ARKANSAS HOSPITALS
Summer 2017

TELEMEDICINE
Between these lines you’ll discover experienced attorneys providing trusted business, regulatory and litigation services. Working as strategic legal advisors, Mitchell Williams plays a critical role in providing quality legal counsel to hospitals and other health care professionals need today to navigate the highly regulated health care business. Our broad experience helps us welcome your specific concerns, with customized solutions for organizations in every corner of Arkansas and beyond. Serving you is right where our team wants to be.

Nationally Recognized Practices.
Nationally Recognized Lawyers.
MitchellWilliamsLaw.com

MITCHELL WILLIAMS

Jonesboro | Little Rock | Rogers | Austin
Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C.
2018 Lexus LC 500

SLEEK
inside and out

PARKER LEXUS
#1 SHACKLEFORD WEST BLVD., LITTLE ROCK • SALES (888) 231-0514 • SERVICE (888) 231-2722
Your Back Office Solution!

Let us handle the billing details so you can handle what matters most, your patients.

Billing Specialists, Inc. (BSI) and Medical Administrative Services (MAS) offer a team of billing specialists and back-office staff to ensure prompt and precise processing of your claims. We work to meet your individual needs.

✔ Reduce Costs
✔ Boost Profitability
✔ Minimize Claim Rejection
✔ Faster Turnaround

✔ Reduce Administrative Stress
✔ Opportunity to Customize
✔ Freedom to Focus on Patient Care
✔ AAPC Certified Coders

Proudly serving the medical community for over 25 years.
CONTENTS

FEATURES

12 Cover Story: Embracing Telemedicine
Piggott Community Hospital serves as a national model for telehealth.

18 Telemedicine’s National Impact
The American Telemedicine Association sets the national tone and provides key support to states.

28 Virtual Care: Mercy System Closes Gap
This virtual care center uses telmedicine to meet patients where they are.

Departments
5 President’s Message
7 Editor’s Letter
8 AHA Calendar
10 Newsmakers and Newcomers
11 All About Hospitals
Quality and Patient Safety
22 UAMS Telemedicine Programs Provide Life-Saving Care and Education Statewide
32 The IOI Program at Age 10
34 Population Health and Telemedicine Intersect at Baptist Health

Coach’s Playbook
37 When Telemedicine and Commitment to Excellence Merge

Statistics

News
58 Leadership Profile: Scott Barrilleaux
60 Medical School at ASU is National Leader with Focus on Telemedicine
64 State of the Law: Arkansas Telehealth
71 AHA Services Presents: Health Reform and Rural Providers

Advocacy
76 The 2017 Legislative Session Report

On The Cover:
Innovator Health’s breakthrough invention, the Rounder, is featured in our cover story beginning on page 12. Photo courtesy of Innovator Health and Dr. Darren Sommer.

Elisa M. White, Editor-in-Chief
Nancy Robertson, Senior Editor and Contributing Writer
Jillian McGehee, Editor and Contributing Writer
Jamison Mosley, Art Director
Marrissa Miller, Graphic Designer

BOARD OF DIRECTORS
Darren Caldwell, Newport / Chairman
Peggy Abbott, Camden / Treasurer
Chris Barber, Jonesboro / At-Large
Molly Burns, Magnolia
Barry Davis, Paragould
John Heard, McGehee
Ed Lacy, Heber Springs
Jim Lambert, Little Rock
Vincent Leist, Harrison
James Magee, Piggott
Dan McKay, Fort Smith
Jason Miller, North Little Rock
Ray Montgomery, El Dorado
Margaret Underwood, Harrison
Doug Weeks, Little Rock
Debra Wright, Nashville

EXECUTIVE TEAM
Robert “Bo” Ryall / President and CEO
W. Paul Cunningham / Executive Vice President
Tina Cred / Vice President of AHA Services, Inc.
Elisa M. White / Vice President and General Counsel
Jodiane Trif / Vice President of Government Relations
Pam Brown / Vice President of Quality and Patient Safety
Lynsey Dumas / Vice President of Education
Susanne Bieman / Vice President of Data and Policy

DISTRIBUTION
Arkansas Hospitals is distributed quarterly to hospital executives, managers and trustees throughout the United States; to physicians, state legislators, the congressional delegation, and other friends of the hospitals of Arkansas.

Arkansas Hospitals is produced quarterly by Vowell, Inc., 910 W. 2nd St., Suite 200, Little Rock, AR 72201. Periodicals postage paid at Little Rock, AR and additional mailing offices.

The contents of Arkansas Hospitals are copyrighted, and material contained herein may not be copied or reproduced in any manner without the written permission of the publisher. Articles in Arkansas Hospitals should not be considered specific advice, as individual circumstances vary. Products and services advertised in the magazine are not necessarily endorsed by the Arkansas Hospital Association.

To advertise call 501-244-9700.
GIVE YOUR PATIENTS SOME
straight talk
ABOUT DIABETES

Have you screened your age 45+ and high-risk patients for diabetes?

Arkansas has one of the highest rates of diabetes in the nation. We spend $1.67 billion a year in direct medical costs for diabetes and another $1 billion in indirect costs.

