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This issue of Arkansas Hospitals is dedicated to mental and behavioral health, and to the devoted health caregivers who do such a great job, day in and day out, bringing skilled care to Arkansans in need of these specialized services.

We are proud of our hospitals for the helpful, hopeful and compassionate care they offer to those needing mental health services. Whether it’s in stand-alone psychiatric hospitals, psychiatric units located within our acute care hospitals, or emergency assistance offered in a multitude of locations, attention to the care of these special needs patients is offered in settings both rural and urban throughout the state.

In Arkansas, our hospitals pride themselves on taking care of the whole person. Though many seek mental and behavioral health services on their own, sometimes their need for this specialized care is discovered in the Emergency Room, or during a scheduled primary care visit, or as one medical issue or another is explored.

Physicians, nurses and office staff alike are tuned in to help Arkansas patients, no matter what the health challenge. And their work in the field of mental and behavioral health is an important part of keeping Arkansas healthy.

We’re glad to report that on March 8, Governor Asa Hutchinson signed the Criminal Justice Efficiency and Safety Act. Among other initiatives, the act provides for Crisis Stabilization Units to help address the needs of individuals with mental illness and keep them out of county jails.

It’s important to focus on this need and provide these new locations for patient access. And it’s good to give attention to the fine work Arkansas hospitals offer our patients in the realm of mental and behavioral health. We thank all who are involved in this specialized field, and we pledge our support in continuing to spotlight hospitals’ and patients’ needs in these important areas.

Bo Ryall, President and CEO Arkansas Hospital Association
NEWSMAKERS and NEWCOMERS

BRIAN THOMAS is the new president and CEO at Jefferson Regional Medical Center (JRMC), Pine Bluff. Thomas served as interim CEO for several months prior to his promotion, and served as JRMC’s senior vice president and chief operating officer beginning in 2010.

JAN BURFORD, president and CEO of CARTI for more than 26 years, retired in late February. CRAIG COMISH, CARTI’s chief operations officer, has been named interim CEO while a national search is conducted. Burford joined CARTI in 1990 as chief operating officer and in 1995 was named president and CEO.

TOM SLEDGE has been named administrator and COO of Northwest Medical Center – Springdale. Prior to joining the Springdale facility, he served as COO of Weatherford (Texas) Regional Medical Center and assistant CEO of Women and Children’s Center in Lake Charles, Louisiana.

DARLA YORK, RN, has been named interim CEO at Springwoods Behavioral Health Hospital in Fayetteville. She succeeds MARK BETHELL, who accepted a position as executive director of Independence Center in St. Louis.

KENNETH SANDERS has been named administrator/CEO of Dallas County Medical Center in Fordyce. He previously served as interim administrator and laboratory director/COO of the facility.

JERRY BERLEY of Camden, past-president of the Arkansas Hospital Auxiliary Association and AHA board member, has been appointed to a three-year term on the American Hospital Association’s Committee on Volunteers. Berley is a volunteer at Ouachita County Medical Center in Camden. He joins LYNN SMITH, volunteer at CHI St. Vincent-Hot Springs, who serves on the national committee as immediate past-chair.

MICHAEL A. DORSEY, FACHE, of Olathe, Kansas has been named CEO of Johnson Regional Medical Center in Clarksville. He has more than 21 years of hospital senior leadership experience and previously served as CEO of St. Joseph Medical Center in Kansas City and St. Mary’s Hospital in Blue Springs, Missouri.

KEVIN SPEARS has been named chief operations officer/administrator at Stone County Medical Center in Mountain View. A graduate of Arkansas State University and Harding University, he recently served in administrative positions with HealthSouth in Memphis and Helena.

ALL ABOUT HOSPITALS

National Park Medical Center

National Park Medical Center in Hot Springs has opened its new Heart and Vascular Center of Central Arkansas and expanded emergency department. The Heart and Vascular Center features 4 cardiac cath labs, an 8-bed CVICU, 12-bed pre- and post-procedure area, and a state-of-the-art Cardiac Rehab and Outpatient Therapy Center. The emergency department features a total of 25 treatment rooms including exam rooms, secure rooms and trauma rooms. The 67,000-square foot project was a $26 million investment.

White River Health System

White River Health System’s (WRHS) Internal Medicine Residency Program was recently accredited by the Accreditation Council for Graduate Medical Education (ACGME), allowing it to move forward with the first class of internal medicine residents in July 2017. The WRHS program is the only ACGME-accredited internal medicine residency program in Arkansas outside of the University of Arkansas for Medical Sciences (UAMS) system. WRHS will be working closely with UAMS to develop the program in Batesville.
At Arkansas Hospitals magazine, we live and breathe health care and hospitals. This magazine enjoys a reputation of being nonpartisan, honest, informative and genuinely dedicated to advancing the best in health care policy.

Over the years, our values as communicators have continually guided us as we seek to earn our readers’ respect.

You will notice a distinctive change in design with this Spring edition as we move forward with a fantastic new publishing collaboration with Vowell, Inc., the publishers of AY Magazine. What hasn’t changed is our continuing dedication to those long-held essential values of communication honesty. Vicki Vowell and our other new colleagues at Vowell, Inc. share our dedication to providing you, our readers, with a great print magazine and a beautiful design.

We also look forward to working with the Vowell, Inc. team to offer eye-catching and informative online pieces for your reading pleasure between each quarterly printed publication. Yes, Virginia, we’ve finally gone digital!

The focus for this edition is one of extreme importance in our state and across the country – mental and behavioral health care. It is fitting that our Spring edition is hitting the streets at the conclusion of a legislative session in which mental and behavioral health has been a huge focus.

The World Health Organization has said that “there is no health without mental health.” We at the Arkansas Hospital Association agree. Without mental health, we cannot reach our full potential as productive members of society. And so, this topic is important not only for our hospitals, but also for each and every person in the communities they serve.

All of us at the Arkansas Hospital Association look forward to continuing to offer you a top-notch publication each quarter, and we would love to hear from you about your ideas and thoughts on the new design. In the meantime, we hope you enjoy this first edition of 2017.

Thank you for reading!

Elisa M. White, Editor-in-Chief
April 12-14
AAHE 52nd Annual Meeting and Trade Show
The Hotel Hot Springs and Spa

April 21
Arkansas Association for Medical Staff Services (ArkAMSS) 2017 Spring Conference
AHA Classroom, Little Rock

April 27
2017 Crisis Response Workshop
Embassy Suites, Little Rock
Highlight on page 10

April 27-28
Society for Arkansas Healthcare Purchasing and Materials Management (SAHPMM)
2017 Annual Meeting and Trade Show
Holiday Inn Little Rock – Airport Convention Center

May 6-10
American Hospital Association Annual Membership Meeting
Washington, D.C.

May 6-8
2017 State Auxiliary Leaders (SAL) Conference
Washington, D.C.

May 7-13
National Hospital Week

May 24
Addressing 2017 Key Compliance Issues: HIPAA and CMS
Crowne Plaza, Little Rock
Highlight on page 11

June 14-16
AHA Hospital Executive Leadership Conference
Embassy Suites, Rogers

June 14, 2017
AHA Board Meeting
Embassy Suites, Rogers
*held in conjunction with the AHA Hospital Executive Leadership Conference

June 22, 2017
Transforming Care at The Bedside (TCAB) Conference
Crowne Plaza, Little Rock

AHA Education Program information is available at www.arkhospitals.org/events.
2017 Crisis Response Workshop

April 27, 2017 · Embassy Suites, Little Rock

How would your team have responded during Orlando’s Pulse Nightclub tragedy? Eric Alberts, Emergency Preparedness Manager with Orlando Health, will discuss lessons learned as a result of this crisis. Each participant will gain at least one major applicable strategy for the improvement of local crisis response plans/operations through interactive gap analysis and group discussion.

We’ll also learn from our neighbors to the south about response to the three unprecedented, catastrophic flooding events that hit Louisiana last spring and summer, offered by a panel including experts from the Louisiana Hospital Association, the administrative director of Louisiana’s Emergency Response Network, and the director of emergency preparedness for Acadia/St. Landry Hospital at Church Point.

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Addressing 2017 Key Compliance Issues: HIPAA and CMS

May 24, 2017
Crowne Plaza, Little Rock

Join us to receive the latest HIPAA and Section 1557 Compliance updates, including the newest avalanche of breaches, the continuing impact of social media on the HIPAA landscape, and the banner enforcement year just completed by the Office of Civil Rights in the area of health care privacy.

You’ll also learn the newest trends in CMS hospital survey and certification oversight. Find out how CMS uses transparency and data to enhance the quality of Medicare-certified hospitals, how to recognize red flag areas that can lead your hospital to enforcement actions, and what tools and resources are available through CMS to maintain a culture of sustainable compliance with the Medicare CoPs.

ARE YOU EMPOWERED?

The Arkansas Hospital Association offers in-person workshops and exceptional educational events that empower your team in all areas of hospital care and management.

When you visit the AHA’s online Educational Calendar, you’ll find dates and instant sign-up information for meetings, forums, workshops, webinars and more. Click through to find detailed information on every upcoming AHA event.

Start empowering your team today! Visit www.arkhospitals.org/events, and explore the many opportunities offered especially for the hospital teams and leaders of Arkansas.

WE’RE YOUR LEGISLATIVE PARTNER

The Arkansas Hospital Association (AHA) serves as an advocate for its member hospitals, representing their concerns and interests to elected officials on both the state and federal level. Through the AHA, Arkansas hospitals present a united voice to lawmakers and regulatory agencies. Each year, the AHA represents members’ views to state lawmakers on dozens of healthcare bills through active lobbying at the state Capitol.

For more information go to www.arkhospitals.org/legislative
LINKING THE UNDERSERVED

SUTTER HEALTH’S T3 PROGRAM
CHANGING LIVES AND HOSPITAL USAGE

By Kelly Brenk

Like most innovative partnerships, our story started with a need and a conversation.

The Need:
A large number of medically vulnerable, underinsured people were presenting in California’s Sutter Medical Center, Sacramento Emergency Department (ED) for non-urgent needs. It became apparent that an integrated health care delivery model was needed to minimize inappropriate ED visits and maximize long-term outcomes.

The Conversation:
In 2005, the Sutter Health Valley Area began a collaborative relationship with WellSpace Health, a local Federally Qualified Health Center (FQHC) based in Sacramento, California. Sutter Health and WellSpace started talking, and the conversation led to collaborative first steps. What evolved is a trusted partnership that has yielded multiple innovative and unique Community Benefit programs to serve some of the most at-risk populations in our community. We hope our ideas may lead your community and hospital system to begin similar strategies.
THE TRIAGE, TRANSPORT AND TREAT PROGRAM

More than a decade after those first talks, WellSpace Health is one of Sutter Health’s most prominent and dedicated partners. While the many programs and efforts developing from this partnership are specific and distinctive, one of the most impactful is the Triage, Transport and Treat (T3) program.

The T3 Program skillfully creates a seamless, interconnected network of resources that seek to treat the whole person and link patients with the right care, in the right place, at the right time.

A T3 patient is likely to have a multitude of ailments, and a quick fix in the ED is a non-sustainable solution. These patients are often unemployed, indigent, homeless and navigating life on the streets, while battling a complex blend of deteriorating health issues and complications resulting from things like untreated diabetes, hypertension, vascular disease and chronic pain, as well as mental and behavioral health issues and substance abuse.

