
AHA Classroom

May 1-4, Washington D.C.
American Hospital Association
Annual Membership Meeting
The Washington Hilton

May 5, Benton
Arkansas Association for Healthcare Engineering (AAHE)
Scholarship Golf Tournament
Silver Springs Country Club

May 5, Little Rock
AHA Workers’ Compensation Self-Insured Trust Annual Education Conference/Healthcare Staffing Services User Group Meeting
AHA Classroom

May 6, Benton
Arkansas Association for Healthcare Engineering (AAHE)
Annual Meeting and Trade Show
Benton Event Center

May 9-11, Little Rock
Basic Crisis Response Training
AHA Classroom

May 10-12, Little Rock
Arkansas Association for Healthcare Quality (AAHQ)
Introduction to Quality Course and Quality Summit Watch Party
Baptist Health Barrow Road Center

May 12, Little Rock
Arkansas Hospital Auxiliary Association (AHAA)
Board Meeting
AHA Boardroom

May 18, Little Rock
Communicating, Networking and Getting Things Done: A How-To Guide
AHA Classroom

May 20, Little Rock
Arkansas Social Workers in Healthcare (ASWHC) 2016 Spring Conference
AHA Classroom

May 25, Little Rock
A Day With The Lawyers
Hilton Garden Inn

May 30, Little Rock
Arkansas Hospital Association Offices Closed

June 15-17, Branson, MO
Hospital Executive Leadership Conference and AHA Board Meeting
Hilton Branson Convention Center

June 24, 2016, Little Rock
Arkansas Healthcare Human Resources Association (AHHRA)
Summer Conference
AHA Classroom

July 4, Little Rock
Arkansas Hospital Association Offices Closed

Communicating, Networking and Getting Things Done: A How-To Guide

Join award-winning author and Arkansas Small Business Hall-of-Famer Kim Hodous as she teaches 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.
NEWSMAKERS and NEWCOMERS

- **JOANIE WHITE-WAGONER**, FACHE, has been named vice president and administrator of Baptist Health Medical Center- Conway, which is slated to open this fall. White-Wagoner is a U.S. Air Force veteran with more than 18 years of leadership experience in the healthcare setting. She was most recently COO/administrator of Texas General Hospital in Grand Prairie, Texas, and prior to that time, vice president of operations and chief of Health Administration Services based out of the Veterans Health Administration in Dublin, Georgia.

- **JIM LAMBERT**, FACHE, president of Arkansas Health Alliance, was recently reappointed by Governor Asa Hutchinson to the Arkansas Board of Health. His appointment expires December 31, 2019. By virtue of this appointment, Lambert will continue to serve on the Arkansas Hospital Association board of directors for that same period.

- **SCOTT PEEK**, CEO for John Ed Chambers Memorial Hospital in Danville for the past 25 years, has been named president of Medical Assets Holding Company in Maumelle. Peek’s 32 years at Chambers Memorial included serving as controller, assistant CFO and CEO.

- **LYNN SMITH** of Hot Springs has been named chair of the American Hospital Association’s 2016 Committee on Volunteers. Smith currently serves as a volunteer at CHI St. Vincent Hot Springs after recently moving to central Arkansas. She is a past president of the Arkansas Hospital Auxiliary Association and former member of the Arkansas Hospital Association board of directors. She also is a past president of the Medical Center of South Arkansas Auxiliary in El Dorado.

- **MERYL GRASSE**, M.D., died January 29 in Chambersburg, Pennsylvania. Dr. Grasse was a long-time member of the Arkansas Hospital Association, receiving the association’s 1991 Distinguished Service Award. In 1952, Dr. Grasse built the Medical Center of Calico Rock, now known as the Community Medical Center of Izard County. Memorials in his honor may be sent to the hospital.

all about HOSPITALS

- **BAXTER REGIONAL MEDICAL CENTER** in Mountain Home has been named a finalist for the American Hospital Association’s 2016 Hospital Awards for Volunteer Excellence (HAVE). The HAVE program was established by the association’s board of trustees to showcase outstanding volunteer initiatives. The awards honor specific volunteer service areas or programs in four categories. Baxter Regional is competing in the Community Service category. Award announcements are expected in April.

- **WASHINGTON REGIONAL MEDICAL CENTER** in Fayetteville will soon undergo a new construction project creating a four-story, 66,300-square-foot medical plaza to house urgent care and family practice services, as well as an outpatient imaging center. Expansions already underway include a women’s and children’s center, second helipad and 350-space parking deck for patients and visitors. The projects total approximately $86 million and will add nearly 200 employees at the facility.

- The **GREATER DELTA ALLIANCE FOR HEALTH** recently announced a grant from the Blue & You Foundation for a Healthier Arkansas. The grant will provide the organization, a 10-hospital network in south Arkansas, funding for its Arkansas Delta Health Education for Local Providers (HELP) project to expand its on-site simulation training for OB emergency situations to its rural health hospital teams. Additionally, the grant will fund Neonatal Resuscitation Program certification training of hospital delivery teams, pre-hospital providers, inter-facility transport providers and emergency department staff in the Arkansas Delta. The training courses are offered free to participating hospitals and ambulance services in twelve counties.

  Alliance hospitals include Ashley County Medical Center (Crossett), Baptist Health-Stuttgart, Bradley County Medical Center (Warren), Chicot Memorial Medical Center (Lake Village), Dallas County Medical Center (Fordyce), Delta Memorial Hospital (Dumas), DeWitt Hospital & Nursing Home, Drew Memorial Hospital (Monticello), Jefferson Regional Medical Center (Pine Bluff) and McGehee Hospital.
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Of the many challenges rural hospitals face today, the most heart-wrenching is, “Can we keep our doors open?” Our hospital, Franklin Hospital, was on the chopping block twice, but hospital board, community, state and national diligence – and cooperation – saved local access to healthcare. Today, the hospital is fully operational, financially secure and growing. We serve as an example that when all looks bleak for a small, rural hospital, there is hope.
A southern Illinois public hospital located in the small, economically depressed rural community of Benton, Franklin Hospital’s first near-closure threatened 20 years ago, before today’s cycle of rural hospital struggles began. But our story isn’t old news; in fact, I believe the steps to our success can help rural hospitals in trouble today.

We have come full circle, and the 360 degree engagement of all entities – from our local hospital board to our patients, the community as a whole, and state/federal agencies – tells our story.

The Setting

Benton, population 7,000, is the county seat of Franklin County (population 39,000). The hospital competes with five prospective payment system hospitals, two 25 miles to the north, two 20 miles to the south and one 35 miles away in the college town of Carbondale. There are nine critical access hospitals (CAHs) within a 50-mile radius. The CAHs compete for medical and technical staff but tend not to compete for patients.

The county suffers from high unemployment and a large indigent population. As a result, a third of Franklin County patients are either covered by Medicaid or are uninsured. This directly influences the payer mix of the hospital.

Until about 1990, jobs in southern Illinois were plentiful due to large, local deposits of high-sulfur coal. The Clean Air Act Amendment of 1990 caused utility companies to stop buying the coal, whose burning is often associated with production of acid rain. Mines closed, and jobs were no longer plentiful. Profitable operation of hospitals in the area became difficult.

In fact, in 1995, the Franklin Hospital District Board was told by its auditors that, absent an influx of cash, the hospital would close. Fortunately, Southern Illinois Healthcare (SIH) had, at that time, as part of its mission, horizontal integration of the area’s healthcare market. SIH presented a management contract, which was signed with Franklin Hospital in late October 1996. First closing averted.

Unfortunately, many small, rural hospitals suffered under the federal prospective payment system in the late 1990s (before institution of the CAH program), and SIH incurred losses of more than $10,000,000. Five years after saving us from closure, SIH leaders realized Franklin Hospital’s operations were not sustainable.

In 2001, SIH informed the Franklin Hospital Board that it would no longer manage and operate the hospital. The board then tried to sell the hospital through a broker, but there were no takers due to the area’s financial history. By spring 2002, Franklin Hospital owed large management fees to SIH and had no access to funding to remain open. Hospital board members, thinking there was no other choice, voted to close the facility.

Distraught community members contacted the Illinois Department of Public Health (IDPH) seeking another option. Two weeks later, after IDPH helped commission a financial feasibility study, the Franklin Board again voted — this time to remain open. In the four months that followed, the hospital stripped services to the bare minimum, downsizing to two beds, keeping only the emergency room and essential services open. A loan for operating capital was secured. Through hard work and sheer tenacity, the hospital reassessed and revamped.

With time, full operations were restored, and despite the region’s continued economic hardships, hospital service lines and our associated clinic have grown. Access for our neighbors was pared down, but never lost. This is a key element for struggling hospitals to bear in mind today.

What Worked?

Bottom line, it was bringing in the right leadership and the fortuitous alignment of the right partnerships.

Working with the Franklin Hospital Board, the community leaders contacting IDPH found the timing to be perfect. IDPH’s federal plan to implement the CAH program had just been approved, and an experienced rural hospital consultant was appointed to meet with Franklin Hospital’s staff. Together, the hospital and key community stakeholders were able to recruit a seasoned chief executive officer with the desired necessary financial and leadership skills. (I humbly note that being recruited for this role warms me to this day.)

The task at hand was to restart hospital operations and manage with an unbelievably tight budget. As a newly-hired CEO, not only was I tasked with rebuilding the medical staff, but also with reopening basic hospital departments and once again generating community confidence in the hospital and its medical providers.

I’m forever grateful for the working relationships established while serving as a CEO in other small, rural Illinois hospitals. In rebuilding Franklin Hospital, these relationships proved invaluable. With our administrative team, new relationships with both the community and state agencies were forged.

During this period, the Franklin Hospital Board of Directors gave me its support and acted on the tough decisions necessary to restart an operation from scratch. Everyone had to be on the same page, being creative and committed to the long term success of the hospital. The community was fully behind its hospital, recognizing not only the need for healthcare access, but also its role as an economic catalyst for maintaining and growing local businesses.

continued on page 14
Fast Forward to 2016

Today, Franklin Hospital is still serving the Benton community. Our emergency room volume is about 6,700 patient visits per year, down from 9,600 in 2004. Rural Health Clinic visits for 2016 are projected at slightly over 23,000, up from zero in 2004. (See Exhibit 1 above.)

Franklin Hospital has been able to shift many unnecessary, avoidable emergency department visits to its rural health clinics. This reduces overall cost of care by moving provision of care to less expensive outpatient modalities. [Emergency room registration costs a patient (or an insurance company) over $2,300, whereas a rural health clinic registration comes in at around $136.]

Review of Exhibit 2, revenue and expense growth over a 10-year period, indicates positive results for the hospital from an overall perspective. Between 2005 and 2015, hospital revenues grew from about $16.5 million to almost $42 million.

Exhibit 3 shows that expenses grew at a smaller rate than the corresponding revenue. For example, between 2010 and 2015, revenue grew by 27% and expenses by 16%. Revenue growth is important in keeping a hospital viable, but we have never shifted from the mindset of our tightest budget days, believing it is equally important to proactively control expenses.

Finally, payer mix has radically changed through the years. In 2010,
nearly 9% of revenue generated was for “self-pay” or uninsured patients. By the end of 2015, the percentage had dropped by roughly 6%, and the total charges for that piece of the pie dropped by nearly half, if adjusted for inflation.

Medicaid and “other” (primarily commercially insured patients) grew substantially. Part of the growth came from the state of Illinois’s willingness to utilize Medicaid expansion to fulfill Affordable Care Act requirements for covering the healthcare needs of the indigent. A portion of the growth came because of successful recruiting efforts on the part of the hospital.

Overall, the effect on the hospital’s viability has been dramatic and a real improvement for our outlook. We attribute a great deal of our success to the state’s willingness to expand Medicaid; in states where the Medicaid program was not expanded, many rural hospitals like ours have closed.

The Net Effect

Patients now have the option to locally access a great primary care system (hospital plus rural health clinics). Our neighbors are receiving primary care in the appropriate venue. This keeps them out of the emergency room and inpatient beds because, overall, they are getting good, solid preventive treatment in their doctors’ offices close to home. This saves the state of Illinois the cost of transporting Medicaid patients to facilities 25 miles or more outside the county, and long term, it will save millions of dollars in the cost of providing chronic condition care to these patients.