We can prevent most type 2 diabetes through:
- Early diagnosis
- Healthy eating
- Weight control
- Exercise

You can make a difference with diabetes screening.

Visit afmc.org/tools and search for “diabetes” to find resources to help your patients control their diabetes.
In this issue of *Arkansas Hospitals*, we have a two-fold look at just what data can do – whether statistical data for analysis purposes or data shared through telemedicine for the good of our patients.

We’ve always known, or at least suspected, that there’s a lot of good to be realized from an expansion of telemedicine in our state. It’s certainly good for our patients, connecting isolated or rural patients with specialists from across the region. We know it’s good for efficiency of care, and we understand that many medical staff members really like the convenience of connecting with faraway patients through the use of telecommunications.

We also have seen a recent advancement in the acceptance of telemedicine by payers, by patients, and by physicians themselves.

But until recently, the question, “Who will pay for telemedicine, and at what rates?” was top of mind. With the recognition of telemedicine practice as a valid medical service by government programs such as Medicare and Medicaid, it seems that telemedicine is potentially positioned to show growth over the next few years.

Because of the Arkansas General Assembly’s recent passage of a new law regarding telemedicine practice in our state, we expect to see slow and steady growth at a pace that is both responsible and cautious. We’re glad our legislators are unfolding telemedicine regulations over a 5-year period, designed to protect patients as providers move forward in a measured fashion.

At the heart of telemedicine is the transfer of data, and the need for increasing amounts of data and its analysis for use in policy-making, measuring the success of new programming, and projecting what hospitals will be facing in the coming years.

To help with our member hospitals’ need for cutting edge data and its analysis, we’re pleased to announce that Suzanne Bierman has joined the AHA staff as our Vice President of Data and Policy. Suzanne comes to us from Arkansas Medicaid, where she served as its Assistant Director.

Suzanne has a strong background in public health and data analysis. She has been a member of teams crafting major policy changes at both the state and federal levels, and was a member of the policy-writing team that came up with Arkansas’s original Private Option waiver and its transition to Arkansas Works. Suzanne holds a master’s degree in Public Health from UAMS, as well as a law degree.

We’d like to remind you that our summer edition always includes your Statistical Section, easy to pull out and keep for reference through the year. Our thanks to Executive Vice President Paul Cunningham for compiling this useful data, and to Suzanne for contributing to this year’s statistical segment.

We hope you will find useful the many opportunities to explore the use of data and the face of telemedicine in Arkansas presented in this issue. We are uniquely “on the map” in this area, and look forward to sharing our state highlights with you here.
Quality, affordable health insurance plans are available now for qualifying Arkansans through My Arkansas Insurance.

Arkansans who experience a life event that affects family size, location, income, or other big changes may qualify to get marketplace health coverage outside of the open enrollment period.

What Qualifies for Special Enrollment Periods?

Loss of health insurance:
- Losing COBRA coverage
- Losing eligibility for Arkansas Works, Medicaid or CHIP
- Losing coverage through a family member
- Losing coverage through a job

Changes in household size:
- Getting married
- Having a baby, adopting a child, or placing a child for adoption or in foster care
- Getting divorced or legally separated

Changes in residence:
- Moving outside of your insurer’s coverage area
- Gaining citizenship
- Leaving incarceration

Other Reasons:
- Gaining status as a member of a federally recognized tribe
- Turning 26 and aging off of parents’ plan

Enrollment Information:
Online — Visit myARinsurance.com
By Phone — Call 844-355-3262,
Monday – Friday, 7:00 a.m. – 7:00 p.m.

Quality Health Insurance for Arkansans myARinsurance.com
Walt Disney understood our obsession with the new discoveries and possibilities of the future. After all, he built an entire section of his Disney theme parks in California and Florida to mirror his vision of what tomorrow would hold.

As a kid growing up in central Florida in the late 1970s and early 1980s, I was lucky enough to visit the Magic Kingdom regularly when out-of-town family and friends came to see us. Each visit, after touring Main Street, singing our way through “It’s a Small World,” and sailing with the Pirates of the Caribbean, we’d head to my favorite Disney “world” – Tomorrowland.

Space Mountain’s roller coaster was, of course, an essential stop, but I loved the attractions showing the high-tech world of the future. At that time, Tomorrowland was a 1970s-era vision of the future, with rocket ships and journeys into space featuring prominently, along with vignettes of scientific discoveries and high-tech inventions.

Although the Tomorrowland of my childhood has since been replaced with one based upon a science-fiction oriented theme, the sleek, white, space-age vision of Walt Disney lives on in my memory. It was there I first saw interactive audio-video on display. Little did I know I was seeing the future of medicine.

In this edition of Arkansas Hospitals, we explore innovations in telehealth and look toward the future of high-tech medical care. Today, physicians, nurses and other health care professionals are able to interact with patients in ways that were not possible just a few years ago.

As Walt Disney once said, “It’s kind of fun to do the impossible,” and we are doing just that in health care. Automation, robotics, electronic records, wearable health monitors, interactive iPhone apps...these are all realities in our modern medical system.