THE CASE MANAGER

Enter the T3 Case Managers, who are employees of WellSpace Health. They seek to connect underserved patients to vital resources through long-term and community-based case management. They address a patient’s immediate needs and shift their care from the emergency department to more appropriate care settings.

The T3 case manager helps patients with everyday issues such as obtaining an ID, a social security card, securing an income, finding a primary care doctor to manage multiple health challenges (including pain management) and eventually, even locating permanent housing. With a T3 case manager, stability is more likely and patient health improves.

IMPACT

The payoff is improved patient health and reduced wait times for those seeking care in the ED for true medical emergencies. Most importantly, by connecting these patients to the health and social services they so desperately need, we see a drastic improvement in the health and overall quality of life for this often-underserved patient population. Baby steps lead to bigger steps, self-esteem and resiliency continue to play larger roles, and incredible progress can happen. Year after year, we see countless stories of success, with patients who once felt hopeless now feeling empowered to take the steps necessary to improve their health and overall lives.

When an underserved patient walks through the doors of our hospital, this provides us with an unmatched opportunity to connect with this patient and help them understand what resources are available and why linking to a medical home and primary care provider is a better way to access care.

In most cases, by focusing holistically on the vast needs of the T3 population, Sutter is able to have a more
Patient repeatedly shows up to Emergency Department (ED) for non-urgent reasons

Patient connects with ED Navigator, who assesses patient’s needs

T3 Case Manager provides long term, post-hospital case management and support

Patient is enrolled in T3 Program

Patient wrapped with health and social resources
significant and positive impact. Over time, we’ve learned that partnering with patients facing major life challenges on all levels of their care can be highly successful. A comprehensive plan that includes support for needs beyond health care and integrates partnership and accountability ultimately creates a healthier patient and community.

**REFERRAL PROCESS AND FOLLOW UP**

While the T3 program serves a very complex patient population, the referral process is fairly simple. Hospital staff identifies patients who could benefit from long term, outpatient support and explains the T3 program and the services provided to enrolled clients. After gaining patient consent, hospital staff then refers the patient to the T3 program and contacts the T3 Case Manager.

When the referral is made, the T3 Case Manager meets the patient at bedside, conducts an assessment and talks to the patient about what is going on in his or her life. It is at this time that the T3 Case Manager makes a personal connection to each T3 client, explaining to them the purpose of the program and encouraging the patient – who is often scared, skeptical or distrustful – to take control of their health and their life by enrolling in the T3 program. The personal connection is key.

Once enrolled, patients are provided with months of outpatient case management services. T3 Case Managers work tirelessly to help individuals establish a primary care home and provide linkages to wrap-around services like behavioral health treatment, insurance, substance
abuse treatment, transportation, public assistance, community resources and housing. Patients are consistently followed through telephonic and in-person contact, driven to medical appointments, assisted with tasks and supported throughout this period of stabilization. During a patient’s time as a T3 patient, they are provided with countless warm handoffs and the consistent encouragement needed to get on their feet, once and for all.

THE RESULTS SPEAK

Since the T3 program began in 2007, the program has served more than 4,200 patients, and year after year, the program continues to yield successful outcomes. At Sutter Medical Center Sacramento in 2016, patients showed a 51 percent reduction in emergency department visits post-T3 program intervention. In addition, the same patient population showed a 57 percent reduction in inpatient stays, a 62 percent reduction in bed days used and a 52 percent reduction in overall hospital usage, post-T3 intervention.

In Sacramento, the T3 program currently meets the needs of an average 170 active patients each month by ensuring that they are engaged in comprehensive health, behavioral health, and ancillary services in the community. Last year, nearly 140 new patients were enrolled in T3, with 344 patients served overall. T3 Case Managers linked 136 patients to a medical home, 37 patients to a mental health provider and provided nearly 600 medical transports to primary care and mental and behavioral health appointments. In addition, 60 patients were placed in temporary shelter and 18 patients were placed in permanent housing.

Due to the success of the program, the T3 program was used as a best practice and duplicated to serve patients in Placer County seeking care at Sutter Roseville Medical Center and Sutter Auburn Faith Hospital. In 2016, 120 new patients were enrolled in the Placer County T3 program and a total of 174 patients were served, overall.

T3+, BEYOND THE ED

In 2014, the foundation of T3 was used as the basis of a new program, T3+, which is similar to T3, except patients are identified in an inpatient setting, rather than in the emergency department. The T3+ navigator also follows the patients after discharge and works with staff to provide a follow-up health plan, telehealth, pain management and other health services. All of this is while the T3+ navigators ensure the success of the patients' other needs by connecting them to things like housing, transportation, community resources and a medical home.

In 2016, T3+ patients showed a 39 percent reduction in ED visits, a 62 percent reduction in inpatient stays, a 49 percent reduction in overall hospital usage and a 71 percent reduction in bed days used, post-T3+ intervention.

COMMITMENT TO CONTINUE

The evolution and growth of the Sutter Health Valley Area Community Benefit programs – both new and old – is incredibly exciting, as we’re on a constant quest to elevate programming and expand the depth and breadth of our outreach.

At Sutter Health, a commitment to the greater community is at the heart of our mission, which is why we work hard to ensure our reach extends far beyond the walls of our hospital. The T3 program is a prime example of Sutter Health’s steadfast pledge to increase access to care for the underserved and is the epitome of the incredible work that can be accomplished through collaboration, innovation and partnership.

This program would not exist without the collaborative teamwork between our FQHC partner, WellSpace Health, and the multiple departments within the Sutter Health Valley Area. Our combined focus on compassion and caring for all those who walk through our doors and a tireless commitment to making our community a healthier, happier place unite us in this successful collaboration. We hope our model can be of help to Arkansas hospitals reaching beyond their hospital walls to serve specific patient populations.
No More Rivers

JIM’S STORY

Jim* was homeless, navigating life on the streets while battling a complex blend of health issues and complications resulting from untreated diabetes, hypertension, vascular disease and chronic pain. He had no job, no driver’s license, no income, no doctor and his health was rapidly deteriorating.

Jim’s challenges are not uncommon, nor are they exaggerated. In fact, he is a real patient who, not long ago, worked with the Sutter Medical Center, Sacramento (SMCS) Triage, Transport, Treat (T3) program and its T3 Case Manager.

Sutter Health’s T3 Case Manager helped Jim medically, by connecting him with a primary care physician to manage his multiple health challenges and with a pain management physician to help manage his chronic pain.

She also helped Jim obtain an ID, a social security card, secure an income and eventually, locate permanent housing.

Now stable, healthier and, he says, “happier,” Jim has made incredible progress and continues to strive toward actively making a better life for himself.

AVA’S STORY

For many years, Ava* lived along the river (and sometimes in and out of motels) in West Sacramento. In October of 2015, she was seen multiple times the same day at the SMCS Emergency Department due to increasing anxiety and panic attacks.

During her final visit, SMCS staff connected Ava to the T3 program. Ava was immediately engaged by the T3 Case Manager and what we call “wrapped with services,” including a medical home at WellSpace Health and placement in an emergency shelter in Sacramento.

Less than two months after Ava became engaged with the T3 program, she was connected with permanent housing. When she saw her new home for the first time, with a huge smile on her face she proclaimed, “I am so blessed! No more rivers...no more rivers!”

Ava continues to keep her primary care appointments at WellSpace Health and actively engages in Case Management services.

*Names Changed.

Kelly Brenk is the Community Benefit Coordinator for Sutter Health Valley Area. You may reach Kelly at brenkkm@sutterhealth.org. Valerie Martinez and Leslie Parker, WellSpace, provided photos for this article.
SUICIDE: Myths, Warnings and How to Help

By Jeanni Brosius

Nearly 500,000 people visited the hospital in 2015 for treatment of self-inflicted injuries. This number suggests that approximately 12 people hurt themselves for every one suicide death, according to studies by the American Association of Suicidology.

This does not include the many suicide attempts that may go unreported.

Suicide is the tenth leading cause of death in the United States, and more than 44,000 Americans died by their own hand in 2015, which is the most recent year for which data are available.

“It is unclear about the exact reasoning, but substance abuse and increased stress in society are major contributors,” said Sinclair Winburn, a behavioral health service provider and licensed clinical social worker in Heber Springs.

Winburn said senior adults and young males between the ages of 16 and 24 are at a particularly high risk. “Females attempt suicide more often than males, but males are more likely to complete the act,” he says.

Dr. Alex Crosby of the CDC Injury Center agrees. “Suicide affects everyone, but some groups are at higher risk than others. Men are about four times more likely than women to die from suicide. However, women are more likely to express suicidal thoughts and to make nonfatal attempts,” said Crosby. “The prevalence of suicidal thoughts, suicide planning and suicide attempts is significantly higher among young adults aged 18 to 29 years than it is among adults aged more than 30 years. Other groups with higher rates of suicidal behavior include American Indian and Alaska Natives, rural populations, and active or retired military personnel.”

Suicide is not caused by one factor but is caused by a combination of individual, relationship, community and societal factors.

According to Crosby, while there have been increases and decreases in rates over time, research shows that
rates across cities and towns in the United States have been rising over the past 15 years, with rural areas experiencing the greatest uptick. “The increased rates in rural areas may be associated with suicide risk factors that are more common in less urban areas, such as limited access to mental health care as well as greater social isolation.” Other risk factors include loss of jobs, homes, and income associated with the Great Recession, as well as the opioid drug epidemic, which is having a greater impact on rural areas.

There are several misconceptions about suicide. One is that suicidal teenagers are “just kids” who are over-reacting to events in their lives. However, it isn’t that simple. What one person perceives as a minor occurrence may be a source of overwhelming distress for another.

Another misconception is that suicide happens without warning. “One of the biggest myths of suicide is that if people want to kill themselves, there is nothing you can do,” said Winburn. In fact, many people exhibit warning signs though they may not clearly state that they are contemplating suicide. “Depression is an obvious risk factor, but other signs include selling or giving away possessions, researching suicide methods and discussing suicide itself.”

Picking up on signs of distress can be key in saving someone’s life. “We should never be silent and should always seek help, whether through the suicide hotline, contacting local community mental health resources, or referring someone for emergency intervention,” Winburn said.

The police also offer “welfare checks” for individuals at risk. Lonoke Sheriff John Staley said checking in on at-risk individuals to ensure their welfare does save lives, and if it is suspected that someone is planning to hurt themselves, he urges people to call the police.

“We experience this a lot,” Staley said. “Many are just needing to talk, and that helps; however, we do get many to agree to seek help from a mental health professional in order to start the healing process.”

When police conduct a welfare check, Staley said they usually have an ambulance waiting nearby.

According to Staley, the responding officer speaks with the individual and attempts to talk him/her into going to the emergency room. If there have been threats of self-harm, the officer can do an involuntary commitment.

Arkansas is ranked tenth in the nation for suicide deaths, and more than twice as many people die by suicide than by homicide each year. According to the American Foundation for Suicide Prevention, in 2015, Arkansas had 577 deaths by suicide. On average, one person dies by suicide every 15 hours in the state.