And, again, our hospital is showing an excess of income over expenses. While we will never be immensely profitable, our hospital is able to make it on its own and serves as an important economic engine for the area.

We have come full circle, and the 360 degree engagement of all entities – from our local hospital board to our patients, the community as a whole, and state/federal agencies – tells our story. It took all of us, working together, to bring Franklin Hospital back home from near closure. We share our story to help other rural hospitals. Our message is, “You, too, can keep your doors open. You can find solutions. Continuing to bring healthcare home to your citizens is possible, and it is priceless.”

Hervey Davis is Chief Executive Officer of Franklin Hospital, Benton, Illinois. He joined the organization in September 2002, when the hospital drastically reorganized to avoid closing. The Franklin Hospital’s phoenix-from-the-ashes story has been featured on the pages of Modern Healthcare magazine and was most recently presented at the American Hospital Association’s 2016 Health Forum Rural Health Care Leadership Conference held in February.

Mr. Davis appreciates the time and assistance of his friend and colleague, Pat Schou, in writing this article. Ms. Schou is Executive Director of the Illinois Critical Access Hospital Network (ICAHN). ICAHN is a not-for-profit 501(c)(3) corporation established in 2003 for the purposes of sharing resources, providing education, promoting efficiency and best practices, and improving healthcare services for its member CAHs and their rural communities.
Lessons to be learned from the Franklin Hospital experience:

- Keep the faith. Don’t let your local healthcare resources slip away. Invest in strong administrative leadership and, as a board, let them lead.
- Make your involvement with your state and federal legislators a priority. Typically, your legislators are dedicated people interested in making your town, your county and your state a success and a good place to live. Your hospital, if not the largest employer in a rural area, will rank in the top three. Your involvement is not only needed, it is welcomed by local and state leadership.
- Stay involved with your healthcare partners by keeping in touch with your state hospital association and the American Hospital Association. If you have the privilege of having a critical access hospital network that you can be a part of, get involved in that organization as well. Seek out leadership positions in these organizations.

What were the major events that allowed Franklin Hospital to stay open and grow?

There were several, but the most critical had to do with financing and reimbursement factors:

- The United States Department of Agriculture (USDA) provided a loan of $4,000,000 for operating capital to kick-start hospital operations. It should be noted that normal USDA provisions for approving loans were waived (typically, operating capital loans are not made by the USDA). Without this operating capital, the hospital would not have been able to take those first steps away from closing the doors.
- The hospital was certified as a critical access hospital (CAH). This provided cost-based reimbursement for the facility from the Medicare program. Between the cost-based reimbursement on the Medicare side of the ledger and the 20% of business that was covered by commercially insured patients, there was enough cash to operate the hospital for the first few years.
- In 2010, the Illinois Legislature passed a law that gave CAHs cost-based reimbursement for outpatient Medicaid patients. This provided roughly $1,000,000 in additional reimbursement for Franklin Hospital – increasing from about 10 cents on the dollar to about 22 cents on the dollar. (Cost, as computed on the Medicare cost report, is currently 29 cents on the dollar.)
- The state of Illinois made the decision to expand the Medicaid program, covering the healthcare needs of the indigent adult population of the state. This, for Franklin, caused the “self-pay” business of the hospital to shrink from about 9% of total charges to just under 4%. Adjusted for inflation, this equated to a decrease of about 50% of previous expectations.
- A well-qualified, dedicated, creative management team and board of directors worked in tandem.
- In addition to receiving necessary reimbursement from governmental sources, rural hospital operations were carefully overseen. Expenses were controlled, and revenue growth was pursued.
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Providing the right blood for the right patient at the right time.
Ida (a pseudonym) was 63 years old and dying with pancreatic cancer. She lived alone. She was in terrible pain. There was nothing more that the medical institution could do for her, so she was discharged from the hospital with no plan for continued care. She was, by the time of her call to us, unable to get out of the house. “Please,” she asked, “is there someone who can come see me? I need help and have none.” As a young resident, I was charged with making an assessment and bringing her story back to the residency. The year was 1982, and I was midway through my family medicine training.

Her need was overwhelming, and at the time, there were no clear answers. There were no procedures or medicines that could reverse her disease.

There were too few hands, ears and minds that were comfortable embracing death; few were willing to stand with someone like Ida, working actively and quietly to raise the experience of dying to a level of significance on par with birth and our lifelong struggle against disease. There was little or no place in the work of the physician for the care of the dying. Much of what we did was awkward, unstudied, and occasionally, harmful.

My residency director, Kenneth Goss, M.D., helped me. “So long as you pursue the science of your involvement and do nothing of questionable ethic, I will stand with you. Take the time you need. Chronicle the experience, and share it with all of us. Let’s see where this goes.” Dr. Goss was a wonderful man and teacher, always affirming, guiding and encouraging.

There were few products that could help Ida’s pain. Only immediate release morphine held any promise, but she eventually could not swallow the pills. We sat and talked as I crushed pills and mixed the resultant powder with petroleum jelly to build rectal suppositories. They had to be given at regular intervals, so my other work, my life at home and sleep were too often interrupted. But, she died with little pain and with someone at her bedside. She was thankful and at peace. It was a good death.

I spent many hours with Ida, in the study of dying and the use of narcotics. I learned from her as she spoke of social disenfranchisement and regular disappointment. She demonstrated the power of faith in mitigating the
sufferings of transition. I learned of kindness and depth, often missed in the superficial interactions of daily living. I learned of her life and then of her dying. Though she had very little, she was rich indeed.

**Searching for My Place**

My work with Ida shaped the way I wanted to practice medicine. This was good work, but it clearly required an organization of caregivers. No one individual could do it alone. The then-youthful hospice movement was beginning to catch people's attention, yet it was still considered countercultural within the medical world of my place and my time. When the idea of establishing such an organization in central Arkansas was brought to hospitals, it was dismissed as unnecessary or outside the scope of missions. Doors were regularly closed. It was disappointing at best, disheartening at worst.

It was much the same as I looked for the would-be home of my medical practice. In that search, I was seen by colleagues not as a source for assistance or partnership, but as competition. I questioned my parents and other individuals and heard repeatedly that there was no real need for additional physicians in primary care. Everyone seemed to already have a medical home, and most practices did not share my vision.

**An Invitation to Serve**

Then, I spoke with Dr. William (Bill) Dedman, a fellow resident who was not only an outstanding physician but also a strong leader and powerful advocate for his patients. I appreciated the quality and intensity of his work very much. We fought together to ensure the best experience possible as we prepared for our life's work.

He recognized my discouragement and suggested what I had never considered. “Come to Camden with me,” he encouraged. “There is a remarkable need for new physicians, and you will be welcomed with open arms. And hospice? If that is something you want to develop, I am sure you will find willingness from the hospital to help and to support you.”

Soon it became time for making the decision to stay in Little Rock or to seek a heightened adventure. Again, Dr. Goss was a trusted counselor. He did more to encourage my wife, Dyan, and me than he could ever know. “You will likely not have all the stuff of Little Rock, but you can travel here,” he said. “When you come, you will appreciate being here more than you ever would if this was home. Your children will do well in any school they attend, as they have grown seeing how you and Dyan embrace education and achievement. In the end, you will miss nothing, and the opportunities afforded you will be countless.”

So, we went south. I, originally from Hawaii, along with my wife, originally from western Canada, and our children moved to Camden, a city on the Ouachita River about 50 miles north of the Louisiana state line, in 1983.

In Camden, I found my personal and professional home. Within weeks, Bill Dedman and I filled our practices. A small community of people, supported by our hospital and its administrator, C.C. McAllister, began building a hospice program, the second in Arkansas. The program remains a vital organization serving our county even today, 33 years later.

Through the years, there have been many other initiatives as well. We established new on-call systems which resulted in improvement to our personal health and our lives at home. A clinic supported by our community brings primary care to the uninsured and the poor. We also have an organization now committed to improving the public health of the community of Camden and the county as a whole.

I tell you this to show that practicing in a rural community affords opportunities that too many urban practices cannot. There is room in rural communities to grow programs for our patients, serving the needs of our patients and bringing them to fruition with our patients’ assistance, as we work together for the good of all.

**Joining the Community**

In preparing to write this article, I asked most of the physicians I work with what they thought distinguished our work in rural southern Arkansas from that of our colleagues in urban areas. Without hesitation, every one of them responded, “relationships.”

It is true that the work of a primary care physician in any setting offers the opportunity to know, deeply, the people they serve. There is a difference, I would offer, in the rural setting.

The neighborhood of the urban center is often defined by its demographic. We migrate to areas where people are “like us.” We can go days on end without ever seeing the desperately poor or the overwhelmingly rich. In urban centers, I suspect, there is less trust – and perhaps even distrust – in the safety of areas filled with groups “different from us.”

In Camden, I live, work, shop, sup, worship, play with and serve every demographic, every day. I truly find myself at home with the whole array of structure and people that make up the diverse community of Ouachita County. When I do a good job, I feel I have done so for an entire community. 

*continued on page 20*
When I fail, I feel that I have failed that community. When I can improve access to care, I feel that I have helped an entire community. When I am in any way responsible for a denial of care, I feel I have injured that same community. For when you choose a rural practice, it is always about community. Not only the “community” in which you live, but the community of individuals you have chosen to serve, whose lives are interwoven with yours at every turn.

Innovations in Care

The challenges have been many. When I began my work, the resources for continuous learning were very limited. I kept a file of any interesting articles from many professional journals in my office. They were filed using the indices of textbooks in obstetrics, pediatrics, surgery and internal medicine. I would keep lists of questions that came up, then one day a month trek north to the University of Arkansas for Medical Sciences (UAMS) library in Little Rock seeking answers. I was eventually able to call upon staffers at our nearest UAMS-affiliated Area Health Education Center for assistance. They consented to do literature searches for me. These days, I have medical resources that I call upon via computer while with a patient in the examining room. To be current in my practice, with only a fraction of my original effort, is a reality I relish!

Another challenge led to the new on-call system I mentioned earlier. Being on call had been murderous. Bill and I alternated call, during which we could count on 10 to 15 calls from patients every night, along with travel after hours to the hospital for emergencies and for delivering babies. We were exhausted.

We sought alternatives and found a work by the University of Colorado that included hiring nurses to take phone calls, after developing protocols for them to ensure they would tell patients what the doctors would have told them. Bill and I felt that our patients would complain, detecting a lack of personal commitment to them. But the Colorado experience suggested otherwise.

We nervously launched the idea, and our patients loved it! The advice and comfort given was right on target and deeply appreciated. The long wait for call-backs that was an accepted part of our work was replaced by the promise of response within five minutes by people who were rested and alert. Our care for our patients was better because we were no longer working to the point of exhaustion. The system was a success.

As our practices became more corporate 20 years ago (when large organizations bought up our work), it became more difficult, with rising overhead and more disciplined administrations, to care for those who were uninsured. Under the corporate structure, we were too often forced to turn the uninsured away. That we would be altruistic in medicine is an opportunity but not a mandate. Yet, we remained true to our natures and in 1996 took on this problem in earnest.

We sought to build an organization that was supported by our wider community. Therein lay the mandate.

The new organization, the Christian Health Center, was built on the expectation that individuals are themselves responsible for the costs of their care. When they cannot afford their care, they should look next to their family, then friends, then churches, and only then, to their wider community. Our role as doctors would be to volunteer our services. The cost to patients began at $8.00 per visit and has grown to $20.00 per visit. Our community has continued its monetary and volunteer support of this work, now in its 18th year. The Center is housed in a renovated bank. It is a beautiful clinic and a star within the county.

You may wonder whether demand for the work of the Christian Health Center diminished with the launch of the Affordable Care Act. We chose to remain open, but to add to our mission. Clinical care is now taking a back seat to direct work with our poor, from food to emergency funds to pathways from poverty. Again, our rural setting and the
close-knit nature of our relationships with fellow citizens allows us to be flexible in meeting direct needs. A new work has begun.

Our county has been at or near the bottom of the “County Health Rankings” for the last several years. We have established a County Health Commission that represents the leadership of the city of Camden and of Ouachita County. The commission is charged with choosing public health problems and defining strategies to combat them. The commission began its work in January of this year. There is a growing excitement within our community for their work. Perhaps we can again find new ways to truly make a difference.