Welcome to Tomorrowland, where nothing is impossible.
**July 13**
Arkansas Hospital Auxiliary Association (AHAA) Board Meeting
AHA Board Room, Little Rock

**July 14**
Arkansas Organization of Nurse Executives (ArONE) 2017 Summer Conference
J.A. Gilbreath Conference Center, Baptist Health Medical Center-Little Rock

**July 21**
AHA Workers’ Compensation Self-Insured Trust Quarterly Board Meeting
AHA Board Room, Little Rock

**August 3-4**
Arkansas careLearning User Group Forum
AHA Headquarters, Little Rock

**August 11**
AHA Board Meeting
AHA Board Room, Little Rock

**August 16-18**
Arkansas Healthcare Financial Management Association (HFMA) Summer Meeting
The Hotel Hot Springs

**August 16-18**
Mid-South Critical Access Hospital Conference
Renaissance Hotel, Nashville, TN

**September 8**
AHA Board Meeting
AHA Board Room, Little Rock

**September 14**
AHAA Board Meeting
AHA Board Room, Little Rock

**September 21**
Reducing Hospital Readmissions Conference
Crowne Plaza, Little Rock

**October 4-6**
AHAA 59th Annual Meeting and Trade Show
Embassy Suites, Little Rock

**October 4**
AHA Board Meeting (held in conjunction with AHA Annual Meeting)
Little Rock Marriott

**October 4-6**
AHA 87th Annual Meeting and Trade Show
Little Rock Marriott and Statehouse Convention Center

AHA Education Program information is available at www.arkhospitals.org/events.

**Don’t miss the 15th Annual Mid-South Critical Access Hospital Conference, August 16-18!** Hospital executives and management teams, community leaders and government agency representatives from across a six-state area will convene in Nashville, Tennessee to focus on health care for rural populations. Registration materials are available on the AHA Events Calendar on the AHA website, www.arkhospitals.org.

Contact Tina Creel at tcreel@arkhospitals.org or 501-224-7878 for additional information.
THE NEW PLAYBOOK FOR HEALTHCARE

JOIN US!

AHA ANNUAL MEETING & TRADE SHOW

OCTOBER 4 - 6
LITTLE ROCK MARRIOTT & STATEHOUSE CONVENTION CENTER
NEWSMAKERS and NEWCOMERS

J. LARRY SHACKELFORD, Senior Vice President, Strategy and Outreach Services, Washington Regional Medical System in Fayetteville, will assume the role of CEO effective September 1. William L. Bradley, who announced his retirement plans last year, will assume the title of CEO Emeritus until his retirement in mid-November and will assist in ensuring a smooth transition. Prior to 2010, when Shackelford began his tenure at Washington Regional, he had served as CEO of Medical Associates of Northwest Arkansas, a multi-specialty physician group practice, since its inception in 1998. He is a CPA and a fellow in the American College of Medical Practice Executives.

WHITE RIVER HEALTH SYSTEM (WRHS) is proud to announce the selection of its first ten medical residents for the Internal Medicine Residency Program. In January of this year, the program was accredited by the Accreditation Council for Graduate Medical Education. White River Medical Center in Batesville will be the primary inpatient training facility for the program. WRHS initially anticipated more than 250 applications to be submitted. By the application deadline of February 22, WRHS had received 766 applications. The program accepts ten medical residents each year for a total of 30 residents during the three-year program.

SUZANNE BIERMAN joined the Arkansas Hospital Association staff in May as Vice President of Data and Health Policy. She will be closely following changes in health care policy, particularly within the Medicaid program, and will be coordinating and leading the association’s data and analytics activities. Prior to joining the AHA team, Bierman served as Assistant Director, Division of Medical Services at the Arkansas Department of Human Services, where she directed several units within the Division, including Coordination of Coverage and Continuity of Care, Behavioral Health and Medical Assistance. Bierman has a JD from the University of Arkansas at Little Rock and an MPH from the University of Arkansas for Medical Sciences.

DAVID FOX, FACHE, FAHRA, MBA, has been named COO at Baxter Regional Medical Center in Mountain Home, following the recent retirement of Rudy Darling. Fox, a certified Nuclear Medicine Technologist, has served in management and executive leadership positions with hospitals in Amarillo and Tulsa, and with Baptist Health and CHI St. Vincent in Little Rock. He is a fellow of the American College of Healthcare Executives and the American Healthcare Radiology Administrators Association.
The Arkansas Department of Health formally recognized 12 hospitals for excellence in stroke care performance at the Arkansas Chronic Disease Forum and Cardiovascular Disease Summit this spring. Hospitals receiving performance awards for defect-free patient care include:

- Baptist Health Medical Center-Little Rock
- CHI St. Vincent Hot Springs
- CHI St. Vincent Infirmary
- CHRISTUS St. Michael Health System
- Medical Center of South Arkansas
- Mercy Hospital Fort Smith
- Mercy Hospital Northwest Arkansas
- Mercy Hospital Waldron
- Sparks Regional Medical Center
- University of Arkansas for Medical Sciences
- Wadley Regional Medical Center
- Washington Regional Medical Center

Saline Memorial Hospital has been named one of the nation’s Top Hospitals for Clinical Quality by Becker’s Hospital Review. The recent listing included 53 hospitals with the lowest proportion of serious complications per hospital discharge. Saline Memorial Hospital is the only hospital in Arkansas named to this list.