Suicide is preventable, Crosby said. But prevention requires understanding and addressing the factors that influence suicide. Prevention is best achieved through comprehensive strategies and approaches that target risk and protective factors across individual, relationship, community and societal levels and across all sectors, private and public.

If someone needs to talk immediately, help is available at the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). The caller will be connected to a skilled, trained counselor in their geographic area. Calling is free and confidential. More information is available at suicideseducation.org.

The online Lifeline Crisis Chat program is available at chat.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx.

**RISK FACTORS**

A combination of individual, relationship, community, and societal factors contribute to the risk of suicide. Risk factors are those characteristics associated with suicide, but they are not necessarily always direct causes:

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is a noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation; a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

*Information provided by the Centers for Disease Control and Prevention.*
Opioid abuse has increased to epidemic levels in the United States, according to the U.S. Department of Health and Human Services (HHS). Data from the 2014 National Survey on Drug Use and Health indicate that 4.3 million people aged 12 or older were current misusers of prescription pain relievers. In 2014, 4.39 percent of Arkansans over age 18 engaged in the nonmedical use of pain relievers.
Exhibit 1. Arkansas ranks 1st in nonmedical use of pain relievers compared to rest of U.S., based on 2013-2014 prevalence estimates.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>(%)</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>4.56</td>
<td>9</td>
</tr>
<tr>
<td>12-17</td>
<td>6.15</td>
<td>1</td>
</tr>
<tr>
<td>18-25</td>
<td>9.67</td>
<td>4</td>
</tr>
<tr>
<td>26+</td>
<td>3.49</td>
<td>18</td>
</tr>
<tr>
<td>18+</td>
<td>4.39</td>
<td>11</td>
</tr>
</tbody>
</table>

There has been improvement in prescription drug use rates in Arkansas, but it continues to have the highest estimated use rate (6.15%) for ages 12-17 years, compared to all states. Arkansas has the fourth highest estimated use rate (9.67%) in ages 18-25 years (see Exhibit 1).

Rates continue to improve in sixth, eighth, 10th and 12th graders. According to the Arkansas Prevention Needs Assessment, between 2008 and 2015 there were noticeable decreases in the rates of lifetime (not shown) and current use (Exhibit 2) reported by Arkansas students. In 2015, Arkansas’s 12th grade students reported a current use rate (5.8%), similar to national estimates of 5.9 percent and a rate of life-time use (14.1%), much lower than the national estimate of 18.1 percent.

An additional indicator, based on hospital claims data, is opiate-use visits, either as inpatient (IP) stays or emergency department (ED) visits. A recent statistical brief published by the Healthcare Data and Utilization Project showed that across the United States, the rate of IP stays and ED visits increased by 64.1 and 99.4 percent, respectively, between 2005 and 2014. In 2014, Arkansas had a relatively low number of opioid-related IP stays (139.3 per 100k) and ED visits (71.6 per 100k), compared to the national rate of 224.6 per 100k and 177.7 per 100k, respectively.

However, Arkansas’s rate of IP stays related to opiate use increased by 23.8 percent between 2009 and 2014 (change in ED visits between 2009 and 2014 was not available).

Exhibit 2. Rates of current use among students have remained steady over the last three years.

There are several possible explanations for why the rate of opioid-related hospital visits increased and self-reported use of prescription pain pills decreased. One possible explanation is that opioid-related hospital visits are increasing because illicit and prescription opiate use cannot be differentiated in claims data. This indicates that, although rates of self-reported use of prescription opiates are going down, users may be replacing them with cheaper alternatives such as heroin or other synthetic opioids. Heroin-related cases reported by the Arkansas State Crime Lab have more than doubled in the last successive two years, from 58 reported cases in 2014, to 201 in 2016.

Recent federal and state initiatives focusing on opioid prescribing practices have led to new recommendations and policy changes for health care providers. Education and prevention efforts have focused on reducing prescription drug abuse. Like many states, Arkansas established an electronic prescription monitoring program (PMP) to collect and store prescribing and dispensing data for controlled substances. The PMP includes records of all physicians prescribing and patients receiving opioids that were reported electronically by Arkansas pharmacies. This helps identify situations where physicians may be over-prescribing or patients may be “doctor shopping.”

At the federal level, HHS, through the Substance Abuse and Mental Health Services Administration
(SAMHSA), has outlined the opioid epidemic, and established prevention tools for health professionals, law enforcement and community members. In addition to prevention resources, SAMHSA also provided state funding to the Arkansas Department of Human Services, Division of Behavioral Health Services (DBHS) through the Partnership for Success to support community prevention efforts addressing prescription drug misuse in Arkansas. Recently, DBHS was awarded a Prescription Drug/Opioid Overdose-Related Deaths (PDO) prevention grant. The Arkansas PDO will focus on reducing prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older through first responder and community training.

The Arkansas State Epidemiological Outcomes Workgroup (SEOW) is a coalition of people and organizations that supports the state’s substance misuse prevention efforts. The Arkansas SEOW, managed by the Arkansas Foundation for Medical Care (AFMC) for the UALR/ MidSOUTH Center for Prevention and Training, provides several free resources for health care providers through the PreventionWorksAR website, including reports and educational tools. Prescription drugs and opioid use are the topics of informational tools and are included in both state and county-level data available through the website. To access specific data resources or informational tools, visit www.preventionworksar.org and select “Tools” or “Contact Us” for more information.

Dr. Bondurant is the manager of program evaluation; Dr. Sanders is an epidemiologist and Ms. Boyd is the director of analytical services, all with AFMC.
After three weeks of decline, the percent of samples testing positive for influenza in clinical laboratories shot up in the week ending March 25, from 17.84 percent testing positive to 20.14 percent testing positive, according to the most recent FluView Report from the CDC.

For the first time this season, the majority of specimens tested in clinical labs (52.7 percent) during the week of March 19 were influenza B, instead of the previously dominant influenza A.

However, influenza A remained the dominant strain in specimens tested in public health labs (53.2 percent).

Additionally, the proportion of deaths attributed to pneumonia and influenza remained above the epidemic threshold during the week of March 19, and the proportion of outpatient visits for influenza-like illness sat at 3.2 percent, higher than the baseline of 2.2 percent.

– Heather Punke, Becker’s Infection Control & Clinical Quality

PATIENT SAFETY
The Certified Professional in Patient Safety (CPPS) credential, introduced for the first time during Patient Safety Awareness week in 2012, celebrates its five-year anniversary this spring.

The CPPS credential was developed to establish patient safety competency standards and elevate the professional stature of those who meet knowledge requirements in safety science, human factors engineering, and the practice of safe care.

Continued
This group of committed individuals spans all 50 states and 12 countries worldwide. It includes patient safety, quality and risk managers, nurses, pharmacists, physicians, executives and those from other health disciplines.

18 health care professionals associated with Arkansas Hospital Association programming have earned their CPPS credential, to date.

NEXT GENERATION OF COMMUNITY HEALTH

The American Hospital Association’s Committee on Research has released a new Hospitals in Pursuit of Excellence report called Next Generation of Community Health, based upon its work exploring what hospitals and health systems are doing to redefine themselves while keeping pace with the changing health care landscape.

Find out about how multiple sectors, including hospitals, come together to form the intersection of community health, population health and population health management by downloading the report.

Hospitals and health systems are focusing on community health in new ways as they integrate outreach activities more closely with public health, collaborate with a wide variety of community partners and engage with the community to build an infrastructure for good health. Find the report on the American Hospital Association website, www.aha.org.
2017 Governor's Quality Award Healthcare Seminar

"Engaging Arkansans for Better Healthcare Outcomes"

June 20 | Embassy Suites Hotel, Little Rock | 8:45 AM – 3 PM

5.5 hours pending from the National Association for Healthcare Quality and Office of Long Term Care

AGENDA

8:45 - 9 am

Welcome

9 - 10:15 am

"Transforming Care Together: Elements of Excellence"
Featured Speaker — Dr. Glenn Crotty

10:15 - 10:30 am

Break

10:30 - 11 am

"Patient Engagement and the Power of the Portal"
Dr. Chad Rodgers

11 am - 12 pm

"On-Set Dementia: Creating Well-Informed Communities"
Dr. Angie Norman, DNP, GNP, ACNP

12 - 1 pm

Lunch

1 - 2 pm

"The Box"
Gerald Cantrell, RN

2 - 3 pm

"#LeadStrong"
Marcy Doderer

FEATURED SPEAKERS

Dr. Glenn Crotty
Executive Vice President and COO, Charleston Area Medical Center, Charleston, West Virginia
2015 Baldridge National Quality Award Recipient

Charleston Area Medical Center has accelerated organizational performance to create better healthcare outcomes. Dr. Crotty will share its Leadership System and demonstrate how it sets the expectations for leading throughout the entire system. The innovative “Transforming Care Together” process for redesigning care delivery will be described. Learn how the strategic planning process and goal cascade results in employee engagement throughout the the highly visible TOP 5 Board and daily work by staff.

Marcy L. Doderer, FACHE
President and Chief Executive Officer
Arkansas Children's Hospital (ACH)

Marcy Doderer took the helm as President and Chief Executive Officer of Arkansas Children's Hospital (ACH) on July 15, 2015. Marcy is a Fellow in the American College of Health Care Executives (ACHE) and is active in many professional organizations. She is currently a member of the Children’s Hospital Solutions for Patient Safety Board of Directors, serves on the Education Committee of the Children’s Hospital Association and the board of Healthy Active Arkansas. As a professional and a mother, Marcy is passionate about improving healthcare for children in Arkansas.

She obtained her BS in Finance from Trinity University, San Antonio, Texas, and her MA in Hospital and Health Administration from The University of Iowa.

Dr. Angie Norman, DNP, GNP, ACNP
Clinical Assistant Professor, College of Nursing at University of UAMS and Associate Director of the Donald W. Reynolds Institute on Aging’s Arkansas Aging Initiative

The number of people living with dementia is increasing exponentially. Until there is a cure, educating patients, families, healthcare providers, and communities on how to better respond together to the symptoms and responses of those living with dementia is the best “treatment” available. Discover how creating well-informed communities, support to caregivers and protection to those living with dementia allows them to safely interact with their surroundings and remain active in their communities.

Gerald Cantrell
Director of Paramedic Services
Baxter Regional Medical Center

Gerald Cantrell serves as the Director of Paramedic Services at Baxter Regional Medical Center in Mountain Home. He has been a paramedic since 1985 and has been an RN since 1992. He most recently completed training as a Community Paramedic in 2013. In 2017 he became one of the first three Licensed Community Paramedics in Arkansas.

Dr. Chad Rodgers
Pediatrician and Partner
Little Rock Pediatric Clinic

Dr. Chad Rodgers is a board-certified pediatrician and a partner at Little Rock Pediatric Clinic. He received his medical degree from the University of Arkansas for Medical Sciences. He is vice president of the Arkansas chapter of the American Academy of Pediatrics and secretary to the board of directors of the Arkansas Medical Society. He is the co-founder of Reach Out and Read Arkansas and serves on its board, as well as on the board of Arkansas Advocates for Children and Families.
A FRAMEWORK THAT FITS ANY SIZE OR TYPE OF ORGANIZATION
What if I told you there is an evidence-based model that helps leaders improve organizations of any size, from any sector, in any geographic location, or even spread across locations? I know that some of you are just as skeptical about that claim as I am about clothing that is advertised as One-Size-Fits-All. But I also know that some of you have seen through this analogy and know that I’m referring to the Baldridge Excellence Framework.