**The Continuing Journey**

I have watched the economic and business health of my community decline over the last 33 years. We have seen a changing demographic, with poverty levels reaching alarming levels. This morning at the gym, I heard the town gossip. Our only remaining hardware store is closing. It makes me sad that struggles will continue for our small town on the Ouachita River.

Then, through the morning’s work, I visited with a mom and her 3-year-old daughter. The little girl had perfect skin and wore a beautiful black-and-white polka dot, freshly ironed dress. Her hair was tightly platted with white plastic balls surrounding her head and face, making cracking sounds as they bounced, one upon the other. Her eyes were bright, her teeth and smile sparkling, untouched by any coming social pressures and injustice. This mom was obviously both proud and committed. I was filled with joy that was immediately juxtaposed with the realization that these two may be hurt in the years ahead.

I love this place and its people. The relationships, the ability to serve others, and the opportunity to innovate, create and work with your fellow citizens on improving the health of your community...these are the precious realities of a rural practice. I am so glad that my wife and I decided to take a chance!

Dr. Lawrence Braden is board certified in Family Medicine and practices at Ouachita Valley Family Clinic in Camden, Arkansas. He graduated from the University of Arkansas for Medical Sciences College of Medicine in 1980 and has been in practice for 35 years. Dr. Braden offers his perspective as a physician practicing in a rural community to show the remarkable opportunities that exist for those who choose such a life. You may reach Dr. Braden at llbraden@practice-plus.com.

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Nationally, approximately 88,000 deaths related to alcohol consumption occur each year.

From 2003–2012, more than 1,700 Arkansans died in crashes involving a drunken driver.

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AFMC and Arkansas Medicaid are ready to help. Our teams have developed tools and materials to assist you in identifying and managing patients affected by alcohol misuse. To find out more, visit us at afmc.org/alcohol.
Decreasing the number of unnecessary laboratory tests and associated costs during hospital admissions is the focus of a new study published in the *Journal of Hospital Medicine*. "A multifaceted approach to laboratory reduction through education, process change, cost feedback and financial incentive resulted in a significant reduction in laboratory cost per day, laboratory cost per visit and the ordering of common laboratory tests at a major academic medical center," researchers say. Application of study practices showed annual savings of more than $251,000 in the test group alone; annual savings, if applied to the teaching hospital’s entire control group, were projected at more than $1.3 million.

Cardiovascular, pneumonia and surgery patients exposed to fully electronic health records were less likely to experience in-hospital adverse events, according to a new AHRQ study. Using 2012 and 2013 Medicare Patient Safety Monitoring System data, researchers examined the relationship of hospitals’ electronic health records adoption and occurrence rates of in-hospital adverse events. Among the more than 45,000 patients who were at risk for nearly 350,000 adverse events in the study sample, 13% were exposed to fully electronic health records. Among all study patients, the occurrence rate of adverse events was 2.3% (7,820 adverse events). Patients exposed to fully electronic health records, however, had 17–30% lower odds of any adverse event. The study, *Electronic Health Records Adoption and Rates of In-Hospital Adverse Events*, and abstract appeared in the February issue of the *Journal of Patient Safety*.

The CDC has issued its latest interim guidelines for healthcare providers caring for pregnant women and women of reproductive age with possible Zika virus exposure. The guidelines were published in the CDC’s *Morbidity and Mortality Weekly Report, Early Release, Vol. 65* and are available for download at [www.cdc.gov/mmwr/](http://www.cdc.gov/mmwr/).

A new Action Planning Tool for the Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety Culture is now available. Organizations can use the tool to brainstorm potential barriers and strategies to overcome them. The Action Plan Template is designed to record goals, initiatives, resources needed, process and outcome measures, and timelines. Access it on the AHRQ website, [www.ahrq.gov](http://www.ahrq.gov).
Thinking Outside the Walls

Patient Safety in the Outpatient Setting

By Nisa M. Maruthur, MD, MHS, and Melinda D. Sawyer, MSN, RN, CNS-BC

We tend to think about patient safety only within the hospital walls. The Institute of Medicine (IOM) has had us thinking about medical errors for nearly twenty years, starting with To Err is Human in 1999. The IOM reports and other work across the country have correctly shed light upon such medical errors as amputation of the wrong limb, inpatient adverse drug events and hospital-acquired infections, and we have made great strides in preventing these errors. However, most patient care occurs outside of the hospital, and little attention has been paid to identifying and addressing patient safety in this setting.
Many people (healthcare providers among them) believe there are no issues with patient safety in the outpatient setting. While there is not much evidentiary documentation on medical errors outside the hospital, this is more a reflection of the absence of research rather than an absence of risk. Patient safety errors do occur in the outpatient setting, and so, our focus on safety must broaden to include this important segment of care.

Identifying Risks
Failure to diagnose a disease in the ambulatory setting is relatively common and is not chronicled, or even thought of, as an adverse event. While failing to diagnose a stroke in the hospital, for example, would be considered an adverse event, failing to diagnose a disease in a physician’s office has not yet reached the same level of concern. This needs to change if we are to address patient risk and improve safety across all settings.

Once diagnosed, there are many disease-specific guidelines outlining recommended care, yet many outpatients do not receive these simple recommendations. Our failure as healthcare providers to deliver these basic recommendations, combined with a dangerously low level of health literacy in many patient populations, puts our patients at greater risk for progression and complications of disease.

In addition, medication errors in the outpatient setting – from prescribing to dispensing to administering to monitoring – can place our patients at higher risk for disease progression, complications and even death.

Finally, failures in teamwork and communication between outpatient providers, i.e. between specialists and primary care providers, can lead to delays, mistakes and excess testing.

A Chronic Example
Let’s think about a medical condition that causes few obvious symptoms until it has progressed to a point at which 17.3% of people can die. This condition affects 21.9 million adults in the U.S. and well over 250,000 in Arkansas. Another 8.1 million people across the U.S., including 60,000 Arkansans, are unaware that they have this condition.

Once diagnosed, it requires patients to self-monitor, often requiring them to check their own blood tests and change their medication doses based upon the results. It also requires that the patient receive routine care, including yearly checkups which are typically performed by specialists.

There are over seven commonly-used classes of medications used to treat this condition, and they all have different side effects; these require regular monitoring, including lab testing, by a healthcare provider. One side effect of many of these medications can cause patients to become unresponsive, have seizures and possibly die.

In the best and most common circumstances, the majority of care for this condition occurs outside the hospital. Given these safety risks, wouldn’t it seem that obtaining a timely diagnosis, ensuring that each patient receives the basic recommended care, appropriate medication monitoring, and maintaining good teamwork and communication among care providers should be at the top of our minds, with robust processes in place to avoid common mistakes and missed care?

We are talking about type 2 diabetes, often called “adult-onset” or “non-insulin dependent” diabetes. Type 2 diabetes is typically diagnosed in adults and does not usually require insulin at the time of diagnosis. However, many children are now developing this type of diabetes, and most adults with type 2 diabetes do go on to need insulin over time. Arkansas has been hit particularly hard by the diabetes epidemic with all counties except for Washington County exceeding the 9.0% median diabetes prevalence in the U.S.

It is a disease of high blood sugar that affects all of the body’s organs. Diabetes is the number one cause of blindness, kidney disease requiring dialysis and limb amputation (not related to trauma) in adults in the U.S.

To control this disease, patients must change their diets, increase their physical activity and, usually, take at least one medication. Patients with diabetes also need to see healthcare providers regularly, including a primary care provider or diabetes specialist at least...
Patients with diabetes also need to see healthcare providers regularly, including a primary care provider or diabetes specialist at least two times per year and an eye doctor for a special diabetic eye exam annually.

FIGURE 2

Age-adjusted prevalence of preventive care among US adults with Diagnosed Diabetes (2013)

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>Arkansas</th>
<th>US Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilated eye exam</td>
<td>72.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Foot exam</td>
<td>93.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Health professional visit for diabetes</td>
<td>90.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Two A1c tests</td>
<td>90.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Attended diabetes self-management class</td>
<td>72.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>Flu vaccine</td>
<td>80.0%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

Patients with diabetes also need to see healthcare providers regularly, including a primary care provider or diabetes specialist at least two times per year and an eye doctor for a special diabetic eye exam annually.

In the best of cases, people with diabetes should be seen by primary care providers regularly to have their disease and medications monitored, but in Arkansas, where approximately 50% of people live in rural areas, there are fewer avenues to primary care and even less access to specialty care.

Jane Smith ... a Case Study

Let’s consider a typical patient with diabetes: Jane Smith is a 62-year-old woman who has had diabetes for 20 years and suffered a stroke five years ago. The stroke has left her with weakness of her left side, and her diabetes has led to vision loss, so she depends upon her children to drive her to medical appointments two hours away.

Similar to many people with diabetes, she is on medications for multiple medical conditions, including two medications for high blood pressure, one medication for cholesterol, two medications for diabetes and one medication for diabetic neuropathy. Her insurance does not pay for insulin pens, so she draws her insulin from a vial to a syringe four times a day to control her blood sugar.

It is hard for Ms. Smith to ensure an accurate insulin dose in the syringe due to poor vision. She hasn’t seen anyone for her poor vision in three years, even though this exam is indicated yearly, because she isn’t aware of this recommendation. During her appointments, her care providers don’t usually get to this recommendation because of other medical issues that arise.

The last time she was seen by her primary care doctor, she noted that her glucose control, measured by her hemoglobin A1c, was “good.” The goal for most people with diabetes is to have an HbA1c of <7%, and hers was 6.8%. Ms. Smith left the appointment feeling good about her diabetes.

Unfortunately, Ms. Smith’s primary care doctor did not get to review her glucose readings because the medical office did not have the ability to download the readings from her testing device. If it had, the physician likely would have noticed that Ms. Smith was frequently having low blood sugar before dinner and should have adjusted her lunchtime dose of insulin downward.

The sad reality: Ms. Smith was not receiving simple diabetes recommendations (like a yearly eye and foot exam), and she was having frequent hypoglycemic events due to a high lunchtime insulin dose. This made her glucose control by HbA1c look “good.” Often, people who have had diabetes for a long time stop having symptoms of low blood sugar, but that doesn’t mean that the low blood sugar isn’t dangerous. In fact, low blood sugar or “hypoglycemia” can cause seizures, unresponsiveness and death.

A few months after the primary care doctor visit, Ms. Smith did suffer a hypoglycemic event that resulted in her death. Unfortunately, there was no investigation done due to her advanced age and the fact that her hypoglycemia was not considered an adverse event that could have been prevented.

Without an investigation of the event, there was no opportunity to identify strategies and principles to improve the healthcare system, including possible improvements in care coordination and patient-provider communication.

Filling the Gaps

In our example, even though Ms. Smith was able to see a primary care physician, many aspects of her care should be considered safety issues. She did not have easy access to specialists to help her maintain her diabetes. Her primary care doctor did not ensure that Ms. Smith received all recommended care for her diabetes because the doctor’s office lacked the technology to track and improve care with respect to these important measures. The lack of
office glucometer-reading software led to the patient’s misinterpretation that her HbA1c reflected “good” blood sugar levels, instead of the dangerous hypoglycemic events that would take her life. As a result, no changes were made to her insulin regimen; this directly led to her death.

A lack of awareness of these events does not make outpatient care less risky than its inpatient counterpart. Outpatient care providers must develop lenses with which to identify, analyze and mitigate errors that are prevalent in this setting. We must be clear that a lack of awareness does not equate to a lack of risk, and we must work together to reduce risks wherever healthcare occurs.

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SOUTH ARKANSAS
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• Medical Center of South Arkansas
• Ouachita Medical Center

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• Northwest Medical Center – Bentonville
• Northwest Medical Center – Springdale
• Northwest Breast Imaging Center at Willow Creek
• Physicians’ Specialty Hospital
• Siloam Springs Memorial Hospital
• Willow Creek Women’s Hospital

Nisa M. Maruthur, MD, MHS, is an assistant professor of medicine and epidemiology at The Johns Hopkins University and serves as co-director of the school’s general internal medicine program. She also sees patients as part of the Levine Group Internal Medicine Practice in Lutherville, Maryland. A native Arkansan, Dr. Maruthur was born and raised in Hot Springs and was a member of the charter class of the Arkansas School for Mathematics and Sciences (now the Arkansas School for Mathematics, Sciences and the Arts).