The University of Arkansas for Medical Sciences has become the only medical center in Arkansas to be certified nationally as an adult Level 1 Trauma Center by the American College of Surgeons. To achieve the certification, hospitals go through a rigorous review process and must demonstrate they can provide the highest level of trauma care for the most serious and urgent cases. The Level 1 verification extends through December 16, 2019.

Washington Regional Medical System celebrated the official naming of the William L. Bradley Medical Plaza on May 11 in a ceremony on the Washington Regional campus. Bradley, who joined Washington Regional as Chief Executive Officer in 2004, announced last year his plans to retire this November. The Washington Regional Medical System board of directors voted unanimously to name the new building in honor of Bradley’s positive, lasting impact on the health of Northwest Arkansas.
That a rural Northeast Arkansas Critical Access Hospital is a national leader in the practice of telemedicine may, on its face, seem surprising.

That the hospital is Piggott Community Hospital, long known for its strategy of connecting with a wide variety of partners to increase health care access for its patients, removes the element of surprise. In fact, “of course!” is a predicted response.

Piggott Community Hospital (PCH) is guided by its longtime Executive Director James Magee, a leader who believes in seeking patient care access through any and all avenues.

“As a community-owned hospital, we are not limited to any one system in the partnerships we can generate,” Magee says. “So to benefit our patients, we participate in as many programs as possible – whether conventional or unconventional and across a broad spectrum – to best meet the needs of the patients we serve.”

Initial logic for the development of the Telemedicine Program was that many of the area’s elderly and financially challenged did not have the capability and/or resources to travel to distant locations for physician specialty care. “Telemedicine was the obvious mechanism to dramatically increase access to specialty care,” Magee says.

There are many avenues of telemedicine being employed at PCH. For example, the hospital is a beta site for a Tele-Emergency program with UAMS, whereby an emergency department physician at PCH can connect with a Board-Certified Emergency Medicine physician for a consult on a complex care issue.

But it is one program, especially, that moves the hospital into the national limelight.

That is the collaboration with Innovator Health and the use of its remarkable telemedicine delivery system, “the Rounder,” which allows patients to build incredibly close relationships with their physicians – even those remotely located.

ANATOMY OF THE ROUNDER

The Rounder is a more than six-foot tall apparatus that looks like a 55-inch television, upended to vertical, and made portable by putting it on wheels. It’s the brainchild of Dr. Darren Sommer, DO, MBA, MPH, a true believer in the necessity of building doctor/patient relationships even absent the face-to-face experience.

“Our goal is to deliver telemedicine experiences that are so rich and natural that neither the patient nor their caregiver ever sees the distance that separates them,” he says.

The Rounder functions as a life-sized connector between physicians and their patients. Besides the screen that brings patient and physician together, the Rounder has a nurse-operated workstation, which includes HIPAA-compliant...
HOW THE ROUNDER CAME TO BE

As both a practitioner of telemedicine and a technology executive, Dr. Darren Sommer understands the importance of creating telemedicine systems that exceed expectations. With a focus on reliability and simplicity, Dr. Sommer’s vision is to deploy Innovator Health technologies so that all Americans have access to the highest levels of care.

Dr. Sommer received his Doctor of Osteopathic degree and holds a master’s in Public Health from Nova Southeastern University’s College of Osteopathic Medicine. He also has more than 20 years of military service and two combat deployments in support of the Global War on Terrorism.

When he was working with sick and badly injured patients during his time in Afghanistan, he would often call for consults with other military physicians located in Germany or other medical bases. These consults would result in specialists’ interventions on behalf of injured soldiers hundreds of miles from their location.

It was through recalling this extreme value to both patient and physician that led him to begin working on his telemedicine breakthrough, the Rounder. Available to serve patients wherever they are, especially in rural or remote locations, the Rounder connects patients with the medical services they need, but that may not be readily available to them locally.

Designed by Dr. Sommer, the Rounder employs technology that seems impossible – it provides real eye contact between patient and physician through a 3D experience, which makes the building of the all-important relationship between patient and caregiver a thoroughly engaging process.

It changes the world of the more common small, impersonal, cart-based telemedicine communications – once the epitome of high-tech telemedicine – to a truly life-sized and personal, immediate doctor-patient experience.

A “ROUNDER” COLLABORATIVE IS BORN

Magee was an early adopter and beta-tester of the Rounder on behalf of PCH’s patients. He was also, cooperating with Dr. Shane Speights and St. Bernards Health System, instrumental in bringing the technology to the new osteopathic school of medicine located on the campus of Arkansas State University in Jonesboro.

“To benefit our patients, we participate in as many programs as possible – whether conventional or unconventional and across a broad spectrum – to best meet the needs of the patients we serve.”

“Dr. Speights, who is now the dean of the New York Institute of Technology College of Osteopathic Medicine (NYITCOM) at Arkansas State, has a long practicing history at St. Bernards,” Sommer says. “St. Bernards helped purchase the Rounder in use at PCH, and is using its physicians to staff it.” The cooperation between the three entities (PCH, St. Bernards and NYITCOM at Arkansas State) is integral to northeast Arkansas’s becoming a national leader in this leap forward in telemedicine utilization.