Since the Health Care Award category was established in 1999, there have been 21 Health Care recipients (including one two-time recipient). This past November the first recipient from the long-term care community was recognized, Kindred Nursing and Rehabilitation Center – Mountain Valley. But is the Baldridge Excellence Framework really adaptable enough to be of value to an organization caring for residents with mental illness and other conditions significantly affect their cognition?

EDGEMOOR DISTINCT PART
SKILLED NURSING FACILITY

Let me introduce you to Edgemoor Distinct Part1 (EDP) Skilled Nursing Facility (SNF). They are a 192-bed not-for-profit “safety net” facility serving the County of San Diego. Their residents are almost entirely Medicaid long term care who cannot be placed in any other facility. Yet EDP achieved the CMS 5-star rating in 2010 and has maintained it since then.

What separates EDP from other skilled nursing facilities is having three full-time physicians on staff. The senior leaders at EDP have achieved high levels of physician engagement through including them on governance committees. The doctors provide professional mentoring and risk management, and they are deeply involved in the care plans of their patients. Rather than having a single Medical Director who stops in to check on patients at 30-, 60-, and 90-day intervals, these doctors have regular interactions with their patients and consistently assigned staff to be true interdisciplinary teams of care.

The senior leaders at EDP have been involved in the American Health Care Association/National Center for Assisted Living’s Quality Award Program, based on the Baldridge Excellence Framework (which includes the Baldridge Criteria). Having earned Bronze and Silver Awards, the center just submitted its Gold application at the end of January. I asked why they got involved with the program. Dr. Robert Gibson said, “We had been doing quality assurance and quality improvement; the Criteria seemed to be in line with that, but it provided more than the basics. It was the whole package.”

Dr. Rebecca Ferrini added, “Achieving recognition with these awards is a way to honor our staff. They’re very invested, and these awards reflect the level of care they provide.” Walter Hekimian observed that the process also encouraged them to seek out comparisons. “We could see that our results put us in the upper echelon,” he said. “By quantifying our performance, we could share that with the staff on a regular basis. It fostered workforce engagement. It was a motivator.”

Continued

As CEO and Principal of BaldridgeCoach, Kay Kendall coaches organizations on their paths to performance excellence using the Malcolm Baldridge National Quality Award criteria as a framework. In each edition of Arkansas Hospitals, Kay offers readers quality improvement tips from her coaching playbook. Contact Kay at 972.489.3611 or Kay@Baldridge-Coach.com.
THE SENIOR LEADERS AT EDP WHO WERE GRACIOUS IN BEING INTERVIEWED ARE:

• Rebecca Ferrini, MD, MPH, CMD
  Medical Director, Edgemoor DP SNF
  Behavioral Health Services
  Health and Human Services Agency
  County of San Diego

• Robert Gibson, Ph.D., J.D.
  Senior Clinical Psychologist, Edgemoor DP SNF
  Behavioral Health Services
  Health and Human Services Agency
  County of San Diego

• Walter Hekimian, MBA
  Administrator, Edgemoor DP SNF
  Behavioral Health Services
  Health and Human Services Agency
  County of San Diego

When I asked how the journey has helped EDP — already an excellent organization — the senior leaders were quick to respond. Mr. Hekimian said, “It gave us a clearer path to some areas where we can still improve. It’s accelerated our progress.” Dr. Gibson added, “It provided a more objective lens than what we had before. You can be blind to your own problems, but this process allowed us to see things we might not have noticed before.”

Then I asked if the use of the Baldrige Excellence Framework had helped them as senior leaders — individually and as a leadership team. Dr. Ferrini was emphatic. “It helped us formalize things we were doing informally. It made us more disciplined,” she explained. “For example, we used to hold regular executive meetings, but we never took minutes. Now we do, and we find that we don’t lose track of actions we committed to take.”

I asked for an example of an “ah-ha” moment with trying to understand the Criteria, which can be a bit daunting to those new to it. Dr. Ferrini talked about the concept of “Voice of the Customer” (VOC). With the kinds of residents we have
at EDP, getting meaningful input and feedback can be difficult, she said. “But as we came to understand VOC and how it’s intended to be used, we realized all of the ways we connect with our residents to discover their wants, needs, and expectations. We develop true patient-centered care customized for each resident.”

**WOULD THEY RECOMMEND THE BALDRIGE EXCELLENCE FRAMEWORK?**

Would they recommend the Baldrige Excellence Framework for other organizations focusing on helping people with mental illness? Dr. Gibson said, “Absolutely.” Dr. Ferrini chimed in with a cautionary note. “You need to find someone who can help you understand the language of the Criteria and the scoring guidelines. When we started on this journey, we didn’t understand it. Some organizations bring that knowledge in-house by having staff members trained as examiners. We didn’t feel like we wanted to spend the time for those people to develop enough expertise to guide us. We went out and found a consultant who already had a deep knowledge of the Baldrige Excellence Framework and the application development process.”

More than any other leadership model I’ve seen, the Baldrige Excellence Framework’s systems perspective and lack of prescriptive approaches truly makes it adaptable for any kind of organization. If you’d like more information, you can find it on the Baldrige website, [https://www.nist.gov/baldrige](https://www.nist.gov/baldrige).

In addition, Arkansas has an excellent Baldrige-based program, found at [http://www.arkansas-quality.org/](http://www.arkansas-quality.org/). Or contact me at Kay@Baldrige-Coach.com. Isn’t it time you took your organization to the next level?

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A “distinct part” is a hospital-based skilled nursing facility, traditionally designed for short-term rehabilitation (skilled nursing and therapy care) to patients in the parent hospital allowing for shorter hospital stays. Edgemoor is not a typical distinct part facility.
It takes little time to get an answer when asking Jason Miller about major issues facing our state right now. “Arkansas ranks 10th in the nation for suicide,” he says. “For such a small state, this is extremely alarming! It reminds us that mental health is as high a priority as physical health, and that we all need to be mindful of this as each of us makes personal health care decisions or encourages others to seek help.”

Miller is a fierce advocate for mental and behavioral health, advocating for patients as well as programming and funding both at the legislative and grassroots levels. He strongly believes in helping people live up to their potential, seeing past what others may identify as insurmountable obstacles.

His encouraging attitude is inspiring. For those around him, including both the patients and staff at his hospital, the culture he generates leads to hope and healing.

Miller serves as CEO of The BridgeWay, the state’s first free-standing psychiatric hospital, which opened in 1983. He came on board as COO in 2011 and assumed the chief leadership position in 2014.

“At The BridgeWay, we have a deep dedication to the science and humanity of behavioral health,” Miller says. “Focusing on the ‘humanity’ aspect is important. Our staff is known for its compassion, inclusiveness and responsiveness. We go the extra mile for our patients, often helping them link with other resources and services that can benefit their overall health and quality of life.”

Too many people view mental health and substance abuse diagnoses in a negative light. “Society often views unfavorably the individuals trying to cope with these issues, even when we have proven there is no valid reason to do so,” Miller says. “We are still overcoming this stigma. Every day, providers like The BridgeWay and others treat patients who have been hesitant to seek the mental health care they need.”

But Miller wants people to look at mental health and substance abuse differently. He reminds us that on any given day, with any given stressful situation, any of us could find ourselves fighting a mental health issue of our own.

“We need to remember that mental health – good or bad – is part of all of us,” he says. “Nearly all of the population deals with mental health issues at one time or another: bouts of depression, anxiety, PTSD, addictions, reactions to trauma and stress. Others are coping with more serious mental illnesses like schizophrenia or bipolar disorder that affect them every day. The important thing is, everyone deserves to be mentally healthy. We don’t talk enough about the importance of mental health in our society, or about how people can access help when they need it.”

Path to The BridgeWay
From the age of five, Miller knew he wanted to be in health care. In fact, during his college years he was pre-med, majoring in health care biology at Hendrix College. But while working after college with Counseling Associates, a community mental health center in west central Arkansas, he knew mental and behavioral health was a niche he wanted to serve.

He enjoys the education and training aspects of this work, and through the years has developed a number of training modules for the industry, including work he did for his master’s degree from Tulane University School of Public Health. His career has included positions with Arkansas Children’s Hospital and the CHI St. Vincent system.

When the position for COO at The BridgeWay opened up, he saw a way to combine a love of hospital operations with his dedication to mental and behavioral health care. “I had worked on the clinical side, but I really like being able to drive change,” he says.

Continued
Jason Miller, CEO of The BridgeWay

What’s the Best Advice You Were Ever Given?
It came from my parents, who have always told me to remember, “you’re never better than anyone else.” No matter what you achieve or how successful you might become, you’re the same as your neighbor. I try to never forget that.

What Would You Do if You Weren’t in Health Care?
I’m a water guy. If money were no object, I guess I’d be living at the beach giving boat rides and maybe selling coconuts every day, enjoying the sun and the water.

What Do You Like to Do in Your Off Time?
In the summer, I’m probably at the lake on the boat...or maybe in the pool with my daughter. If I’m inside, I’m probably watching movies. Watching them is my way of letting go. I’d rather sink myself into a good film than a book any day.

What is Something People May Not Know About You?
I was diagnosed with Tourette Syndrome when I was 12. And while my case is relatively mild and manageable, there are many others who are not so lucky. Aside from talking with others and sharing my own experiences with the disorder, I re-organized the Arkansas Chapter of the Tourette Association back in the late ’90s and served as its chair for a number of years.
Out of the Shadows

The health care climate seems to be changing daily. Mental health care is a focus of discussion, both at the state level and nationally.

"I’m encouraged that the Arkansas Legislature is considering a state-specific Suicide Prevention Hotline," he says, "and that the proposed changes to Medicaid have been able to be driven by a new, provider-led model that is promising."

But he urges Arkansans, whether in the political arena or at home across the state, to become more open to discussions about mental health and substance abuse as a whole, bringing it out of the shadows of stigma and into the light of acceptance.

"My hope is that people will intentionally grow in the recognition of how serious mental health is to our society," he says. "And that to increase our understanding of the severity and ramifications of mental health, we have to look beyond dollars on a spreadsheet or false beliefs that these issues impact only the downtrodden. We must, at the governance level, recognize, provide and appropriately fund access to care for all who need it."

It Applies to All of Us

“There are dangers when society chooses not to give something real, like mental health, the attention it deserves,” Miller says. “Maybe we do this more when we think it doesn’t apply to us. But in reality, this applies to all of us. We continue to miss the fact that mental health is health, the same way that physical health is health. There is no longer a debate about that. So it’s important that our picture of health become more inclusive, less exclusive.”

His advice: whether in health care or not, talk with people about mental health’s importance to each of us, individually, and to society as a whole. Help bring mental health and substance abuse issues into open discussion. Educate those making big decisions about the issues people face. Become an advocate for mental health parity. And never think you or your family are somehow immune to something from which there is no immunity.

“We need advocates, as well as caregivers,” he says. “Everyone can help bring the importance of mental health and substance abuse into focus, giving rise to more funding and access to care. It’s likely you or someone you know will need this care during your lifetime. Each of us must work to be sure it’s there when we need it.”