Melinda D. Sawyer, MSN, RN, CNS-BC, is the assistant director of patient safety at The Johns Hopkins Armstrong Institute for Patient Safety & Quality. A board certified clinical nurse specialist, Sawyer spent nine years as a bedside nurse in progressive care and then in bed management and as a member of the hospital’s resuscitation team. Her clinical experiences led her to the field of patient safety and a particular interest in multidisciplinary collaboration as a tool to improve patient outcomes.
In Quality, Small Can Still Be Mighty

By Nancy Robertson Cook

Can a critical access hospital be a hotbed of innovation and quality process improvement? Can such a small operation become a major economic driver in its community, as well as a haven for the sick and a launching point for the healthy? If you are talking about Howard Memorial Hospital (HMH) in Nashville, Arkansas, the answer is YES!

“Debra Wright, CEO of Howard Memorial, doesn’t just say she supports hospital quality,” says Nancy Godsey, RN, CPHQ, Director of Quality and Patient Safety at the Arkansas Hospital Association (AHA). “She walks the walk!” Debra looks for ways to improve, as well as grow, the services offered to the community. Under her leadership, several new services have been added that allow the citizens of Howard County to receive their medical services at home, rather than having to travel.

Those programs include the recent addition of mental health services, expansion of the community’s medical offices to include specialty clinic services, and offering of mobile MRI and mobile PET CT scanning. These, along with the hospital’s “Take Your Health Further, Not Farther” cardiac and pulmonary rehab programs, are ways Howard Memorial is a leader in the area of healthcare quality improvement.

Quality Begins at Home

Howard Memorial serves not only its home community of Nashville, but also the entirety of Howard County and several communities beyond. Because of the specific needs of the area’s geriatric population, the hospital opened a newly constructed outpatient clinic on its campus in the fall of 2015 to house an innovative behavioral health program. The program is specifically designed to provide for the mental and emotional needs of area senior citizens, including psychiatric evaluations, psychosocial assessment, nursing assessment and lab monitoring. Addressing issues ranging from grief to loss of independence to psychiatric illness, the clinic can meet the needs of local patients who now don’t have to travel to Texarkana or Little Rock for care.
Ensuring the community’s access to physician care is also a priority for HMH. Primary care is offered by seven physicians, with an additional primary care physician recruited to come on board this summer. For specialty care, HMH, like many small, rural hospitals, offers specialty clinic services through the contracting of visiting physicians, most of whom schedule appointments at least two days per month.

What sets Howard Memorial apart in both primary and specialty care is its foresight in design and construction of clinic space. HMH’s new medical office building, which was completed in August of 2015, has an innovative design that creates shared resources structured around “pods,” which each have space for two physicians and up to two Advanced Practice Nurses. Primary care, outpatient cardiac and pulmonary rehabilitation services are offered in this new building, while specialty care is provided in two additional clinic locations on the hospital’s campus. Whatever their office location, physicians at HMH have everything they need, from medical equipment to computer terminals, right at their fingertips.

The leadership and board of HMH conduct an intensive community needs assessment every two years. Based upon viability, due dates are assigned for exploration of improvements and/or new resources desired by citizens in the hospital’s service area. Through past community needs assessments, HMH identified the need for a number of specialty services. Over time, it has put into place specialty clinics to meet these needs, including cardiology, OB/GYN, medical oncology, urology, pediatrics and dermatology services. Mobile MRI and mobile PET CT scanning are available weekly, with open Saturday appointments for PET CT to alleviate the need for patients to take time off from work for their continued on page 30
test. Outpatient wound care, sleep clinic solutions and provisions for cardiac stress testing are additional programs that have originated through the bi-annual community needs assessment.

**Both Sides of the Page**

CEO Debra Wright, through personal commitment and involvement, helps elevate HMH as a standout in quality and process improvement. “Full CEO engagement is vital for any process improvement program,” Godsey says. “Debra has formal training in both nursing and business. She identifies areas which can be tweaked either clinically or administratively and works with her staff to develop improvement processes that make things happen.”

Wright’s quality team includes leadership provided by Director of Performance Improvement Beth Schooley, Director of Cardiopulmonary Services Gayla Beaird and Chief Nursing Officer Alesha Collins. This team has led Howard Memorial’s efforts in the two national AHA-sponsored Hospital Engagement Network (HEN) programs and continues to be instrumental in bringing new ideas and process improvement innovation not only to the hospital, but also to colleagues statewide.

HMH’s multi-disciplinary quality team is thorough in its approach to process improvement and has a focused approach in the adverse event area. Along with other HEN hospitals, HMH this year has taken on the new challenges of workplace safety, patient mobility and post-surgical assessment. Howard Memorial has a proven track record in the area of patient safety (taken house-wide and tied to every job description), and it has participated in programs to modify Foley catheter usage and to reduce the number of hospital-acquired infections, such as *C. difficile* and MRSA.

Due to its designation as a Level IV Trauma Center, HMH nurses have advanced training in the care
of trauma patients and are certified in advanced cardiac life support. HMH also participates in the Arkansas Saves Stroke Program and ensures that its nurses receive additional training on the assessment and treatment of patients experiencing stroke symptoms. Vascular certification also adds to the HMH quality improvement wheelhouse.

Quality Travels and Communication Counts

Taking quality and process improvement further out to the community, Howard Memorial staffers make themselves available to speak with community groups on a number of topics. An example: Jeff Williams, RN, recently spoke to the Nashville Rotary Club about HMH's ability to locally place PICC (peripherally inserted central catheter) lines, the extensive training the placement team received, and why this is a plus for the community.

Communicating with area citizens about health and wellness is enhanced through the pages of Engage magazine, “connecting the community to health.” This 8-page quarterly is available in print and online, emphasizing ways people can take active steps toward their own wellbeing.

Communication is also available 24/7 via posting of the continually updated quality report on the hospital’s easy-to-navigate website. Other communication highlights are the patient portal, a dynamic social media presence and twice-yearly town hall meetings with the community. Each of these efforts fits together with clinical and fiscal structures to help Howard Memorial continue on its quality improvement path.

Communication with the wider region shares HMH's efforts and opens the door to incorporating best practices. Both Wright and Schooley serve on the 2016 Rural Quality Advisory Council. This 16-member committee provides feedback, guidance and insight on the development, implementation and evaluation of rural quality improvement strategies, tools and resources. It also offers advice and counsel on development of QI goals and metrics, and on their integration into new and existing programming.

Tying Individual Performance to Hospital Satisfaction

Though the hospital’s employee satisfaction survey scores have regularly ranked at the 4.2 out of a possible 5.0 level, the HMH leadership strives for more. HMH’s Performance Evaluation Program, a pay-for-performance model, is being revised to place greater emphasis on employees’ performance expectations to align them with HMH’s mission, vision, values and strategic plan, which contains both corporate and departmental goals. Job descriptions tie individual performance to the hospital’s quality efforts, keeping employees engaged, helping each see their part and purpose in the care of patients and improvement of the hospital as a whole.

As employee satisfaction grows, patient satisfaction survey scores tend to follow, and those at Howard Memorial are no exception. Also increasing is the percentage of corporate goals met under the community needs assessment and strategic plan. The plan focuses on three areas for improvement: provision of outstanding customer service; creation of a culture of continuous improvement; and looking toward system growth and development. In 2014, the HMH team met 94% of its corporate goals, and department directors averaged 96.6% completion of departmental goals.

As a nation, we are shifting our healthcare focus to one based upon population health. HMH is ahead of the curve in this transition. With the ultimate goal of helping the community improve health and wellness, HMH teaches patients how to care for themselves upon discharge and teaches families how to interact with physicians and the hospital. This all ties back to HMH’s commitment to quality and process improvement.

From encouraging and offering avenues to wellness, to process-oriented care through every hospital service, Howard Memorial is at the forefront of the QI movement in healthcare. It is a beacon for other hospitals and proves that a small hospital can still be mighty when it comes to the advancement of quality and patient safety.

Addressing issues ranging from grief to loss of independence to psychiatric illness, the clinic and its services were designed to meet the needs of local patients who now don’t need to travel to Texarkana or Little Rock for this medical care.
Reducing Hospital Readmissions in the Delta

By Jo Nycum, MPH, RN, Arkansas Foundation for Medical Care

Healthcare quality experts focus on improving transitions of care because of the high incidence of patients who return to the hospital within 30 days post discharge. Of particular concern is the transition from hospital to home or to another healthcare setting.

In September 2012, the Centers for Medicare & Medicaid Services (CMS) awarded the Arkansas Foundation for Medical Care Quality Improvement Organization staff a Care Transitions (CT) Special Innovation Project (SIP). This project provided an opportunity to develop and test interventions to improve care transitions for Medicare beneficiaries.

The Arkansas Delta region was chosen as the target area in which to develop a sustainable, community-based CT coalition. Arkansas’s Lower Mississippi River Delta region is comprised of seven socio-economically depressed counties where residents have low life expectancy, poor access to healthcare and elevated 30-day readmission rates within the Medicare population.

Subsequent to the SIP award, the Arkansas Care Transition (ACT) Delta Coalition was formed in 2013. The coalition was comprised of varying healthcare providers, civic leaders and other professionals. The coalition’s initial development included a root-cause analysis, which determined that many 30-day readmissions were for beneficiaries discharged with home health services that had poor provider-to-provider communication and few referrals to community resources.

ACT Delta Coalition members successfully tested two interventions:

- The INTERACT™ program for home health agencies (HHAs) ran from Oct. 16, 2013, through March 15, 2014.
- A community resource guide (in online and print formats) was developed to improve provider and beneficiary awareness of medical and social community resources and to increase referrals to community resources.

The goal was to reduce 30-day readmissions by 17% among a subset of beneficiaries residing within the ACT Delta community by June 30, 2014. Results showed a relative improvement rate of 46% from baseline, which far exceeded the initial goal. The SIP results demonstrated that the HHA coalition’s use of INTERACT and the development of a community resource guide may have significantly reduced the 30-day readmission rates for the Medicare subset.

For sustainability, coalition members identify several keys to the program’s success. Foremost

| Community Rate of 30-day Hospital Readmissions over the Reporting Periods |
|-----------------------------|-----------------------------|-----------------------------|
|                             | Community                  | Community Goal              |
|                             | State                      |                             |

During CMS’s transition to the 11th statement of work and restructuring to a regional quality program in 2014, the ACT Delta Coalition maintained its commitment to improving care coordination and care transitions.
is its patient-centered focus. Another is the support of a unique partner and stakeholder, the Greater Delta Alliance for Health (GDAH). Several GDAH CEOs serve on the ACT Delta steering committee and support their staffs’ participation in coalition activities. Correspondingly, several coalition members sit on the GDAH board of directors, allowing for bi-directional, consistent messaging.

Arkansas’s Delta Coalition was the first ACT coalition to recognize the value of maintaining a steering committee as an engaged core group. The steering committee holds monthly conference calls to ensure that coalition goals and objectives are being met. Committee members work together to obtain the data needed for issue selection and for review and measurement of intervention efficacy.

During CMS’s transition to the 11th statement of work and restructuring to a regional quality program in 2014, the ACT Delta Coalition maintained its commitment to improving care coordination and care transitions. It now uses a more structured approach to reducing readmissions by focusing on the high-risk population of persons with diabetes. Augmenting the coalition’s approach, the GDAH is striving to increase access to free diabetes workshops across all seven counties. ACT Delta healthcare providers also implemented a dashboard with embedded diabetes intervention measures that can be used across healthcare settings.

The cooperation between coalition members and the GDAH has had a significant impact on reducing unnecessary hospital readmissions. It provides an ongoing opportunity to align continually evolving quality initiatives to address process and outcome evaluation.

Jo Nycum is an outreach specialist with AFMC’s quality division.
Addressing these challenges is not an easy task for small, rural hospitals. Nonetheless, we have seen that a focused effort on process management and process improvement have dramatic impacts for our rural healthcare clients. What magnifies the impact is the often overlooked component of process management. Without this component, even in a culture of continuous improvement, we find random acts of goodness rather than an aligned effort producing exponentially greater improvement results.