“It would be hard to find a rural hospital more innovative and aggressive in the adoption of telemedicine than PCH,” says Dr. Sommer. “We are grateful to Mr. Magee for working with St. Bernards and Dr. Speights as we explore a connection for helping today’s medical students become comfortable with the practice of telemedicine.” (Please see the article about Telemedicine Education at NYITCOM-ASU later in this issue of Arkansas Hospitals.)

Dr. Sommer works with NYITCOM-ASU students, beginning in their very first year of medical school, in building the all-important physician/patient relationship through and by use of telemedicine technologies. His title? Professor of Telemedicine.
ESSENTIAL CONNECTIONS FOR RURAL PATIENTS

“Telemedicine is an extension of face-to-face medical practice,” Magee says. “At PCH and in our rural health clinics in Rector and Campbell, we also advocate for our patients to see their telemedicine physicians in person when the doctors make their regularly scheduled trips to our various locations.”

What are some of the other many telemedicine opportunities for patients in the Northeast Arkansas/Southeast Missouri region served by PCH?

- Cardiology/Heart Clinic visits through St. Bernards telemedicine;
- Dermatology visits through a physician located in Searcy/Jonesboro;
- Sleep Study services through pulmonologists at St. Bernards;
- Gastroenterology consults through a physician located in Cape Girardeau, Missouri;
- AR SAVES stroke consults through UAMS;
- Tele-ICU (e-ICU) consults through Baptist Health;
- Mental health consults through the Mid-South Health System;
- And coming soon: ear, nose and throat services through St. Bernards.

“One of our goals is to make telemedicine services available in our rural health clinics,” Magee says. “We are also in discussion with our large home health, assisted living and skilled nursing care locations on ways to employ telehealth – and the Rounder – for the care of these patients.”

Ben Bloom, principle with Affinity Healthcare, Inc., a healthcare management firm that has worked with PCH for more than 15 years, is helping Magee continue expanding the hospital’s telemedicine reach.
“There are a lot of health care venues that talk about a commitment to telemedicine,” he says, “but Piggott Community Hospital demonstrates its commitment. Both from the top down (leadership commitment) and the bottom up (professional staff buy-in at all levels), PCH is dedicated to providing telemedicine excellence for its patients.”

A perhaps unanticipated challenge faced by PCH in its desire to increase its telemedicine outreach is not in the areas of technology or patient satisfaction; the challenge is often in getting physicians comfortable with the practice.

“If we can get our specialty physicians (located in other locations who travel to Piggott for outpatient services) to try telemedicine, they most often report liking and appreciating it,” Magee says. “We will never eliminate the needed face-to-face physician visits, but we find we can reduce the number of in-person encounters greatly when our specialists embrace telemedicine.”

Physicians typically agree to use telemedicine when they see the positive impact it has on their patients.

“It’s easy to see how telemedicine can be a boon to rural health care, bringing specialists into reach for patients in remotely located and underserved areas. And PCH’s examples of how to utilize and encourage participation in telemedicine are already bearing fruit in neighboring states. Besides the use of
PCH telemedicine programs by patients located over the state line in Missouri, two hospitals in Mississippi are replicating PCH’s extensive and wide-ranging telemedicine practices after visiting the hospital for a close-up view of how the programs are woven together.

PCH is also in discussion with long-term care facilities in the Northeast Arkansas region to see how the Rounder could be employed to better serve individual patients in these organizations.

“We can see how patients can benefit from having the Rounder brought to their rooms and having a telemedical physician visit and a diagnosis be made on the spot, without having to bring these fragile patients out into the weather or having them endure waits in the ER or clinic,” Magee says.

“The most important thing telemedicine, in all its forms, brings to our patients is increased access to health care and local access to specialists they would otherwise only see by traveling long distances,” Magee adds. “We’re proud that PCH is seen as being far ahead of the curve in its multi-disciplinary approach to telemedicine, and for setting the bar for what’s possible for rural and Critical Access Hospitals across the nation.”

With the Rounder, it’s as if your doctor is right there in the room.
TELEMEDICINE’S NATIONAL IMPACT

by Jillian McGehee, Editor

Two things are certain in health care – technology will evolve, and policy will change. With evolution and change come new ways to look at how care is delivered, and new avenues for patient care and access.

Telemedicine combines technology with policy and is currently surging across the country, as well as in Arkansas. Recent changes in telehealth laws enacted by the Arkansas General Assembly likely will facilitate even greater use of telemedicine.

Though it has enjoyed a long history, American telemedicine started coming more of age in the early 1990s as communications technology took off. In rapid succession, the World Wide Web opened up and became more user-friendly, the first webcam was built, the Pentium processor was introduced and the first smart phone was released. With the boom in telecommunications and computer technology came new applications related to health care, and in 1993 the American Telemedicine Association (“ATA”) was born.
The ATA’s stated goal is to promote access to medical care for consumers and health professionals via telecommunication technology, while working to transform health care by improving its quality, equity and affordability.