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SUICIDE: ARKANSAS 2017 FACTS & FIGURES

Suicide Death Rates

<table>
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<tr>
<th>Number of Deaths by Suicide</th>
<th>Rate per 100,000 Population</th>
<th>State Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>577</td>
<td>19.11</td>
</tr>
<tr>
<td>Nationally</td>
<td>44,193</td>
<td>13.26</td>
</tr>
</tbody>
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Suicide is the 10th leading cause of death overall in Arkansas.

On average, one person dies by suicide every 15 hours in the state.

Suicide cost Arkansas a total of $540,251,000 of combined lifetime medical and work loss cost in 2010, or an average of $1,208,615 per suicide death.

IN ARKANSAS, SUICIDE IS THE...

2nd leading cause of death for ages 25-34
3rd leading cause of death for ages 15-24
4th leading cause of death for ages 35-54
5th leading cause of death for ages 10-14
8th leading cause of death for ages 55-64
16th leading cause of death for ages 65 & older

More than twice as many people die by suicide in Arkansas annually than from homicide; the total deaths to suicide reflect a total of 11,286 years of potential life lost (YPLL) before age 65.
HOW TO HANDLE ANGRY AND DANGEROUS PATIENTS

By Kit Schindell, RN, BSN, MA

Editor’s Note: While writing this article, Kit Schindell came face-to-face with the type of patient she was describing. Quickly, her writing moved from a short educational piece to a compelling essay relating her experience. Kit’s experience offers valuable insight into the day to day reality faced by health care providers.

Anger is a normal and usually healthy emotion. Most of us are able to express our anger in an assertive and civilized manner. But sometimes anger becomes aggressive or passive-aggressive. It is anger that is out of control that alarms us. We all know horror stories of situations that went terribly wrong. And very often we are just the people whom the angry people come to see.

So what do we do? We all see angry patients and families in our work and some of them are pretty scary. I have met a lot of very angry individuals in my long years in psychiatry and in patient relations. Maybe some of what I have learned will help you, too.

**STAY CALM** This is easier said than done, especially if this individual frightens you. Count to three (you don’t have time for “ten”). Keep your hands in front of you where the other person can see them. Hold your own hands if you need to (if they are shaking).

**KEEP YOUR VOICE QUIET** It often causes the person whom is yelling to lower her voice, too. Your quiet voice can help to bring some order to the chaos noise brings.
ASSESS THE LEVEL OF ANGER Anger can escalate to the point where the person is so consumed with fury that he is unable to hear your comments or process your helpful information. This can also be a very frightening time for the person (and possibly dangerous for you). You may need help at this point, but if you are alone speak quietly, simply, reassuringly, giving the person time to de-escalate and recover somewhat.

BE RESPECTFUL, ALWAYS Some of the people who come to my office have never been treated respectfully in their lives. They do not know any other way to behave. Even something very simple, such as, “May I call you by your first name?” denotes respect and consideration to a person feeling disenfranchised, angry, mistreated.

LISTEN It is important to hear what has made this person so angry. Some people have grown up without ever feeling heard, and feel their only recourse is to yell — that gets attention. Try to hear the words as if they were being said at normal volume.

ACKNOWLEDGE HIS/HER CONCERNS We all know this. But sometimes it is so difficult not to become defensive when people want to hold us personally responsible for their issues with the hospital, their doctor or the bad outcome in the life of someone they love. But just saying something like, “This must have been a nightmare for you,” or something that fits your own personality, will help the individual feel that she is not alone against the world.

DON’T PROMISE THE WORLD The angry individual has come to you for help, and it often seems that you can calm the person by instantly agreeing to his demands. Instead, say, “I’ll do everything I can to help you,” or “Let me look into this for you.”

SAY WHAT YOU SEE “I can see that you are really upset right now.”

STAY SAFE When I have an extremely angry individual in my office, I keep the door open. My colleagues in our office cluster know to just walk by and make sure I am okay. I don’t mind if the person sees this. Sometimes I even gently explain, “It’s okay. They hear you yelling and they are afraid for me.” The person nearly always looks surprised and lowers his voice.

REMOVE ANY POSSIBLE MISSILES FROM YOUR DESK OR TABLE, IF NECESSARY If someone decides to throw something at me, I’d prefer it be the box of tissues than the heavy silver card-holder. If things get really out of control, slip your pen out of sight. Pens can be lethal weapons. Do you have the number for Security memorized? Is your chair nearer the door than the visitor’s chair?

IF YOU WORK ALONE, ARRANGE TO HAVE SECURITY DO WALK-BYS, OR EVEN REMAIN IN YOUR OFFICE AREA IF YOU HAVE ANY CONCERNS ABOUT YOUR SAFETY And never, ever feel guilty if you do this, and it turns out that Security officers weren’t needed after all. You do not have to die in order to show them you were right.

DEBRIEF When these events occur, talk about them to your Critical Incident Stress Management folks, or to a trusted colleague. There really is a great benefit to sharing the load and “normalizing” the impact of these abnormal events.

DON’T BE A HERO Often if you are frightened, the other person is, too. But if you are in real danger, yell for help. Leave. We want you back tomorrow.
As I was putting the finishing touches on this article, my secretary, Susan, announced that there was a gentleman to see me. I went out to the waiting area and invited him into my office. No sooner had he sat down than I knew I was in trouble. He began to raise his voice, escalating from zero to eighty in about four seconds. I remember him demanding that I close my door; I quietly refused. I remember him yelling something about “lack of respect,” but I do not know what he was saying beyond that because my brain was focused on somehow getting this man out of my office. The screaming intensified, accompanied by unrelenting profanities. Within seconds my gut instinct took over for my brain, and I knew I did not have time to figure out how to get him out of my office. I needed to get myself out. I got up and flew out the door, but he came after me, still screaming, still shrieking profanities and threatening me. And suddenly, he burst out the door of our department and was gone. I asked Susan to call Security if she saw him again, and I personally notified Security that this man was around. And that was it...

...until, an hour or so later, he came back. Someone hurriedly warned me and I locked my office door. When Security arrived, this man went completely ballistic – and suddenly the violence began in earnest. The screaming and swearing continued and he threatened to kill the officers. Patients and staff and physicians on the entire floor were terrified. In the end this resulted in a full-fledged takedown with five security officers and six policemen. It was one of the most violent and ugly takedowns I have ever witnessed, and the screaming and swearing never stopped until he was literally dragged onto the elevator.

Turns out this man is well known to the police and usually carries nails to use as weapons. He spent the night in jail, and was released on the condition that he stays away from Susan, two specific security officers, and me. He is not to be within two blocks of this hospital.

But he’ll be back...

Worst Case Tips

There are times when “speak quietly; be respectful; listen attentively” take second place to keeping yourself alive. This man had no interest in anything I had to say. His fury was so intense he could not even hear me.

Situations such as these only occur rarely, but once is too often. Here are a few worst-case scenario tips that I hope you will never need:

- If you are in real danger, just get out of your office. Leave everything behind you. Just go.
- Yell for help. Scream, “Security!” or “Police!” if you have to.
- If you do not know the person, and have misgivings, arrange to meet in a more public place – a conference room, or over coffee in the cafeteria.
- Take a look around your office. How safe is this place for you? Do you have a door that locks – and a deadbolt?
- If you work alone, arrange to have Security do walk-bys, or even to remain in the area while you see this person.
- If you think that an offer of refreshment might calm someone, offer water (not a hot drink) and serve it in a paper cup, not ceramic. If he throws it, you’ll just get wet, not concussed.
- Remove any possible missiles from your desk or table. (I get up from my desk and join my visitors at a table in my office. Only a few brochures and a box of tissues are on the table. No heavy ornaments).
- Do you wear your ID around your neck? You may want to clip it to your waist, instead.
- Get those pens out of sight!
- Get a peephole installed in your office door, if your office, like mine, opens onto a corridor or public area.
- Have a code with your colleagues so they know to call Security stat, if necessary.
- Have a panic button installed in your office near where you usually meet with clients. The button should bring Security running without further calls from you.

I would encourage you to take some safety training. No one wants to stand around and spar with a violent person. If, however, someone behind you closes his hands around your throat to kill you, forget all those fancy moves about ducking and diving and such. They often only work if you weigh 250 pounds and teach body building. Reach up, grab one of his fingers in each of your hands and bend them back until they break. This will keep you alive a bit longer, and give you a few seconds to run. (You can do this even if you are tiny and light. Your hands will always have sufficient strength.) Everything in us tells us not to do anything harmful, but you will not be alive to reconsider this kind of scenario.

I hate writing this. I love helping people, I love to see people satisfied and feeling heard and respected. I love happy endings. I loathe violence. But I want to survive my job.

And I hope you have a safe and satisfying workplace.

Kit Schindell worked in acute adult Mental Health for over thirty years, and in Patient Relations for a large hospital cluster for twelve years. Retired from health care now, she is a fiction editor and lives in Vancouver, British Columbia, Canada.
You probably know patients who present with entitled attitudes, and you may think there’s not much you can do about them. Entitled patients often demand excessive attention and may question your competence when they are not satisfied with how important you make them feel.

By using one or more of the following approaches, you can manage entitled patients respectfully while reducing your risk of stress and burnout.
1 Be on the same side.

When an entitled patient brags about knowing your CEO, your best strategy is to praise your CEO with a lot of specifics.

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

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

2 Use empathy to absorb tension.

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

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

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

3 Take patients as you find them.

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

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

4 Focus on the person, not the personality.

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

5 Use the million-dollar phrase.

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

You need a safety net response to prevent situations from escalating out of control. Focus on slowing down your responses. Pause before answering.

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

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

6 Find a team member to step in for you.

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

Susan Keane Baker, MHA, speaks about patient experience issues. Additional resources, including a free e-course, are available at her website, susanbaker.com
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SUICIDE PREVENTION PROGRAMS AND INITIATIVES

- Arkansas HB 1887 (adopted 4/4/15) establishes the Arkansas Suicide Prevention Council to serve as a central body on suicide prevention efforts across the state, including setting priorities for statewide suicide prevention.

- The Arkansas Suicide Prevention Network was formed in 2010 as a cooperative effort of multiple public and private agencies that work together to prevent suicide across every lifespan. In 2012, the Network received 501(c)(3) status.

- The Network hosts annual suicide prevention conferences, facilitates monthly webinars, and coordinates with member groups on fundraising activities in addition to a number of other initiatives.

- In February 2010, the Arkansas Strategy for Suicide Prevention was signed by the Governor, Attorney General, Director of Behavioral Health, and General for the Arkansas Army National Guard. A lifespan plan is currently in development and can be found at http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/injuryPrevention/Documents/PlanArkansasStrategySuicidePrevention.pdf.

- Arkansas law (§6-17-708) mandates two hours of suicide prevention training every five years for public school employees. This was accomplished through the Jason Flatt Act of 2011 (HB 1778 – signed 3/30/2011).

LEADING THE FIGHT AGAINST SUICIDE

We fund research, offer educational programs, advocate for public policy, and support those affected by suicide. Headquartered in New York, AFSP has local chapters in all 50 states.

GET INVOLVED

The AFSP Arkansas Chapter brings together people of all backgrounds in communities throughout the state to fight suicide. For more information or to volunteer, please contact:

AFSP – ARKANSAS
arkansas@afsp.org

BECOME AN ADVOCATE IN ARKANSAS

AFSP’s Arkansas advocacy volunteers build relationships with public officials and advocate on behalf of sound suicide prevention policy.