What is process management? At its most basic form, it involves defining one or more processes, establishing responsibilities, evaluating performance and identifying opportunities for improvement. The first step is identifying your organization’s key processes – all processes, not just clinical – that add value to your patients and workforce and are operationally important. Refer to the sidebar to view a sample list.

Why is this systematic approach the key to achieving bottom-line improvement? Most senior leaders do not walk into green field operations where they get to design processes from scratch on a blank sheet of paper. Most walk into organizations with existing processes that may have been designed a long time ago to meet a certain set of requirements but haven’t been evaluated since then.

The next step is assigning a process owner. This should be a single person – by an individual’s name, not by department name – who is responsible for overseeing the effectiveness and efficiency of the process. Process owners are typically senior leaders in the organization. The process owner also has the responsibility for ensuring that the process is documented, that related in-process (leading) and outcome (lagging) measures are identified, that these metrics are regularly reviewed and that corrective action is taken when an adverse trend or other trigger is detected.
Small gains in efficiency and effectiveness repeated through process management and continuous process improvement can quickly add up to big advances in bottom line measures. Where will you start with your organization?

Another responsibility of the process owner is scheduling regular reviews of the process to identify additional opportunities for improvement, even in the absence of negative feedback or an adverse trend. This proactive approach to process improvement is one of the key differences between average healthcare organizations and those that are high performing. Process owners seek out validated best practices from other organizations and encourage the people in the organization who perform the process to generate not just continuous improvement but breakthrough ideas or innovation. Even though this may sound counterintuitive, we have found that the actual improvement methodology used is initially less important than having it be well-deployed and consistent throughout the organization. A common language and approach allows teams to form quickly and begin to address an improvement opportunity.

The tried and true method of Plan-Do-Check-Act, supported by the repeated use of the seven basic quality tools, can produce significant improvements. Dr. Kaoru Ishikawa estimated that “as much as 95% of quality-related problems … can be solved with these seven fundamental tools” (shown on page 36).

Another advantage of beginning with these tools rather than more complex methodologies such as Six Sigma is that they are easily learned, require very little advanced statistics, and appear to most people to be a common sense approach to problem-solving. continued on page 36

Identifying Key Processes
A Sample List

- Leadership Direction–Setting
- Senior Leader Communication
- Governance
- Legal, Regulatory and Ethical Behavior and Compliance
- Societal Responsibility and Community Support
- Strategic Planning
- Translation of Strategic Objectives and Deployment of Action Plans
- Voice of the Customer
- Customer Satisfaction and Engagement Determination
- Determination of Healthcare Service Offerings
- Customer Relationship Management, including Marketing
- Complaint Management, including Resolution
- Performance Measurement, including Analysis and Review
- Knowledge Management and Organizational Learning
- Assessment of Workforce Capability and Capacity
- Recruitment, Hiring and Retaining New Workforce Members
- Ensuring Workplace Health, Security and Accessibility
- Assessing Workforce Engagement
- Motivating the Workforce
- Performance Management (performance evaluations or appraisals)
- Workforce and Leader Development
- Career Progression, including Succession Planning
- Process Improvement
- Innovation Management
- Cost Control and Other Financial Management
- Supply Chain Management
- Safety and Emergency Preparedness
- Your key processes should also include those that create value for your customers. These might include:
  - Admission
  - Assessment
  - Treatment
  - Education and Discharge
In 2013, Sutter Davis Hospital (SDH) located in Davis, California was the first small hospital (48-bed acute care) to win the prestigious Baldrige Award for Performance Excellence. The non-profit organization engaged its entire workforce in process improvement and achieved not only impressive clinical outcomes, but also top decile patient and workforce engagement scores while improving its financial performance. SDH’s margins topped 25% in 2011, and its net operating margin has grown steadily since 2008, significantly outperforming larger competitors and the Truven Health Analytics “Top 100 Hospitals.”

In 2014, Hill Country Memorial (HCM) received the Baldrige Award. HCM is an 86-bed non-profit community hospital that offers both general and acute care services to 10 counties in a remote area known as the Texas Hill Country. It, too, engaged its entire workforce on the journey to performance excellence. Similar to SDH, HCM demonstrates outstanding clinical outcomes and patient and workforce engagement scores, along with enviable financial results. For example, HCM’s net income increased from $10 million to nearly $20 million from 2010 to 2013, at the same time that cash and investment-to-debt ratios improved from less than 1.5 to greater than 3.

In addition to using process improvement to drive better clinical outcomes and financial results, these two organizations addressed another challenge common to rural hospitals – attracting and retaining highly qualified staff. At HCM, voluntary turnover is now lower than the top 10% of all hospitals nationally. At SDH, the overall vacancy rate is approaching the advisory board’s top decile.

While small, rural hospitals have challenges, they have one unique advantage over their larger urban counterparts. Because of their small size, lack of layers of bureaucracy, and typically family-like culture, small, rural hospitals can easily share improvements, replicate them quickly in other areas, and inspire others to piggyback on one improvement to identify innovation in other processes. Small gains in efficiency and effectiveness repeated through process management and continuous process improvement can quickly add up to big advances in bottom line measures. Where will you start with your organization?

### 7 Tools

The Seven Basic Quality Tools, so named by Dr. Kaoru Ishikawa, have been used for quality improvement for decades. Why? Because they are easy to learn and powerful for providing insights to aid in problem solving and process improvement.

1. **Cause-and-effect diagram (also known as a fishbone diagram or Ishikawa diagram):** Sorts ideas of possible causes of an effect into categories;
2. **Check sheet:** A simple form developed to collect and analyze data;
3. **Control chart:** Statistical chart that shows how a process behaves over time;
4. **Histogram:** A graph that displays the distribution (or frequency) of data;
5. **Pareto chart (named for Vilfredo Pareto, who claimed that 80% of effects come from 20% of causes):** A bar graph showing the frequency or impact of problems arranged in descending order from left to right to help illustrate which problems are most significant – the 20% causing 80% of the effects;
6. **Scatter diagram:** A graph of paired numerical data that helps identify possible relationships; and
7. **Run chart:** Simple display of data over time (without the control limits of a control chart).
SHARE Launches Clinical Analytics Tool to Help Hospitals and 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, hospitals and 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.”

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An emergency committee convened by the Director General of the World Health Organization (WHO) met in March to discuss the Zika virus outbreak and offer updated recommendations for addressing the virus. In addition to transmission by mosquitoes, local transmission had been reported in 52 countries and territories as of March 3, according to the WHO. Zika has been linked with neonatal microcephaly and Guillain-Barré Syndrome. The WHO has declared Zika a “public health emergency of international concern.”

In a recent *Health Affairs* blog post, Lloyd Dean, President and CEO of Dignity Health, one of the nation’s largest health systems, urged his fellow hospital leaders to do more to reduce the industry’s environmental footprint. Progress in this area has been slow, but with increased focus on climate change, many hospitals are adjusting their practices to become more ecologically sustainable. Dean noted that adopting climate-friendly policies not only will improve the overall health of hospital staff, patients and communities, but also could save approximately $15 billion over the next decade. The full post is available here: [http://healthaffairs.org/blog/](http://healthaffairs.org/blog/).

This year, the Medicare program began reimbursing physicians and certain other providers for end-of-life counseling for patients. It established separate payments and payment rates for two new codes for advance care planning services provided to Medicare beneficiaries. This development is consistent with the public’s wishes, according to a 2015 Kaiser Family Foundation poll, which found that 89% of individuals favor end-of-life discussions between physicians and patients. There has been no national coverage determination on advance care planning; instead, each Medicare Administrative Contractor (or MAC) will implement the new payment policy.

On March 15, the Centers for Disease Control and Prevention released guidelines for prescribing opioids as part of the federal effort to address the ongoing opioid addiction and overdose epidemic that is responsible for more than 40 deaths each day. The new guidelines are for primary care providers – who account for nearly half of all opioid prescriptions – treating adult patients for chronic pain (pain lasting longer than three months or past the time of normal tissue healing) in outpatient settings. They are not intended for guiding the treatment of patients in active cancer treatment, palliative care or end-of-life care. Access the guidelines at [www.cdc.gov](http://www.cdc.gov).
Margaret West
Practicing the Spirit of Excellence

By Nancy Robertson Cook

Assuring the good health of others is the keystone of Margaret West’s career. From her early days as a registered clinical dietitian to her current work as CEO of Magnolia Regional Medical Center, West has put patients first every step of the way.

“I have been working in hospitals since I was 21 years old,” West says. “I started out as a tray-aid at Jefferson Hospital (now Jefferson Regional Medical Center) in Pine Bluff, where I developed a love for nutrition and its importance to health.”

Fast forward several years, and we find her a mother of two, working full-time and attending the University of Arkansas at Pine Bluff, where she earned the four-year dietetics degree in a remarkable 2½ years. In-state dietetic internships were scarce, but her long-term experience in hospital food service helped land a coveted internship at the UAMS and VA hospitals in Little Rock.

Four years as clinical dietitian and assistant director of Jefferson Hospital followed, when in 1986 West’s life took a turn. While serving as state nutritional consultant for the Arkansas Division of Aging and Adult Services, she met her husband-to-be, married and moved to Magnolia. Her first role with Magnolia Regional Medical Center (MRMC), then still known as Magnolia City Hospital, was as Nutritional Services Director/ Clinical Dietitian.

West learned much from then-administrator Bill Hedden, who taught leadership by example. Generous in the encouragement of his staff to pursue higher education and professional outreach, West received her master’s degree in nutrition from Louisiana Tech. Hedden also urged West to become active in the Arkansas Dietetic Association where she served for 13 years in various offices, including president and legislative coordinator. Soon she was serving on the National Legislative Policy Board of the American Dietetic Association and found herself lobbying Congress in Washington, D.C., advocating for passage of the Medical Nutrition Therapy Act. This bill, passed in 2000, allowed direct Medicare reimbursement to registered dieticians for the first time.

With significant leadership experience now added to her work in nutrition, West was promoted by new administrator, Kirk Reamey, to the position of Chief Ancillary Officer. “The year was 1998,” she recalls. “That’s where I really learned the financial scope and magnitude of running our six ancillary departments. I was given the opportunity to seek and write grants on behalf of the hospital. I love a challenge, and I found grant writing to be something I truly enjoy!”

She is being humble. Writing grants is a daunting task, but West has a gift for this work. In the summer of 2008, MRMC’s new hospital was being built. She applied for and obtained, on behalf of the hospital, three United States Department of Agriculture grants totaling $950,000. This allowed MRMC to make the move to electronic health records (EHR) before they were mandated. “We were able to move ahead of other hospitals because of those grants,” she says.

June 2009 brought implementation of the new EHR system – and the week the system was to go live, West was appointed interim administrator. Her staff at MRMC urged her to apply for the full-time position, and she was selected as MRMC’s CEO in September of 2009.

West believes her hospital excels because “people treat each other right, and that makes all the difference.” Sensing that this attitude could be enhanced and directed, she and the hospital board put the entire hospital staff through the Disney “Spirit of Excellence” Program, aimed at achieving excellence in customer service at every level of the organization. Now, moving in the same direction with one focus, hospital employees practice continued on page 42
What’s your favorite part of the CEO position? Working with my people! I love learning our staff’s personalities. It’s amazing how we mesh, creating a workforce to give excellent care for patients and their families.

What’s the best advice you’ve ever received? It came from Dr. Maxine Hinton during my internship at UAMS. “You can’t know everything, so don’t be afraid to say, ‘I don’t know.’ Follow that with, ‘but I’ll find out and get back with you,’ then do it! Don’t be afraid to ask for help. If you think you know it all, you’re not going to grow.”

What is something in your office that’s a good conversation-starter? I have earned a lot of medals for running 5Ks and ½ marathons. People see my medals and ask if I’m a runner, and it opens lines of communication. Plus, they get my talk on the importance of exercise and good nutrition and how they saved my life. (West knew there was something wrong when, in 2014, she had difficulty getting her breath while training for a race. Her physician ordered a stress test and found three arteries with 90% blockage. She underwent a quadruple bypass and maintains that good nutrition and exercise have probably prolonged her life by at least 15 years.)