It’s no longer rare to see the elements of telemedicine integrated into the everyday operations of hospitals, specialty departments, home health agencies, private physicians’ offices and even consumers’ homes and workplaces, say association experts.

“But basically, telemedicine allows patients to remotely receive care from healthcare providers,” says Latoya Thomas, director of the ATA’s State Policy Resource Center. “Providers are able to provide care from one location to another through telecommunications.”

**NATURAL EVOLUTION**

In Arkansas, as throughout the nation, people are used to having information at their fingertips. The readily available use of video and processing of data through means like FaceTime, Skype, Fitbit, Netflix, and various banking applications has changed the way people live and think, Thomas points out. The expectation for faster answers and easier access to what we want – whether movies on our phones or physician access on our computers – is prompting ever more creative uses of telecommunications technology that can be adapted to health care applications.

Overall, Thomas says, telehealth has improved health care and sets the stage for different schools of thought about where health care is headed.

“Today, folks are thinking differently about health care in general,” she says. “Hospitals are saying, ‘People trust us to come to provide quality care in every situation. Can we find ways to do that, even if don’t have, for example, a neurologist on staff or a psychiatric unit on the premises?’”

Telehealth is leveraging health care providers’ ability to connect patients with the care they need. “We’re also exploring this movement from the patient’s side,” Thomas adds.

“Patients want health care the way they want it. They want immediate answers and more than one opinion, and they also want to be able to measure the fiscal impact of any diagnosis on their lifestyle. They don’t want to fear being fired from their jobs if they have to take off from work to keep doctor’s appointments. More than anything, they want choice.”

**MAJOR BENEFITS**

Practicing medicine via telehealth reduces not just service-related costs, but also patients’ expenses, Thomas says. “It reduces patients’ travel time and related expenses when they must go a great distance to obtain care. It gives them more flexibility and choice.”

The American Hospital Association agrees. A 2016 issue brief by the association notes that “growing use of telehealth reflects larger health care trends that place the patient’s care and experience at the center of treatment decisions.”

Telemedicine services remove potential barriers to care by facilitating access to physicians, particularly specialists who may not be readily accessible in the patient’s local community. The American Hospital Association views the increased use of telehealth as an essential tool to help ensure patients receive the right care, at the right place, at the right time.

The ATA has found that health care providers also like the flexibility inherent in telemedicine delivery methods. “They appreciate the opportunity to provide sophisticated solutions for their patients,” Thomas says. Providers see telemedicine as an opportunity to improve patient outcomes and patient satisfaction.

In 2015, American Well®, a provider of telemedicine services, conducted a national survey in collaboration with QuanitaMD. Fifty-seven percent of the more than 2,000 primary care physicians who responded to the survey stated they would consider video visits with their patients. In addition to improved patient outcomes, the responding physicians cited work-life balance as a motivating factor for increased use of telehealth.
provide coverage for telemedicine services, but the criteria for coverage differ among the state programs. Medicare has historically provided only limited telemedicine coverage, but recent proposals indicate that the federal government may be open to expanded coverage. Private insurance companies have been the most willing to cover these services after seeing the potential for efficient care and cost savings from pilot programs.

**COMMON CHALLENGES**

A challenge to telemedicine policy relates to the lack of a national telemedicine standard of practice. Each state has its own laws governing the practice of telemedicine within its boundaries, and telemedicine policies don’t necessarily translate from state to state without restriction, Thomas says, noting this issue is not unique to telehealth and is common in other fields as well.

Another barrier to adopting telehealth services is a lack of uniformity in coverage and payment for this care. For example, a number of states have parity laws – laws that require private insurers to cover services provided by telemedicine to the same extent the service is covered when provided in-person – and this is an important development.

But parity laws do not address insurance coverage for technologies that have no in-person equivalent (such as using telemedicine for remote monitoring of patients with chronic conditions). To increase the use of telehealth, public and private payers must be willing to cover new services that are provided only through telemedicine.

Medicare and Medicaid coverage and payment policies also may present a challenge. Most state Medicaid programs provide coverage for telemedicine services, but the criteria for coverage differ among the state programs. Medicare has historically provided only limited telemedicine coverage, but recent proposals indicate that the federal government may be open to expanded coverage. Private insurance companies have been the most willing to cover these services after seeing the potential for efficient care and cost savings from pilot programs.

**TOWARD THE FUTURE**

The use of telemedicine is expanding in Arkansas and throughout the nation under the oversight of state regulatory boards and innovative health care providers and facilities. With its tremendous potential to expand patient access to care, while improving outcomes and promoting efficiency, expanded use of telemedicine is likely to have an important role in improving the U.S. health care system.

For more information about the American Telemedicine Association visit http://www.americantelemed.org.
TRUSTED
by Arkansans
for more than 65 YEARS

LIVE FEARLESS
Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association
Jackie Gosselin first became aware of ANGELS telemedicine in 2014, when the program serving mothers with high-risk pregnancies was introduced to her. It must have seemed like something out of a Gene Roddenberry screenplay – Star Trek™ medicine brought to life.