To get involved, contact:
Nicole Gibson
Director of State Policy & Grassroots Advocacy
nigibson@afsp.org

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ARKANSAS HOSPITAL ASSOCIATION - 39
Engaging nurses and frontline staff to improve the quality and safety of patient care on medical and surgical units in hospitals is the idea behind a new collaborative, Transforming Care at the Bedside (TCAB), led by the Quality Team from the Arkansas Hospital Association (AHA) and sponsored by the AHA’s Hospital Improvement Innovation Network (HIIN). Currently, 17 Arkansas hospitals are participating in this innovative project, which held its kickoff event January 19.

TCAB was originally launched as a pilot program with the Institute for Healthcare Improvement. Since the program’s beginnings in 2003, TCAB has served as a learning laboratory for change, with a focus on improving the delivery of care in medical/surgical units.
The goal of TCAB is to engage nurses, frontline staff and leaders at all levels of the organization to:

- Improve the quality and safety of patients’ care on medical and surgical units;
- Increase team vitality and retention of nurses;
- Engage and improve the patients’ and their families’ experience of care; and
- Improve the effectiveness of the entire care team.

TCAB is not a traditional quality improvement program. One primary characteristic that sets TCAB apart from others is its focus on engaging frontline staff and unit managers. Many transformational care delivery ideas are initiated directly from nurses and other bedside care team members. The TCAB process empowers these caregivers to identify where change is needed, suggest and test potential solutions and decide whether the innovations are implemented.

“This is a great project led by bedside nurses for bedside nurses, supported by leaders!” says Kelly Dicks, RN, Cline Emergency Center Director at Baxter Regional Medical Center in Mountain Home.

“Being able to impact care where it occurs, at the frontlines, is exciting!” says Pamela Brown, BSN, RN, CPHQ, CPPS, Vice President of Quality and Patient Safety at the Arkansas Hospital Association. “Improving outcomes while supporting the nurses at the heart of patient care is so important!”

Monthly conference calls allow participating hospitals to network, sharing best practices and seeking answers to challenges that occur in such areas as nurse bedside reporting, patient and family involvement, optimizing team conversations, leadership and communication strategies, improvement of handoffs, peer coaching, hourly rounding and enhancing engagement.

Hospital teams are measuring their improvement, compared to baseline data, in areas that include nurse time at the bedside, nurse communication, responsiveness of hospital staff, physician communication, medication information and discharge information. Hospital cleanliness and quietness are also considerations for this project.

“Our Arkansas hospitals show their commitment consistently to the patients they serve,” Brown says. “Participation in this collaborative is just another example of their intense dedication.”

Arkansas Hospitals Participating in the TCAB Program
(The limited 15-hospital cohort size was extended to 17, and includes both general medical-surgical and critical access hospitals):

- Ashley County Medical Center
- Baptist Health Medical Center-Heber Springs
- Baptist Health Medical Center-N. Little Rock
- Baxter Regional Medical Center
- Bradley County Medical Center
- Chicot Memorial Medical Center
- Delta Memorial Hospital
- Forrest City Medical Center
- Helena Regional Medical Center
- Howard Memorial Hospital
- Johnson Regional Medical Center
- NEA Baptist Memorial Hospital
- North Arkansas Regional Medical Center
- North Metro Medical Center
- Saline Memorial Hospital
- UAMS
- Unity Health-White County Medical Center
AHA’S QUALITY TEAM LEADS THE WAY

Health care in America is changing, but one thing that remains constant is the determination of Arkansas’s hospitals, supported by the Arkansas Hospital Association’s Quality Team, to consistently improve the quality of care delivered!

Led by Pamela Brown, BSN, RN, CPHQ, CPPS, the team also includes Nancy Godsey, RN, CPHQ and Nikki Wallace, RN, who travel regularly for face-to-face strategizing meetings with quality team members at Arkansas hospitals.

As we move into the springtime, it’s a good time to review the many projects AHA’s Quality Team is currently directing in the areas of Quality and Patient Safety:

- Leading Arkansas’s Hospital Improvement and Innovation Network (HIIN), with 55 hospitals
- Leading Arkansas’s Transforming Care at the Bedside Collaborative, with 17 hospitals
- Collaborating with the Arkansas Department of Health (ADH) on Antimicrobial Stewardship
- Collaborating with the Arkansas Foundation for Medical Care (AFMC) and Arkansas Health System Pharmacists in the work to reduce adverse drug events
- Planning the kickoff of a Sepsis Collaborative in Summer 2017 with AFMC, ADH, and the University of Arkansas for Medical Sciences (UAMS)
- Continuing to offer specific face-to-face meeting support twice a year with AFMC in improving care transitions and reducing readmissions through community coalitions
- Leading Arkansas’s ICU-specific work to reduce catheter-acquired urinary tract infections (CAUTI) and central line-associated blood stream infections (CLABSI)
- Currently recruiting for Project STRIVE, which is supporting the improvement of infection prevention and control practices focused on C. difficile infection (CDI), CLABSI, CAUTI and Methicillin-resistant Staphylococcus aureus (MRSA) in collaboration with AFMC and ADH
- Working with our hospitals in partnership with ADH and the March of Dimes in improving outcomes for infants through programs such as Safe Sleep, reduction of early elective deliveries and advancing breast feeding in our state

In addition, AHA’s Quality Team represents hospitals on these advisory groups and coalitions:
- Quality of Care Committee for the State of Arkansas Employee Benefits Division
- Healthcare-associated infections (HAI) Advisory Committee with the Arkansas Department of Health
- ST-segment elevation myocardial infarction (STEMI) Advisory Committee with the Arkansas Department of Health
- Safe Sleep Committee with the Arkansas Department of Health
- Breastfeeding Committee with the Arkansas Department of Health
- Infant Mortality Committee with the Arkansas Department of Health
- Cervical Cancer Task Force
- South Central Telehealth Resource Center Advisory Committee
- Falls Free Coalition
The AHA Diamond Awards program encourages improvement in the quality, effectiveness and impact of health care marketing and public relations within the state of Arkansas.

Nominations are now open for the 2017 awards. The Diamond Awards are co-sponsored annually by the AHA and the Arkansas Society for Healthcare Marketing and Public Relations. 2016 saw 19 Arkansas hospitals receive Diamond Awards for their excellence in bringing the hospital message to Arkansans.

Awards are presented in several categories, including advertising, annual report, foundation, publications, and writing.

Diamond Awards divisions include hospitals with 0-25 beds (Critical Access Hospitals), 26-99 beds, 100-249 beds, and 250 or more beds. Emphasis is placed on the budget for each entry within each division.

Nominations due: 4:30 PM; May 5, 2017
Award Date: October 5, 2017

www.arkhospitals.org
COMMUNITY PARAMEDICINE AND MENTAL/BEHAVIORAL HEALTH CARE: WHAT’S THE CONNECTION?

by Nancy Robertson, Senior Editor

Community Paramedicine, now a major part of patient care in two Arkansas regions, is on the radar for possible expansion nationwide by a major insurer.

We have reported previously on the successful Community Paramedicine program initiated in 2013 by Baxter Regional Medical Center in Mountain Home and the fledgling program initiated last fall by the Metropolitan Emergency Medical Services (MEMS) paramedics in Central Arkansas. (Fall 2016 edition).
Community Paramedicine helps hospitals extend patient care services by keeping non-emergent patients out of the ER, helping discharged patients recover well at home instead of returning to the hospital, and encouraging population health while keeping costs down. It expands the role of EMS personnel to serve communities more broadly in the areas of primary care, public health, disease management, disease prevention and wellness, mental health and oral health.

Community Paramedics (CPs) receive advanced training through an intensive standardized curriculum, allowing them to adapt to specific roles needed in their locales.

**THE MENTAL/BEHAVIORAL HEALTH CONNECTION**

Community Paramedicine as a form of out-of-hospital care has developed in response to needs of patients who slip through the gaps in our current health care system. These patients frequently call 911 to handle non-emergent issues, and are known as the “high utilizer group.” CPs are trained to be on-scene providers who can assess the situation, offer immediate help, then assist the patient in navigating the health care system to match each patient with existing resources.

“Mental health is an underlying issue with approximately 50% of our patients, both regular ambulance and community paramedicine,” says Ed Gilbertson, RN, BSN, Community Paramedicine program director at MEMS in Little Rock. “We keep our patients’ mental health in mind no matter what kind of call we’re making.

“For example, if we’re called because a patient is having an episode, say, due to their diabetes, we know that if a patient has mental or
behavioral health or developmental disability issues, this can affect their ability to take medications correctly. Improper use of medications and/or forgetting to combine medications with the proper nutrition can greatly interfere with physical health overall.

Sometimes, mental health issues are dominant. When these mental or behavioral health issues dominate a call, CPs go to their web of resources to put patients and solutions together.

Gilbertson recalls one patient referred to MEMS by the police. “The patient was feeling violent and called the police for help. The officer gave the patient my number, indicating that we would be able to help him,” Gilbertson says. “He had been treated for bipolar disorder as a child. For the past five years, he had taken himself off of his medication, and his life spiraled downward. He lost contact with his family, his friends…his girlfriend left him. I interviewed him and had to assess whether he was going to be dedicated to getting help, getting re-established with his physicians and was not looking for a simple, quick fix. I arranged screening for him, and I followed up to see that he kept the appointment. He got the help he needed and is on his way to a more stable life.”

It sometimes takes getting people to “step out of their own brains” to accept help, Gilbertson says. “It’s like we’re saying, ‘Take my hand and let me guide you through this.’” It changes lives.

For patients with mental and behavioral disorders, the relationships of trust established with CPs through the Community Paramedicine program make all the difference. “We can’t fix their mental status, but we can help them fill out paperwork, help them understand processes, set them up with nutritional help, counseling, social security representatives – whatever is needed,” Gilbertson explains.

Another patient example involves a senior with congestive heart failure. “Patients who have mental health issues get used to dealing with challenges, but a new disease process can really throw them,” Gilbertson says. “One of my CHF patients called about the extreme swelling in his legs. I asked him if the nutritionist had been to talk with him. ‘Yes,’ he replied, ‘but all they want to talk about is salt! I want my legs to quit swelling.’” His mental health connection got in the way of his understanding what the nutritionist was telling him. Knowing his challenges, we were able to help him make the connection between salt and the swelling of his legs, and to tell him exactly what to do and not to do in very simple terms.”

CPs remind us of the old-fashioned doctors who made horse-and-buggy house calls. They knew their patients, they knew each person’s situation. They knew the whole person and they had well-established relationships, often through generations.

“One of the things we bring to our patients is a real
person, one who has a face-to-face relationship and who they come to trust, over time,” Gilbertson says. “We deal with the whole person. I cannot overstate the value of the trust connections that are built through Community Paramedicine.”

MEMS PROGRAM TO DATE
How is the MEMS program progressing? All seven of the CPs are finished with their classroom training and are completing their clinical rotations. Though they each have more than 10 years’ paramedic experience, they are now seeing patients under the new program.