What’s your favorite way to de-stress? Exercise. It gives me energy. I’m not a morning exerciser…I exercise after work. It helps me transition to my home life, letting me work out the things that have happened during the day.

If you had a superpower, what would it be? If I could have my way, there wouldn’t be any fussing. Everybody would get along. Wouldn’t it be a wonderful world if we all worked harder at getting along?
the Spirit of Excellence at every turn. “Though we had a good foundation before our training, I’d say we have had a measurable turnaround in overall behavior,” West shares. “Our staff has really gotten into the Disney standards, stepping back to examine not only how we treat our patients, but also how we treat each other as co-workers. This greatly affects our ability to progress in every phase of the operation.”

West and her clinical staff were early adopters of quality and process improvement, joining the national Hospital Engagement Network (HEN) sponsored by the Centers for Medicare & Medicaid Services, the American Hospital Association’s Health Research and Educational Trust, and the Arkansas Hospital Association. HEN participation has sharpened MRMC’s quality focus, bringing new awareness and access to national best practices through measurable data.

In 2012, West wrote a Health Resources and Services Administration (HRSA) grant called Care Connection (now used as an example by HRSA for future grants), which allowed MRMC to hire two care coordinators specifically to track and document process improvement in patient outcomes and reduction in readmissions. In 2013 (year one), the documented prevention of readmissions numbered 122, for a savings of $1.0 million. The year 2014 saw 144 prevented readmissions for a savings of $1.3 million, and 2015 marked 156 prevented readmissions for a savings of $1.4 million. On the patient outcomes side, 2012 showed there were 99 preventable hospital stays at MRMC; in 2015, that had dropped by more than a third to 61.

West has written a sustainability plan to justify maintaining the care coordinator position, certifying that tracking and measuring data/results keep staff focused on finding ways to further reduce readmissions, making a positive difference in patients’ lives and the hospital’s profitability.

Preparing for this interview caused her to reflect on all who have given her career opportunities and encouragement, and who took a chance on her. “I have been fortunate in my career,” West says. “I think back to those who have been mentors to me and hope I am likewise a mentor to others.”

“I love MRMC and the community of Magnolia, which have been a part of my life for nearly 30 years,” West says. She encourages people not to merely accept the status quo, but to actively think about each situation life brings and the opportunities that are possible. “You’d be surprised at what doors might open when you stay focused,” she counsels. Her life of service is a reflection of that mindset.
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.”

Thank you to our hospital partners for providing high quality healthcare to Arkansans!
Community Health Needs and Healthy Active Arkansas: A Winning Partnership

By Greg Bledsoe, MD, MPH, Arkansas Surgeon General

Expanded coverage and enhanced payment models hold great promise for improving health, but they will not be enough without an increased focus on upstream interventions to reduce preventable disease. As hospitals assess opportunities to address unmet health needs in their communities, most will find high rates of chronic conditions like diabetes, hypertension, heart disease and other potentially life-threatening conditions that consistently place Arkansas at or near the bottom of most national health rankings.

Tobacco use and obesity are the most predominant upstream causes of chronic disease. While tobacco is still a significant health problem, policies and programs for reducing its use are in place and have had some success, especially among our young people. Obesity has proven to be a much more challenging problem, rooted in many factors both socioeconomic and cultural. Obesity has become a global issue, especially problematic for America’s southern states. Unfortunately, Arkansas has been identified by the Trust for America’s Health as having the

A Healthier Future

What does a Healthy Active Arkansas look like? It is a state where all of our citizens enjoy access to wholesome foods and opportunities for fun, exertive activities! The Healthy Active Arkansas plan is a 10-year initiative that is available at www.healthyactive.org. It contains a framework of nine priority areas and action steps for achieving two-, five- and 10-year goals. This framework was developed through a series of facilitated discussions with a consortium of partners and includes evidence-based strategies for encouraging and enabling healthier lifestyles in Arkansas. The nine priority areas are:

- Physical and built environment
- Nutritional standards in government, institutions and the private sector
- Nutritional standards in schools – early child care through college
- Physical education and activity in schools – early child care through college
- Healthy worksites
- Access to healthy foods
- Sugar-sweetened beverage reduction
- Breastfeeding
- Marketing program

The Arkansas Department of Health, the Arkansas Center for Health Improvement, the Arkansas Coalition for Obesity Prevention, the Arkansas Minority Health Commission, the Arkansas Hospital Association, Baptist Health, University of Arkansas for Medical Sciences (UAMS) and Winthrop Rockefeller Institute are just a few of the organizations that have begun working on implementing the plan. More partners are joining every day to be a part of realizing the vision of a healthy, active state – and you can join, too. Visit www.healthyactive.org to learn more.
highest rate of obesity in the nation and also as the most physically inactive state in the country.

Over the years, many good efforts to address Arkansas’s obesity crisis have been implemented around the state. Despite the laudable activities undertaken, including those originating from hospital Community Health Needs Assessments (CHNAs), we have yet to appreciably lower the statewide percentage of obese children and adults.

The need for a concerted statewide effort to strategically tackle the many factors contributing to the obesity epidemic prompted the creation of Healthy Active Arkansas, a 10-year strategic plan for eradicating the obesity epidemic and creating a culture of health in our state. The plan was developed by leaders in the field, including hospital representatives, and has been endorsed by the Arkansas Hospital Association. It includes the best research-based strategies for encouraging and enabling healthier lifestyles, outlined in two-, five- and 10-year goals meant to be used by the full array of stakeholders.

With the support of Governor Asa Hutchinson, Healthy Active Arkansas has become a movement with a vision that can become a reality if we work together. Every Arkansan has a stake in creating a healthy, active Arkansas and will benefit from helping to increase quality of life and productivity while reducing healthcare expenses, establishing a more attractive environment for economic development, and providing a healthier, more vibrant place to live.

While the focus of the CHNA process is to address unmet health needs, the federal CHNA guidance encourages a more holistic approach to community health, which can highlight health behaviors and socioeconomic factors that influence health. Because of the changing health system landscape in Arkansas, hospitals have an opportunity to broaden the scope of community benefit activities to address a wider range of factors impacting health as communities become less

continued on page 46
As the second round of CHNAs is undertaken by Arkansas’s nonprofit hospitals, Healthy Active Arkansas offers a framework for maximizing the impact of activities hospitals develop to meet the health needs of their communities. The need for shared resources and the creation of economies of scale to generate maximum impact has been recognized by the IRS, and joint-CHNA implementation strategies between hospitals, public health agencies and government health departments at the local and state level are encouraged.

The overlap of Healthy Active Arkansas and the CHNA process offers many opportunities to create winning partnerships within all of our communities. I hope you will reach out and find ways that your organization can benefit by joining with others in the Healthy Active Arkansas movement. Together, I know we can help individuals, businesses and communities to prosper through improved quality of life, higher productivity and lower healthcare expenses.

Dr. Bledsoe is a board certified Emergency Medicine physician and a graduate of both the College of Medicine and the Emergency Medicine residency program at the University of Arkansas for Medical Sciences. After completing residency, Dr. Bledsoe spent five years on faculty in the Johns Hopkins Department of Emergency Medicine completing a two-year fellowship in International Emergency Medicine and a Master of Public Health from the Johns Hopkins Bloomberg School of Public Health. In January of 2015, he was appointed by Governor Asa Hutchinson as Surgeon General for the state of Arkansas. He also serves as Director of Clinical Innovation at Arkansas Heart Hospital.
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Drug Discovery Holds Potential to Combat Late Effects of Radiation and Diseases of Aging

Submitted by the UAMS Office of Communications

A research team from the University of Arkansas for Medical Sciences (UAMS) and other institutions has discovered the first broad spectrum drug that can potently kill senescent (or aging) cells in culture. This drug would effectively clear the cells in animals by specifically targeting a pathway that is critical for the survival of senescent cells.

The team is led by Daohong Zhou, M.D., a professor of pharmaceutical sciences and the deputy director of the Division of Radiation Health in the UAMS College of Pharmacy.

The discovery has been reported recently in the scientific journal *Nature Medicine*.

Because senescent cells are believed to play a role in the late effects of radiation on normal tissues and certain age-related diseases, this study has broad implications for future therapies targeting the common biological mechanism that contributes to late tissue injury caused by radiation and aging.

Cellular senescence, the loss of cells’ ability to divide, normally functions as a tumor suppressive mechanism; however, senescent cells become “toxic” as they accumulate after exposure to radiation and with age. This is because they cause stem cell aging that reduces the ability of tissue regeneration and repair, and they drive chronic inflammation and oxidative stress.

Since chronic inflammation and oxidative stress are thought to be the root cause of some late effects of radiation and many age-related diseases, including radiation-induced long-term bone marrow injury and age-related osteoarthritis and atherosclerosis, eliminating senescent cells has the potential to mitigate radiation-induced late tissue injury and treat many age-related diseases.

“Our results demonstrate that clearance of senescent cells by a pharmacological agent is beneficial, in part, by rejuvenating aged tissue stem cells,” Zhou said.

A *Nature* 2011 publication showed that genetic clearance of senescent cells from a progeroid animal is beneficial, leading to delayed onset of age-related phenotypes.

In the current study, ABT-263, a molecule initially developed as an anti-cancer therapy, was given orally to either normally aged mice or mice irradiated to induce premature aging of the hematopoietic system (the organs and tissues involved in production of blood). ABT-263 effectively depleted senescent cells, including senescent “stem cells” of the bone marrow and muscle. Depletion of the senescent cells appeared to reduce premature aging of the bone marrow caused by irradiation, and even rejuvenated the function of stem cells in normally aged mice.

“Because a decline in tissue stem cell function is associated with exposure to radiation and aging, we believe clearing senescent cells and rejuvenation of tissue stem cells could have a major
Cellular senescence, the loss of cells’ ability to divide, normally functions as a tumor suppressive mechanism; however, senescent cells become “toxic” as they accumulate after exposure to radiation and with age.

impact on mitigation of radiation injury and treatment of diseases of aging,” Zhou, the senior author of the Nature Medicine article, said.

“ABT-263 was originally developed as an anti-cancer agent. It has toxic side effects that make it inappropriate for development as an agent for diseases of aging. We are investigating next-generation, small-molecule drugs that are optimized to clear senescent cells without drug-induced toxicity,” Zhou said.

Jianhui Chang and Yingying Wang are the co-first authors of the study, along with Lijian Shao, Wei Feng, Yi Luo, Xiaoyan Wang, Nukhet Aykin-Burns, Kimberly Krager, Usha Ponnappan and Martin Hauer-Jensen as co-authors from UAMS. Other authors include Remi-Martin Laberge, Marco Demaria and Judith Campisi from the Buck Institute for Research on Aging; Krishnamurthy Janakiraman and Norman E. Sharpless from the University of North Carolina at Chapel Hill; Sheng Ding from the Gladstone Institute of Cardiovascular Disease and Aimin Meng from the Institute of Radiation Medicine of the Chinese Academy of Medical Sciences.
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Your hospital needs one and you can get it free.
For complete, no obligation, information on how we can provide your Hospital Patient Guide, call or email today.

Gary Reynolds 1-800-561-4686 ext. 115 or greynolds@pcipublishing.com
A simple question can reveal as much as a test.

“What are our goals for today?”

Ask your patients about their health priorities at each visit. When you do, both you and your patient can make the most out of the time you have together, and they’ll feel more invested in their own care. Not only does that improve efficiencies, but it also helps improve health outcomes.

For tools and tips to share with your patients, visit www.ahrq.gov/questions
Reinventing the Diamond Awards

By Jennifer Kostelecky, Director of Educational Operations and Liaison to the Arkansas Society for Healthcare Marketing and Public Relations, Arkansas Hospital Association

Big changes are coming to the Diamond Awards Competition!

For Arkansas’s hospitals, Diamond Awards have represented the standard of excellence in healthcare marketing and public relations for 20 years. Incremental changes in criteria and categories have been made in the past, but 2016 marks the debut of a totally revamped and modernized program.