Telemedicine collapses space by shrinking the distance between a medical specialist and her/his patient. It often saves critical time, eliminating the need for patient travel and allowing rural or isolated hospitals to provide their patients access to the expertise of otherwise unreachable specialists.

“My third pregnancy brought my first experience with telemedicine,” Gosselin says. “I was at the UAMS Northwest campus in Fayetteville, and the doctor interpreting my ultrasound was at UAMS in Little Rock. Using a camera, she was able to read and discuss my ultrasound results with us right away.”

It was important for the Gosselins to know immediately what the doctor saw. Jackie, a resident of northwest Arkansas, discovered the baby had a kidney ailment that required careful monitoring.

Through the ANGELS telemedicine program, she and her unborn child gained access to UAMS specialists nearly 200 miles away, and she and her husband could learn the doctors’ findings without the anxiety of waiting on results.

The ANGELS (Antenatal and Neonatal Guidelines, Education and Learning System) program is an innovative consultative service connecting patients to a wide range of physicians including family practitioners, obstetricians, neonatologists and pediatricians in Arkansas.

Sometimes called distance health, telemedicine – including the ANGELS program – includes an expanding array...
of telecommunications applications and services featuring two-way video, smart phones, email, wireless tools and other forms of telecommunication. Through its use, patient and doctor converse “face-to-face” across vast distances, with accompanying medical data made available to the physician immediately.

What seemed a generation ago to be futuristic and other-worldly, today’s telemedicine routinely involves the remote diagnosis and treatment of patients through live high-speed, high-resolution video connections. It can mean access to specialized care in rural Arkansas communities, sometimes available to these patients “locally” for the first time.

Gosselin’s fourth pregnancy in 2016 also resulted in the need for ANGELS consultations with UAMS specialists on the main campus in Little Rock.

“I needed several ultrasounds, which would have required several trips to Little Rock,” Gosselin says. “Through the ANGELS telemedicine connections, I was able to have my level 2 ultrasounds done at the northwest campus, but interpreted in Little Rock. I could stay in Northwest Arkansas and take care of my children, and my husband didn’t need to take off work to travel with me. He could even come over on his lunch break to attend my telemedicine appointments. Thanks to the ANGELS telemedicine program, we were able to get immediate results and talk to the doctor about our concerns.”

SPREAD THIN

Despite decades of growth in Arkansas’s urban areas, the state remains largely rural with hundreds of small towns and a widely-dispersed population.

Many communities and counties simply don’t have the population density necessary to support a variety of medical specialists.

In the early 2000s, Curtis Lowery, MD, chair of the UAMS College of Medicine’s Department of Obstetrics and Gynecology, began the quest to connect medical expertise in the state’s urban areas to patients in rural Arkansas. Specifically, he wanted mothers-to-be with high-risk pregnancies living in rural communities throughout Arkansas to have access to the obstetrical expertise they and their unborn babies required for the delivery of healthy infants. His mantra became, “Where you live shouldn’t determine whether you live or die.”

In the early 1990s, UAMS had begun a small distance education program using live video classes for nursing education and another early telemedicine outreach programs aimed at a handful of rural hospitals. The emphasis was on education.

Lowery looked at this education program and realized the potential it held for patient care.

The UAMS distance learning program expanded into the distance health program. Over time, the use of new mobile devices like tablets and smart phones would enable on-call physicians the freedom to travel, so long as they could connect to the Internet. One specialist could take call for the entire state, allowing others to get their much-needed rest. And then, the possibilities expanded beyond imagination.

“It’s a game-changing technology for health care,” Lowery says.

BIRTH OF ANGELS

Lowery, along with Tina Benton, BSN, RN, and a small team of clinicians and staff, in 2003 founded ANGELS and the UAMS Center for Distance Health to bring maternal-fetal medicine to pregnant women across the state needing medical help with their pregnancies, but living too far from required specialists.

Over the years, the program has expanded exponentially. Today, experienced registered nurses staff the Center for Distance Health’s Call Center every day, around-the-clock. They provide counseling, telephone triage of immediate health concerns and education concerning health problems during pregnancy. In 2016, the Call Center managed 175,728 calls, including 417 obstetrical consultations and 12,957 nurse triage calls.

Through telemedicine and distance health tools, UAMS, for more than a decade, has delivered subspecialty care services to high-risk Arkansas mothers and their fragile infants.

Jackie Gosselin, her husband and their four healthy children, are thankful for it.
Since the ANGELS program was first introduced in 2003, the Center for Distance Health has expanded telemedicine into an increasing diversity of clinical areas to extend medical expertise and learning to medically underserved areas of the state. Here are some of those programs:

**CDH Language Interpreter Video Exchange (CDH LIVE)** uses standalone devices like tablets or video teleconferencing systems as a low-cost option to meet the medical interpreting needs of patients.

**Psych TLC** allows primary care providers across Arkansas to connect with board-certified child and adolescent psychiatrists at UAMS and Arkansas Children’s Hospital.

**The Trauma Hand Program (via high-speed, high-resolution live video)** enables hand surgeons to visually evaluate hand trauma patients for direct care, streamlining transfers to the most appropriate facility. It has facilitated more than 1,500 hand consultations since its founding in January 2014.