Ed Gilbertson is spreading the word about the value of Community Paramedicine throughout the state. He’s a part of the Arkansas Foundation for Medical Care’s ACT coalitions, and is working with home health agencies, pharmacies, hospice and hospitals to partner for the good of patients.

“We may be competitors outside our coalition meetings,” he says, “but inside, we’re all looking for ways to cover those who fall through the gaps. This is truly a coming together of experts.”

STILL NO COVERAGE
There is still no insurance coverage for the practice of Community Paramedicine. However, one insurer in Arkansas has learned about the program, and has asked for a business meeting to discuss how a pilot program for covering CP visits might evolve. “They look at it as treating the patient with prevention of disease progression in mind. They want to measure results. If this comes to pass, it could have a big impact on the long-term health of our patients,” Gilbertson says. “We’re building this program to be what the patient needs from it. And that’s the best for all concerned.”
TODAY, ALCOHOL WILL CONTRIBUTE TO
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WORKERS’ COMPENSATION: BETTER OUTCOMES AND LOWER COSTS WITH PRESCRIPTION REVIEWS

by Carlisle Medical, prepared in collaboration with Carlisle’s staff pharmacists Christina Bond, Pharm. D. and Heidi Dufrene, Pharm. D.

Prescription medications account for an estimated 19% of the total medical costs for workers’ compensation claims, according to the National Council on Compensation Insurance (NCCI), and this estimate has been rising over the last several years.¹ This translates to an estimated $5 billion annually in pharmacy drug costs nationwide. Medication costs for claims older than 11 years can reach as high as 40%. Reviewing medication costs can be one of the most effective ways to control the high cost of workers’ compensation claims. Pharmacists and Pharmacy Benefit Managers (PBMs) have programs to identify and implement safer and more cost-effective alternatives. After more suitable alternatives have been identified by the pharmacist, the findings are then best communicated to the physician through a consultation with a nurse case manager.

MEDICATION COSTS KEEP RISING IN THE WORKERS’ COMPENSATION INDUSTRY

Workers’ compensation medicine and medical costs have increased an average of 4-6% each year, according to an NCCI 2013 study.¹ The major contributors to these costs include: physician dispensing, utilization of brand name medications, high prices for compounds, specialty medication...
The average **30-YEAR COST** of five commonly prescribed medications is **$201,216.24**

**MEDICATION COSTS* OVER A 30 YEAR LIFE EXPECTANCY**

<table>
<thead>
<tr>
<th>Medication</th>
<th>30-Year Cost</th>
<th>30-Day Cost</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify 10mg</td>
<td>$385,236.00</td>
<td>($1,070.10)**</td>
<td>1 per day</td>
</tr>
<tr>
<td>Duragesic 100mg</td>
<td>$105,897.60</td>
<td>($294.16)**</td>
<td>2 pkg month</td>
</tr>
<tr>
<td>Butrans 20mg</td>
<td>$58,640.40</td>
<td>($162.89)**</td>
<td>1 pkg month</td>
</tr>
<tr>
<td>Imitrex 20mg</td>
<td>$51,955.20</td>
<td>($144.32)**</td>
<td>1-2 pkg month</td>
</tr>
<tr>
<td>Oxycontin 80mg</td>
<td>$404,352.00</td>
<td>($1,123.20)**</td>
<td>2 per day</td>
</tr>
</tbody>
</table>

*Typical dosage as per discussion with pharmacy. **Redbook Price for 30 Days. [41]

and rising generic drug costs. In 2011, physician dispensing represented 17% of the total workers’ compensation drug costs, according to the NCCI. Drugs commonly dispensed by physicians cost 60% to 300% more than those dispensed at retail pharmacies, according to the Workers’ Compensation Research Institute. Given these extreme market factors, a collaborative utilization approach by PBM and health care professionals can effectively keep costs under control.

**PHARMACIST-PROVIDED PRESCRIPTION REVIEWS DRIVE EFFECTIVE MANAGEMENT**

Prescription reviews consist of tracking and studying patient data to determine cost-effective alternatives to improve healthcare outcomes overall. Pharmacists are trained to ensure that the medications prescribed are safe, appropriate, and necessary to treat the injury, while restoring health and productivity of the claimant. Pharmacists and PBM understand that appropriate treatment can be reached while reducing medication costs.

Prescription review opportunities can be identified through adjuster requests, pharmacist intervention or internal red flag reporting by a Pharmacy Benefit Manager.

- Has the treating physician(s) failed to respond to inquiries?
- Does the claimant’s monthly medication cost exceed $500?
- Is the claimant prescribed brand name medications that have a generic equivalent?
- Is the claimant prescribed two or more medications in the same therapeutic class?
- Is the claimant prescribed medication that may be unrelated to his/her injury?
- Is this a Medical Only file that has been open for over five years?
- Is the claim approaching settlement?
- Are there two or more treating physicians on this claim?
- Has the claimant had one or more inconsistent drug screens?

Pharmacist-provided prescription reviews examine the relatedness of treatment to the injury and medication history for the claimant over the prior 90 days. Utilizing patient-specific factors, as well as manufacturer guidelines, retrospective reviews can
help identify potential drug-related problems to the claimant including:

• Inappropriate dosage, based on manufacturer guidelines;

• Therapeutic duplication (use of multiple drugs from the same therapeutic drug class);

• Excessive duration for prescription drug products;

• Drug-disease advisory;

• Compound ingredient analysis; or

• Drug to drug interactions.

Once the pharmacist identifies a problem, the prescription review will be presented to the physician, providing evidence-supported recommendations for positive changes to the claimant’s current drug therapy. National studies support the helpful impact that pharmacists can have on decreasing unnecessary medication use and total costs.\(^2\) The nurse case manager plays a critical role in the process, by then effectively communicating the proposed changes to the prescribing physician.

It is important to note that prescription reviews do not impact the treatment. Patients are receiving the same treatment with only minor changes in the medication.

COMMUNICATION BY A NURSE CASE MANAGER IS CRITICAL

Typically, nurse case managers are involved with catastrophic claims where there are many details to coordinate between the claimant, employer and physician. However, in recent years it has become clear that nurse participation is vital for successful outcomes. Nurses are now being utilized on all types of claims, including those involving a lesser degree of trauma. With nurse case managers working only 10% of all claims in the workers’ compensation industry, one could make a case that they are being highly underutilized. The goal, however, remains the same: to design, implement and monitor an effective and efficient schema of post-acute care.

The role of a workers’ compensation nurse case manager can be defined by looking at the accepted definition of case management:

Case management is a collaborative process of assessment, planning and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.\(^3\)

The prescription review/task assignments are a more specific utilization of a nurse case manager’s skills. The pharmacist-provided prescription review and the treatment alternatives are discussed between the pharmacist and nurse, so these changes can be effectively communicated to the physician during the task assignment. The communication between the nurse, physician and claimant facilitates a much more successful outcome than the passive mailing or faxing of a prescription review directly to the physician’s office. Historical tracking by Carlisle Medical shows that the mailing or faxing of a prescription review to a physician only facilitated the requested alternative changes 15% of the time.

**PRESCRIPTION REVIEW: STEP-BY-STEP**

- Adjuster approves a pharmacist-provided prescription review.

- Pharmacist and nurse case manager perform the prescription review.

- Completed review is presented to adjuster for approval for physician consultation.

- Nurse case manager contacts the physician’s office to schedule a consultation to discuss the prescription review.

- Nurse case manager meets with the claimant’s physician to discuss prescription changes recommended by the pharmacist.

- Physician recognizes benefits of alternative therapy and provides prescription changes to the dispensing pharmacy.
In contrast, utilizing a nurse case manager to deliver the prescription review and discuss alternatives yields a success rate of 80%. The reasons for increased success can be attributed to a few key points:

* Information is provided clearly and concisely, and the physician is provided the opportunity to have questions answered immediately by the consulting nurse, as it relates to the claimant’s prescription history and suggested alternatives.

* The physician can conveniently write the new prescriptions to make the suggested changes during the consultation.

* The nurse can also facilitate the delivery of the prescription changes to the dispensing pharmacy so changes can be immediate.

INTERNAL EDUCATION
Health care professionals can further alleviate rising drug costs by educating adjusters, case managers and risk management resources personnel on prescription review services. Educating claimants about costly treatment can be helpful. Behavioral research has demonstrated that claimants care about the cost of the treatments they receive, including physician-dispensed medication.

CONCLUSION
Prescription drug costs will likely continue to escalate for the foreseeable future. Employers and administrators can help contain these costs and drive better overall workers’ compensation claim outcomes by using these types of prescription reviews and consultations. Many companies have the potential to save millions of dollars by partnering with an experienced PBM that is consistently reviewing drug prescription costs and their relation to the claimant’s medical needs.

REFERENCES
[4] Actual prescription costs are for generic drugs, when applicable, and were procured using AWP Redbook values.

Information in this article courtesy Carlisle Medical, www.carlislemedical.com
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REALITIES OF PAY AND BENEFITS FOR BEHAVIORAL HEALTH

By Theresa Worman, Executive Vice President, Compdata Surveys & Consulting

From a workforce management perspective, behavioral health organizations are not without their unique challenges. Like many health care organizations, the work is demanding, and behavioral health organizations tend to have difficulties in recruiting, retaining, and motivating employees. These workforce issues are often attributed to low pay and less than competitive benefits. This article will provide a snapshot of how compensation and benefits at behavioral health organizations in Arkansas stack up against the rest of health care in the state.

According to the 2016 AHA Healthcare Survey, behavioral health centers reported a 17.8% voluntary turnover rate, which is surprisingly in line with the 17.2% average among all health care organizations in Arkansas, while only slightly higher than the 15.9% reported by hospitals. Further analysis shows behavioral health’s average is significantly lower than turnover rates at health care employers such as long-term care with the highest voluntary turnover at 26.6%, hospice at 22.7% and even home care at 18.7%.

Arkansas behavioral health centers’ pay practices, such as salary increases, pay increase budgets and pay structure adjustments, fall closely in line with other health care organizations in the state. For example, the pay increase budget for behavioral health is 2.4% versus 2.5% average for all health care organizations. In addition, it appears that most benefit offerings are consistent with other health care organizations, or in the case of retirement, behavioral health is slightly above average.

However, behavioral health does have some differences in compensation worth noting. Behavioral health employers in Arkansas reported median RN
pay of $24.82 per hour, which is 7.5% below all health care organizations who reported pay of $26.71 per hour. This is a difference of over $3,900 annually. This trend is also seen among social workers in health care settings. Behavioral health organizations reported pay of $24.32 for social workers who have earned their MSWs compared to all health care organizations at $26.31 per hour. This is a difference of 7.5% and over $4,000 annually. The greatest salary gap occurs for social workers with their BSWs. The median pay of Social Worker-BSW in behavioral health centers is $18.87 per hour compared to $21.57 in other health care organizations. This is a gap of 12.5% and over $5,600 annually.

While behavioral health organizations are following the market when administering their pay increases and other general practices, the competitiveness of their pay rates is significantly below the labor market for specific positions that play critical roles in those organizations. Although voluntary turnover rates are surprisingly in line, the differences in pay may heavily impact turnover for a few specific positions. Recruitment and retention may very well be affected for these jobs, but the higher turnover rate for a few jobs is masked by better retention in other roles. An organization would need to take a closer look to find the true story.