“In past competitions, we have only been competing with ourselves,” explains Rebecca Pitillo, president of the Arkansas Society for Healthcare Marketing and Public Relations (ASHMPR) and Executive Director of Philanthropy and Development, Jefferson Regional Medical Center, Pine Bluff. “The submissions were judged as individual pieces that may or may not have been ‘Diamond Award material.’ With the changes, we are raising the bar of excellence. Now, hospital marketing and communication pieces will be judged against one another, and the one best piece submitted from the state of Arkansas will be chosen to receive the Diamond Award. To me, personally, this makes winning a Diamond Award more exciting and the award itself much more prestigious.”

New this year:
- Each division will have only one Diamond Award winner per category.
- The number of categories is decreasing from 15 to 8.
- An early bird deadline of April 1 with a discounted entry fee is being offered.
- A project may be submitted in one category only.
- Efficiency of budget will be emphasized.
- Emphasis will be placed upon what is produced internally versus externally.
- The narrative will play a bigger role in the judging process.
- The Diamond Award itself will be redesigned.

Previous features that remain:
- The competition is co-sponsored by the Arkansas Hospital Association (AHA) and ASHMPR.
- Hospitals will compete in divisions, by bed size.
- Diamond Awards will be presented during the AHA’s Annual Meeting Awards Dinner (October 6, 2016).
- Certificates of Excellence will be mailed prior to the Annual Meeting.
“I encourage all AHA members to submit at least one entry this year for the 2016 Diamond Awards,” Pittillo says. “This award not only offers the Diamond bling for hospital marketing departments to proudly display, it also provides an opportunity for departmental evaluation. When preparing submissions, hospital marketing departments will need to step back and take a closer look, truly evaluating their marketing efforts from the past year and then deciding from that work what they believe is the best product. This process is important because it gives us, as professionals in the communications and marketing fields, yet another chance to ask ourselves, ‘Did our marketing efforts align with hospital priorities, strengthen operations and contribute to the communities we serve?’”

Diamond Award entries are now being accepted. A brochure providing details of the awards competition was mailed to hospital CEOs and marketing and public relations directors in mid-February and is available at http://www.arkhospitals.org/events/annual-meeting; please select “2016 Diamond Award Brochure.” Entries, accompanied by appropriate documentation, must arrive at AHA headquarters no later than April 22, 2016. For questions regarding the Diamond Awards competition or the new criteria, contact Jennifer Kostelecky at jkostelecky@arkhospitals.org or 501.224.7878.

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<th>Diamond Award Divisions, by Bed Size</th>
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<td>0-25 (CAHs) 26-99 100-249 250 and above</td>
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<td>• Advertising – Special Visuals</td>
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ATTNENTION MEDICAID ELIGIBLE PROFESSIONALS

Don’t miss out!

AFMC is now offering no-cost assistance to Medicaid eligible professionals in Arkansas to achieve and sustain meaningful use.

2016 is the final year to begin participation to earn incentive payments of up to $63,750.

For more information about this program and our services, visit afmc.org/healthit or call 501-212-8616.
Access to Physicians in Arkansas

By Kurt Mosley, Vice President of Strategic Alliances, Merritt Hawkins

Where does our state rank relative to other states when it comes to patient access to physicians? That question is put in perspective by a new data resource from Merritt Hawkins, the nation’s leading physician search and consulting firm, which is endorsed by AHA Services as its preferred physician search provider.

The Physician Access Index, as the Merritt Hawkins ranking system is called, tracks nearly three dozen metrics that influence patient access to physicians, physician assistants (PAs) and nurse practitioners (NPs) in each state using a variety of proprietary and non-proprietary sources. Metrics include physicians per capita in the state, physicians trained per capita, medical residents per capita who stay in the state, PAs and NPs per capita, percent of the population with health insurance, physician Medicare and Medicaid acceptance rates, household income, incorporation of telehealth, urgent care centers and retail clinics per capita, percent of physicians close to retirement and a variety of other metrics.

Each state is given a score for each metric. The more favorable the metric (i.e., a high number of physicians per capita), the lower the score. Massachusetts, for example, has the most physicians per capita and is given a score of one for this metric, while Mississippi has the fewest and is given a score of 50. At 442 points, Massachusetts has the lowest score and hence the most positive physician access variables.

Arkansas has a relatively high score of 988 and is ranked 43rd out of 50 states in patient access to physicians. The table to the right shows the highest ranking and lowest ranking states and their cumulative scores based on the 33 metrics considered in the Physician Access Index.

While these scores paint an overall picture of physician access in each state, there are a number of factors that can influence access within a particular state. Though New York trains more physicians per capita than any state besides Massachusetts and is ranked 11th best for physician access, it ranks 34th in percent of mental healthcare needs met. New Mexico, which ranks third to last in the overall rankings, ranks sixth in patient encounters per capita in Federally Qualified Health Centers (FQHCs), indicating the state has a robust safety net program for traditionally underserved patients.

No state is without its challenges and strong points where patient access to physicians is concerned. There are pockets of patients with poor physician access in highly ranked states and pockets of patients with good physician access in states with low rankings.

Arkansas, for example, though ranked 43rd out of 50 states, is ranked 6th in terms of medical residents retained after training, suggesting that once residents are familiar with the state, they like it enough (and have enough

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<tr>
<th>Ranking</th>
<th>State</th>
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<tr>
<td>1</td>
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<td>50</td>
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Source: Physicians Access Index; Merritt Hawkins, 2015
job opportunities) to stay. Hawaii, by contrast, thought to be a premier destination state, ranks 41st in number of residents retained.

In addition, Arkansas is one of some 30 states that expanded Medicaid through the Affordable Care Act, and is given a low (favorable) score of one in this category, as were other states that expanded Medicaid. Arkansas ranks 4th in percentage of population covered by Medicare and 9th by percentage of population covered by Medicaid, and therefore, it is given a low (favorable) score in these categories. Arkansas also is ranked relatively high (11th) in terms of physicians in the state who accept Medicaid as a form of payment and is given a favorable rating in this category.

Unfortunately, patient access to physicians in Arkansas is limited by a comparative lack of healthcare providers per population. Arkansas ranks 48th in physicians per 100,000 population, 49th in PAs per 100,000 population and 34th in NPs per 100,000 population. Though Arkansas does a good job of retaining the physicians it trains, the state’s ability to “grow its own” physicians is limited, as it ranks 32nd in residents per 100,000 population. Eighty-five percent of physicians in our state report they are overworked or overextended, according to the Physician Access Index. This is the seventh highest number in the nation.

Other serious limiting factors in the state are income levels and poverty rate. Arkansas has the 6th highest poverty rate in the nation and the second lowest median household income. Lack of financial resources severely restricts the ability of many residents of the state to access physicians and other healthcare professionals. Arkansas trails only Mississippi in terms of percent of population who did not access a physician in the previous year due to a lack of finances.

continued on page 56

Source: American Association of Nurse Practitioners

Healthcare is becoming more consumer-driven, and therefore, a greater emphasis is being placed on enhanced access to physicians and other clinicians.
Physician distribution in the state is an additional challenge, though Arkansas has a more favorable ranking in terms of Health Professional Shortage Areas (HPSAs) per population than might be expected for a largely rural state. Arkansas ranks 29th in primary care HPSAs per capita and 16th in providers needed to remove HPSA designations per capita. Using Health Resources and Services Administration data, the Physician Access Index notes that Arkansas has met 65.3% of its primary care need, earning a relatively favorable rating of 17th out of 50 states in this category.

Arkansas has a ratio of 55.6 NPs per 100,000, 34th out of 50 states, and a ratio of 10 PAs per 100,000 population, 49th out of 50 states. Arkansas is rated as a state with “medium” NP practice autonomy, which may be one reason for the relatively few NPs per capita in the states. NPs are more likely to locate in states where they can practice autonomously.

Referencing American Telemedicine Association data, the Physician Access Index indicates Arkansas received a “C” rating for incorporation of telehealth. In addition, Arkansas is ranked 49th out of 50 states in terms of urgent care centers per capita, as derived from Urgent Care Association of America data.

While the Physician Access Index shows in what categories states have physician access challenges, it also suggests how these challenges might be addressed. Poverty rates and low per capita incomes can be key barriers to physician access, and these are societal problems that take time to resolve. Yet there is hope for improvement in the near term. States like Arkansas can take more immediate steps to increase the number of physicians they train by funding residency positions, and they can increase the percent of physicians they retain after training through educational loan repayment and other retention incentives. States also can reduce barriers to telehealth implementation, expand the practice parameters of NPs and PAs, and increase or expand FQHCs, if they have not done so already.

Healthcare is becoming more consumer-driven, and therefore, a greater emphasis is being placed on enhanced access to physicians and other clinicians. This is clearly demonstrated through the exploding number of urgent care centers, retail clinics, free standing emergency departments, ambulatory surgery centers and online physician appointment services that are being established nationwide. Payment models increasingly reward providers for patient satisfaction, which in many cases is directly tied to how quickly patients can be seen.

Merritt Hawkins’s Physician Access Index offers a new informational resource AHA members may find useful as they consider the issue of patient access to physicians and advanced practitioners. AHA members who would like a complete copy of this resource are welcome to call or email us using the contact information below.

Kurt Mosley is Vice President of Strategic Alliances for Merritt Hawkins (www.merritthawkins.com), a company of AMN Healthcare. He can be reached at kurt.mosley@amnhealthcare.com or at 469.524.1446.

Rich Gehrke is a Regional Vice President of Marketing for Merritt Hawkins and can be reached at rich.gehrke@merritthawkins.com or at 469.524.1657.
iVantage Health Analytics, a strategic partner with AHA Services, Inc., recently released the 2016 Rural Relevance Study: *Vulnerability to Value*. The study found that 19 facilities in Arkansas are now vulnerable or at risk for closure. The loss of a local point of care can have a powerful impact on a community. iVantage modeled the potential impact on those 19 communities in the event these vulnerable hospitals were to close and estimates:

- **1,876** Healthcare Jobs Lost
- **221,316** Lost Patient Encounters
- **2,589** Community Jobs Lost
- **$5.3B** Loss to GDP (10 years)

**HOW ARE RURAL CRITICAL ACCESS HOSPITALS PERFORMING IN ARKANSAS?**

The iVantage Hospital Strength INDEX® is the industry standard for assessing – and benchmarking – rural and Critical Access Hospital performance. Using the Hospital Strength INDEX, iVantage examined 71 performance indicators to measure the performance of all of the 47 rural hospitals and 29 Critical Access Hospitals in Arkansas, and compared their performance to national medians.

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Contact Troy Brown for a copy of the study or for your hospital’s INDEX summary report at tbrown@ivantaghealth.com or 207-518-6707.
Arkansas hospitals bring southern compassion and hospitality to the healthcare environment. Clinical staff members care for patients like family, and organizations place the needs of their communities first. However, in a field that is experiencing increasingly strict regulatory standards, tighter budgets and staffing shortages across the board, these hospitals are faced with growing challenges.

The Continuous Service Readiness (CSR) program from Joint Commission Services (JCS) provides hands-on, personalized healthcare compliance and safety guidance to over 800 organizations throughout the United States. CSR consultants have helped several Arkansas hospitals achieve a higher quality of patient care and stand ready to help your hospital improve its performance.

We discussed the challenges hospitals face with Pamela Smith, MSN, CJCP, a CSR consultant of more than four years, who has played an integral part in many of these productive relationships.

Q: As a CSR consultant, what challenges do you see hospitals in Arkansas working to overcome?

Pamela Smith: Arkansas hospitals are facing budgetary constraints and a shortage of available, dedicated staff who are trained in regulatory expectations. Arkansas state regulatory standards are very detailed, and this means more care must be taken by hospitals when rules are updated. So, you’re looking at a situation where hospitals are being asked to do more with less, including managing patient safety initiatives on top of complying with complex state standards. These are not new challenges, although they are particularly difficult for those facilities with low budgetary support for outside regulatory compliance resources.

Q: How have you seen organizations address these challenges? How have you helped?

PS: Organizations experiencing budget cuts hope that managers or department directors will know and understand regulatory expectations required by CMS and will ensure that the hospital is always in compliance. However, many organizations have deficits when it comes to keeping up with changes in Conditions of Participation or Joint Commission Standards. Difficulties with compliance can lead to a multitude of negative outcomes, including patient harm, bad press and even the loss of deemed status.

An investment in outside assistance can help an organization avoid negative patient outcomes, as well as improve the overall quality of care provided to its community. CSR consultants offer hospitals insights into the requirements of not only The Joint Commission, but also of other state and federal regulatory bodies.
We have also helped Arkansas hospitals by tracing their facilities and identifying areas for improvement. When I trace a facility, I follow the experience of care, treatment or services for one or more patients through the facility's entire process. Using this methodology, consultants, including myself, can help an organization identify areas that need improvement or processes that might put patients at risk.

Q: How can CSR consultants benefit hospital systems?

PS: In a multi-hospital system, it may be difficult to ensure that all sites are fully and equally compliant with the latest regulatory requirements. This can also be said about the application of proven best practices. CSR consultants must complete ongoing educational courses which keep us up to date with the latest advancements and changes in hospital safety and care. As a consultant who serves the state of Arkansas, I am thoroughly familiar with changes to state regulatory requirements. CSR consultants are also trained in proven best practices. We know how to help implement and disseminate these practices throughout a system.

CSR consultants can also work with an organization to create unique educational plans tailored to specific needs. We understand that one size does not fit all. What works for a large, urban hospital may not always be the best approach for a small, rural hospital with limited resources. We can also help system hospitals disseminate proven solutions adapted at one site to all facilities within the same system.

Overall, CSR consultants bring fresh eyes and a new perspective when we come into a hospital or hospital system. We act as a sounding board to the organization’s current accreditation and compliance team.

Q: Can you describe the JCR CSR program?

PS: The CSR program consists of an assigned consultant who works with a system or facility both on-site and online. This means that CSR consultants are readily available by either email or phone and can also be brought on-site for more hands-on engagements. CSR consultants utilize a variety of performance improvement strategies, including “lunch and learns,” meetings with leadership and departments, conducting tracers and reviewing documents and policies.

Consultants can also provide resources and research to help demonstrate and implement proven solutions.

In addition to a dedicated consultant, the CSR program provides clients with online advantages including newsletters, tools and other resources.

To learn more about the JCR CSR program and its benefits, visit our website: http://www.jcrinc.com/consulting/continuous-service-readiness-csr/.

At JCR, we are privileged to work with leaders and front-line employees throughout the U.S. to help them achieve accreditation and certification readiness and improve patient safety and quality of care through evidence-based solutions. If you are interested in working with JCR, please call 630.268.7400, or visit us at www.jcrinc.com. For additional information, you may also contact Elisa White, who serves as the AHA’s liaison with JCR, at elisawhite@arkhospitals.org or 501.224.7878.
LEGISLATIVE ADVOCACY

Your AHA Political Action Committee
A Critical Component of Our Advocacy Efforts

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

With the election cycle for federal, state and local races simmering, advocacy efforts are in full swing in just about every arena. At the Arkansas Hospital Association (AHA), our approach to successful advocacy is three-pronged:

1. Hospital employees, volunteers, healthcare providers and patients must talk with candidates and elected officials about hospitals and the healthcare system;
2. AHA staff must provide pertinent information about the impact of policy and regulatory changes, along with accurate data, to hospital advocates, candidates, and to elected officials and their staffs; and
3. The AHAPAC – the Arkansas Hospital Association’s Political Action Committee – must be well-funded to do bipartisan work targeted to strong supporters of hospitals and the healthcare industry, in order to educate candidates and address problems in our healthcare system.

What is the AHAPAC?
Political Action Committees, or PACs, have been around since 1944 when the Congress of Industrial Organizations formed the first one to raise money for the re-election of President Franklin D. Roosevelt. Since that time, multiple types of PACs have been formed, each with different rules and regulations for its operations and for the transparent reporting of donors and activities. The AHAPAC is a state PAC bound by Arkansas rules, which allow contributions from certain for-profit corporations and from individuals.

Why give to the AHAPAC?
Sharing information and listening to a variety of perspectives to help shape good policy and regulatory solutions often comes easily for those of us who are passionate about our work caring for patients. We understand why our own, personal advocacy efforts are important.

AHAPAC donations, however, are equally important. Your dues do not fund the PAC; it receives funds only through your donations. Your AHAPAC is a non-partisan, state-based organization that unifies Arkansas hospitals, regardless of size, location or service mix. It provides our hospitals with the platform for concerted political action by amplifying the voices of individual hospitals and directing donations to state and local governmental leaders who share our collective goals and interests.

Is the timing of AHAPAC donations important?
In a word, yes. With the recent change in primary dates, not only are your donations imperative, the timeliness of them is extremely important, too. The AHAPAC needs donations much earlier in the year now that primary elections are being held in late February or early March.

During the Special Session of 2015, Senator Gary Stubblefield (R-Branch, AR) filed SB 8, now known as Act 4 of the Special Session of 2015, which modified the date of the preferential primary and general judicial elections. Instead of being held in late May, the preferential primary now occurs “three weeks before ... the fourth Tuesday in March.” That date, for 2016, was March 1! Having a primary two months earlier means the AHAPAC began receiving fundraising requests much earlier from candidates with contested primary races.

The state House of Representatives has 2-year terms, and all 100 seats will be decided by the 2016 elections. Currently, there are 64 Republicans, 35 Democrats and one Independent representative. There are 57 unopposed races. Thirty-nine of those have only Republican candidates, and 18 have only Democratic candidates. Forty-
three races will be determined by the voters – nine were determined in the primary election (seven in the Republican primary and two in the Democratic primary), while the remaining 34 will be decided in the general election this November.

Arkansas Senate terms are staggered. Currently, there are 24 Republicans and 11 Democrats occupying the 35-member chamber. There are 17 senate seats that will be decided by the 2016 election. Of these, 10 are running unopposed – eight Republicans and two Democrats. Seven races will be determined by the voters – two were determined in the primary election, and the remaining five will be settled in the general election.

In past years, the AHAPAC has sent quarterly invoices to state PAC participants and has been able to collect enough money to support state candidates in both the primary and general elections. However, in 2015, the AHAPAC’s fundraising campaign raised roughly 13% less than was collected in 2013 and 2014 – not nearly enough during a time of such dramatic change in the healthcare arena.

This year, the AHAPAC gave heavily to primary candidates to ensure that the individual candidates who support hospitals have every opportunity to educate voters on their positions. It is no secret that the AHA remains an avid supporter of continued coverage for the more than 200,000 Arkansans who gained insurance coverage under the Arkansas Private Option (APO). The APO is set to end in December of this year, and the governor’s plan, “Arkansas Works,” may very well be the policy that enables coverage for Arkansans and continues to keep the burden of uncompensated care in check.

As the governor and the legislature continue to work toward improving Arkansas’s healthcare system, it remains

continued on page 62
vitally important that hospital supporters are elected. The current, recognized requirement of a 3/4 vote for healthcare spending appropriations continues to remain a high hurdle. Seventy-five of the members of the House and 27 of the members of the Senate must agree on the appropriation for the budget portion that so heavily impacts our hospitals, doctors, nurses, healthcare workers, and most importantly, our patients.

Now that the primaries are over, we have a much longer general election fundraising period ahead. So, we need your donations now rather than later in the year to allow the AHAPAC to make appropriate donations prior to the election in November.

Why give to the AHAPAC when I make individual donations to candidates?

Unlike individual campaign contributions, which are usually based on personal preferences or partisanship, AHAPAC is a nonpartisan vehicle for supporting officeholders and candidates who are sensitive to hospitals' concerns. AHAPAC helps give hospitals a collective voice in the public arena – a large enough voice to initiate conversations that can lead to better understanding of issues impacting a broad swath of matters ranging from community access to care, up to and including hospital operations and revenues.

Most of the dollars that are used by candidates go toward offsetting expenses of public relations, like mail flyers, yard signs and political advertising. Those are necessary to help voters get to know the candidates and know what to expect of the candidates once they become public servants in the roles they are seeking. Also, as electoral campaigns become more sophisticated, there are expenses associated with opposition research (i.e., what are the topics that are important to voters, what does the candidate's opponent think of those topics), polling, message development, data analytics, voter targeting and get-out-the-vote drives.

Political Action Committees play an important role in magnifying an individual's monetary contribution. If many individuals contribute to a particular PAC, the PAC then has the ability to contribute a larger amount than an individual might contribute otherwise. In addition, because of the reporting and transparency laws and regulations, candidates are able to use the fact that a particular PAC is supportive of his or her candidacy as an educational part of his or her campaign.

Through the AHAPAC, you can make a meaningful impact on the Arkansas election process by acting together with other hospital supporters, taking advantage of strength in numbers to get your message to candidates. Together, we are stronger than any one of us standing alone.
WHY IN THE WORLD DO YOU WORK IN A HOSPITAL? It’s a fair question and one that we probably ask ourselves quite often. Perhaps the answer is as simple as: “to pay the mortgage.”

However, (and this is important) I’m betting that when you started out working in health care that just paying the mortgage was not your goal or your mission. I often get asked by young people whether a career in health care is a good choice. My answer to them is simple. It depends on why you want a career in health care. If it is simply to pay the bills, then my answer is “No.” Quite frankly, there are a lot easier ways to make a living than to do what we do day in and day out in our hospital settings.

This pertains to every single job within our hospitals. For example, if you work in finance, I believe that your job as a CFO of a hospital is many times harder than working as the CFO of a retail business. Few retail business have to deal with governmental auditors, CPT codes, Medicare cost reports, and the list goes on and on and on.

And finance is just one example. Let’s also take janitorial services as an example. Those that clean the local hardware store never have to worry about the risks of MRSA spreading throughout the store. My point is that working in health care is hard. So why did you start doing this? Even if your answer today is “to pay the mortgage,” I’m still betting that’s not why you started. I’m guessing that you wanted to make a difference in the lives of others. I’m thinking that you cared about the well-being of people that may be suffering.

So, how do we reboot and redirect our REASON for doing what we do?

My story can be a bit overwhelming to some. I’m a physician, and I started my career in medicine in a typical way. However, in 1998, my career and my life took a turn that I never expected. At that time, my son was instantly killed in a car accident and my daughter received a skull fracture in the same accident. As an ER physician, I had treated countless victims of accidents, but I never really envisioned myself or my family on the patient side of these accidents. Whether or not I had envisioned it was irrelevant. It was now an undeniable fact of my life.

God held my family together. I’m confident that my son is safely in Heaven. My daughter made a complete and full recovery. However, my life and my perspective on it was forever changed. In reevaluating my life, I saw several changes that I needed to make both personally and professionally. It’s the professional changes that I’ll share with you today.

Following the events of my life in 1998, I looked on my career as a physician and saw that I needed to recommit my career to the patients and the families that I treated and served. Every patient was a soul with real feelings, real hurts, and real needs. I could choose to view them as “bronchitis in exam room 1,” or I could choose to view them as “Sally Jones, age 6, daughter of Jim and Linda Jones, who is scared and struggling to breathe.”

As a physician, I knew how I would forever choose to see “Sally.” However, I wanted to do more than just affect the patients that I personally treated. Thus, Correct Care was started.

My children’s accident occurred on July 10th, 1998. By March 1, 1999, Correct Care began managing our first emergency department. Today we are a committed group of more than a thousand physicians that provide our special brand of care to patients throughout the South. Whether in an ER, an Urgent Care, or in a Hospitalist setting, our physicians know that we are not simply here to “pay the mortgage.” We are here to make a difference in the world and in the individual lives of every patient and every family that we treat.

We hope that you will join us as we strive to change the world as our goal is to provide the absolute best in health care. Does your hospital need a “reboot” on the REASON that we are in this line of work? If so, give us a call, and see how Correct Care can help you provide the correct care.

Sincerely,

Eddie J. Dease
Eddie Dease III, MD
President/CEO
CONSTRUCTION
Preconstruction
Construction Management
General Contracting
Design Build

INDUSTRIAL
Machinery Alignment
Installations & Relocations
Rigging
Plant Maintenance
Metal Fabrication & Machining

CIVIL
Excavation
Site Preparation
Utility & Drainage Installation
Road & Highway Construction

ENVIRONMENTAL
NEPA Assessments
Remediation Services
Asbestos Solutions & Consulting

SPECIALTY SERVICES
Renovations
Tenant Finish-outs
Facility Maintenance & Management
Emergency Response & Repairs
Energy Performance Contracting
Lighting Retrofits
Firestopping

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