Theresa Worman is Executive Vice President of Comdata Surveys & Consulting, which is an endorsed vendor of AHA Services, Inc. and a national compensation survey data and consulting firm. Over the last 25 years, Comdata has amassed the largest and most comprehensive database of current compensation and benefits information.

For more information on Comdata’s services, contact Theresa Worman at 800.300.9570 or tworman@comdatasurveys.com, or AHA Services Vice President Tina Creel, 501.224.7878 or tcreel@arkhospitals.org.
“We have neglected the mental health challenges in our nation for far too long.”
- Asa Hutchinson
CRIMINAL JUSTICE IN CRISIS:
THE INTERSECTION OF LAW ENFORCEMENT AND MENTAL HEALTH CARE

by Elisa M. White, Vice President & General Counsel
Arkansas Hospital Association

On March 8, 2017, Governor Asa Hutchinson signed Act 423 of 2017, the Criminal Justice Efficiency and Safety Act. Sponsored by Senator Jeremy Hutchinson and Representatives Clarke Tucker and Matthew Shepherd, this bipartisan legislation was the product of two years of study and deliberation by the Legislative Criminal Justice Task Force and the Council of State Governments (CSG).

Among other initiatives, Act 423 establishes crisis intervention training requirements for law enforcement agencies and provides for Crisis Stabilization Units to help address the needs of individuals with mental illness and keep them out of county jails.

Funding of $5 million for three Crisis Stabilization Units was included in the Revenue Stabilization Act, which was approved by the House and Senate on April 3, 2017. The planned units, coupled with crisis intervention training for law enforcement officers, are intended to improve public safety and reduce prison overcrowding. Physical sites for the units will be provided by the counties in which they will be located.

Ongoing operations of the units are to be funded through a county-state partnership. The state plans to work with CSG on implementation. CSG will provide technical support as well as an additional $500,000 for implementation needs spanning all of the requirements in Act 423, including the stabilization units.

In a statement about the criminal justice proposals, Governor Hutchinson said, “We have neglected the mental health challenges in our nation for far too long.” The governor hopes that the creation of these centers will “provide much-needed assistance to those suffering from mental illnesses, and also provide relief to our law enforcement officers who so often have to deal with incidents involving those who need help rather than detention.”
Facing a projected 47% increase in its prison population by 2025, Arkansas leaders in 2015 requested support from the U.S. Department of Justice’s Bureau of Justice Assistance (BJA) to explore a “justice reinvestment” approach to curb this projected growth, contain spending and decrease recidivism. BJA approved the request and engaged the CSG Justice Center to provide technical assistance to collect and analyze data and to help develop policy initiatives.

The CSG describes justice reinvestment as a “data-driven approach to reduce corrections spending and reinvest savings in strategies that can decrease recidivism and increase public safety.”

According to the U.S. Department of Justice Bureau of Justice Statistics, at the end of 2015, the United States had an estimated 1,526,800 prisoners under the jurisdiction of state and federal correctional authorities. The United States incarcerates far more individuals than any other country in the world, and within the United States, the Arkansas incarceration rate is well above the national average. In 2014, Arkansas’s incarceration rate of 599 people per 100,000 residents was the fourth highest in the nation.

To address these issues, the Arkansas legislature established the bipartisan Legislative Criminal Justice Oversight Task Force in 2015 to study the state’s criminal justice system. The Task Force worked diligently with CSG and other stakeholders to develop recommended policy initiatives, including the Crisis Stabilization Units. When these units are operational, if law enforcement officers suspect someone whom they encounter is in need of mental health treatment, the staff at the centers can offer evaluations and treatment.

As of June 2015, an estimated 1,292 county jail inmates had serious mental illness and 5,168 suffered from substance use disorder. County jails typically have had no treatment-related resources available to deal with these issues other than those required by law. Often, if any of these inmates had a crisis, they were transported to the local emergency room, which typically is not the best setting for those suffering from mental health and substance abuse (MHSA) conditions.

The American Hospital Association reports that many emergency departments are not equipped with “quiet rooms” or with staff specifically trained to care for MHSA patients. A lack of community-based resources and a shortage of inpatient psychiatric beds means that MHSA patients may find themselves waiting for hours in the emergency department until a bed can be found.

In this situation, law enforcement and health care providers share a common goal—the health of the community. Providing appropriate resources to treat and
support those with mental health and substance abuse conditions allows effective use of law enforcement and health care resources and helps to ensure public safety.

The Legislative Criminal Justice Oversight Task Force has also recognized the need to address the high recidivism rate in Arkansas. As individuals who suffer from MHSA conditions transition out of the prison system, it is important to provide those individuals with enrollment assistance to obtain insurance coverage and with support and coordination so they can access the treatment they need.

The legislature began to address this issue in the 2015 session with the passage of Act 895, the Criminal Justice Reform Act of 2015. Although federal law requires Medicaid coverage to be suspended while a person is incarcerated, Act 895 establishes a process for reinstatement of that coverage promptly upon release. For inmates who previously were uninsured, the Arkansas Department of Human Services will accept an application for coverage up to 45 days prior the inmate’s release.

Act 423 builds upon the foundation established in 2015 to enhance the availability of insurance coverage. Individuals who are diverted from county jail to one of these units may be assisted in applying for Medicaid or other coverage for which they are eligible. This will help to ensure that they have access to further mental health treatment if needed.

The criminal justice issues faced by Arkansas will not be solved overnight, but the state has taken important steps forward with the passage of Act 423 and the initial funding for Crisis Stabilization Units. This provides a good foundation for the state’s ongoing justice reinvestment efforts.
A BALANCED APPROACH TO HEALTH CARE REFORM

by Elisa M. White, Editor-in-Chief

Our nation’s health care system is complex, and even well-conceived and well-intentioned proposals may have unintended consequences that undermine the goal of increasing access to high quality, affordable health care.

The Arkansas Hospital Association believes that balance is needed. Patients need reasonable and affordable (not just accessible) coverage. Insurers need a stable market that incentivizes them to continue to offer a range of plans to ensure consumer choice. And health care providers, including hospitals, require reasonable payments for the health care they provide. It isn’t acceptable to ask any one of these groups to go bankrupt or close their doors because another part of the balance is out-of-kilter.

We think Arkansas is well on its way to a well-functioning, balanced approach to health reform. Our leaders did not allow the perfect to be the enemy of the good and decided to work within the framework of the ACA – no matter its flaws – to improve care for Arkansans.

Frank discussions that led to legislation first dubbed The Private Option, later "Arkansas Works," brought patients, providers, hospitals, insurers, those in charge of Medicaid and those who govern into the same room to set a course addressing the need for increasing the number of insured in our state.

Together, we crafted a plan to take the good parts of the ACA and make them work for Arkansas while mitigating the negative aspects of the ACA, such as the drastic cuts to hospitals’ Medicare funding. Our method was later adopted by other states.
The March 23 Washington, D.C. House “vote that didn’t happen” stopped the rushed consideration of a “repeal and replace” option too quickly crafted and not fully vetted. That option, titled the American Health Care Act (AHCA), would have obliterated the years-long engineering and re-engineering of the ACA. An admittedly imperfect instrument, the ACA was still foundational and provided valuable first steps toward the improvement of health care in America, making it available and affordable for all. Had the ACA been eliminated, thousands of hours of work, compromise and thinking outside the proverbial box would have been destroyed.

Today, there’s hope that many in Congress from both sides of the aisle may be ready to talk things out and bring new ideas, and perhaps compromise, to the health care table.

Because the ACA is still the law of the land, 360,000+ Arkansans still have health insurance. Doctors are still seeing patients in their clinics, and uncompensated care continues to decline across inpatient, outpatient and ER services. Under the Arkansas plan, Arkansans are getting healthier and hospitals are, too, as the incredible burden of annual double digit percentage rises in uncompensated care continue to fall.

Helping Arkansans, individuals and families alike, achieve health care coverage has measurably increased the health of our citizens, one of the best investments any state can make in its workforce. Achieving health care coverage reduces worry and increases the seeking of wellness and preventive care. Without the ACA and Arkansas’s unique application to our population, this would not have happened.

Access to affordable coverage has changed Arkansas’s health horizons. With lowered numbers of uninsured and rising coverage for the working poor, decreases in uncompensated care have been remarkable.

But we realize that moving the needle from “poor” to “excellent” in the world of assuring affordable coverage doesn’t happen overnight. The ACA helped us move the needle from “poor” to “fair,” and in many instances, to “good.” But there’s much that needs to be tweaked, and we still have a long way to go to move us to an excellent system that is balanced and fair for all – for providers, for insurers, and most importantly, for patients and their families.

That’s why discussion of a bi-partisan approach to furthering coverage improvement is so exciting. Arkansas is already well down the road to a considered and balanced approach to health care coverage. Now, we hope the rest of the nation will join us.
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Prefab bathroom pods at Baptist Health Medical Center - Conway
Bill's first job after completing his education in 1974 was at the corporate headquarters of Hospital Corporation of America (HCA) in Nashville, Tennessee. After working in HCA’s corporate headquarters, Bill was CFO of HCA’s largest (342 bed) acute-care hospital at that time – Doctor’s Hospital in Little Rock, Arkansas. Bill has a BSBA in Accounting, an MBA, and a Juris Doctorate from the University of Arkansas all with honors. He is also a CPA (Inactive). After leaving HCA in 1981, Bill has practiced law in Little Rock, Arkansas representing hospitals and other healthcare providers.

Bill has extensive experience in complex issues inherent in healthcare laws which affect hospitals and other healthcare providers. He provides representation related to transactions such as the purchase or sale of healthcare facilities, the purchase of physician practices and the formation of physician hospital joint ventures. Bill also provides representation related to resolution of Medicare and Medicaid reimbursement disputes, development of hospital policies, compliance with the Stark and Anti-Kickback statutes, tax-exempt matters for non-profit hospitals, development of PHOs, Clinically Integrated Networks and ACOs, and compliance with other laws which regulate hospitals. Bill updates Hospital Compliance Plans to comply with the OIG Guidance. Bill has represented many non-profit hospitals in connection with the issuance of tax exempt bonds. Bill Marshall has represented hospitals for 40 years.

Education
- University of Arkansas, Little Rock’s Bowen School of Law, J.D. - with honors.
- Law Review – Published Law Review Article
- University of Arkansas, Fayetteville, B.S. B.A. accounting – with honors, and M.B.A. (First in Class); Certified Public Accountant (now inactive)
- Omicron Delta Kappa, Phi Eta Sigma, Sigma Chi Social Fraternity, Student Senator, and President of Order of Omega, a Greek Honorary Society.

Services
- Health Law
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- Corporate Law
- Tax Law
- Real Estate

Recent Key Matters
- The representation of a large non-profit hospital in a hospital joint venture transaction with a large for-profit healthcare company.
- The representation of a physician owned endoscopy center sale of its ASC to a hospital, the sale of the physician owned building to a developer, the leaseback of the building from the developer to the hospital and the physician employment agreements with the hospital.
- Sale by a hospital of its home health agency and its nursing homes.
- The sale of a nursing home chain.
- Development of Clinically Integrated Network and negotiation of shared savings agreement with large commercial insurance payor.
- Successful Medicare appeal for Oncology Group.
- Purchase of division from NYSE Company and later resale of the division to a NYSE Consulting Firm.

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