**The Hand and Burn Program** is a new offshoot of the Trauma Hand Program. From May to December 2016, it facilitated nearly 350 consultations between burn surgeons and burn patients across the state.

These programs offer patients in rural Arkansas the access to specialty care they need. In addition, many of these programs help patients receive their medical care in place, avoiding the strain and cost of travel or medical transfer.

**EDUCATION THROUGH TELEHEALTH**

The earliest use of telemedicine at UAMS focused on providing continuing medical education. Though distance medicine has taken a major role in medical care, the original provision of continuing medical education has continued to grow as well.

**Learn On Demand** has been making available continuing education credit to health care professionals through online modules they can complete without traveling for conventional classwork since January 2014.

**UAMSPatientsLearn.org** educates patients regarding health and wellness by offering online modules with the most up-to-date information.

**The Neonatal Resuscitation Program** is an online self-study course providing instruction on the resuscitation of the newborn for physicians, nurses, respiratory therapists and other health care professionals.
STABLE is an instructional program for nurses working in neonatal critical care. Stable is a mnemonic that stands for the six assessment and care modules in the program: Sugar, Temperature, Airway, Blood pressure, Lab work and Emotional support. A seventh module, Quality Improvement, stresses the professional responsibility of improving and evaluating are provided to sick infants. STABLE’s goal is to reduce infant mortality in Arkansas medical facilities.

Telemedicine is a tool for sharpening the skills of the state’s health care professionals. UAMS telemedicine programs offer care through almost every stage of life, from pre-birth (ANGELS) to adolescence (Psych TLC) to adults of all ages affected by stroke and other maladies.

UAMS telemedicine is positively affecting health outcomes and enhancing care for patients across Arkansas. It’s a medical force propelling health care toward stronger connections with Arkansans. Gene Roddenberry would be proud.
The American Hospital Association’s Health Research & Educational Trust (HRET) has released an infographic snapshot of 2016 achievements from its work with national, state and regional partners to advance health in America. These partners include our own Arkansas Hospital Association quality and patient safety team, in collaboration with participating member hospitals. The HRET initiatives highlighted include those focusing on high-reliability organizations, emerging models of care, population health and approaches for team-based care. For more on the 2016 achievements, as well as other HRET initiatives, visit hret.org/drivingimpact2016 and www.hret.org.

QUALITY AND PATIENT SAFETY

FOCUS ON QUALITY

SAFETY CULTURE

You take care of your patients & we’ll take care of your practice.

- HIPAA Compliance & Training
- Licensure Matters
- Employment Issues
- Medical Malpractice Defense
- Regulatory Law & Governmental Affairs
- Medical Device & Pharmaceutical Products Defense
- Insurance Defense

An Arkansas resource for Arkansas’ health care providers and insurers.

WRIGHT LINDSEY JENNINGS

THE RESULTS ARE IN!

The American College of Healthcare Executives (ACHE) and the National Patient Safety Foundation’s Lucian Leape Institute (LLI) have released a new resource to guide healthcare leaders in creating a culture of safety in their organizations.

The resource – Leading a Culture of Safety: A Blueprint for Success – is the culmination of work conducted over the past year by ACHE and the LLI, in partnership with a number of healthcare organizations and renowned experts in leadership, safety and culture.

The result is a practical, tactical resource for healthcare leaders to use in their organizations’ culture transformation. Download the guide at www.npsf.org/page/cultureofsafety.
Trey Auten was taking a break during a bike ride last fall when he began to feel strange. His right arm and leg were weak, and his vision faltered. Still, when the friend he was riding with said it was time to go, he struggled to put on his helmet and continued.

A few minutes later, as they neared an intersection, Trey’s bike wobbled, and he fell over.

“I remember falling over, but I didn’t even know I was going that slowly,” he said.

Auten was also unaware that he was suffering a stroke. And from that moment, the clock was ticking because parts of the brain begin to die when stroke cuts off its blood flow.

His wife, Lisa, rushed to the scene to transport him to Mercy Hospital Northwest Arkansas in Rogers. Immediately, Auten was taken for a CT scan. Though they didn’t know it, a “virtual neurologist” would quickly be reviewing Trey’s information remotely using technology Mercy calls TeleStroke.

At age 50, Trey wasn’t a typical stroke patient, but many symptoms, including his increasing confusion in the emergency department, pointed to stroke.

Trey and Lisa Auten discovered first-hand the benefits of the telehealth care provided by Mercy Virtual and its TeleStroke program.

by Jennifer Cook, Senior Media Relations Specialist, Mercy
After looking at Trey’s scan, vital signs and information from emergency department personnel, the neurologist examined Trey via a TeleStroke cart, which allows physicians to “see” a patient virtually through a secure video connection and a camera so sharp and sensitive, it can detect changes in pupil dilation.

Within minutes, the neurologist diagnosed a stroke and determined that Auten was a good candidate for the so-called “clot-busting” drug tPA. After it was administered, medical personnel noted immediate improvement in Trey’s limb movement and speech.

The sooner tPA is given, the better chance a patient won’t suffer long-term effects from a stroke, says Mary Tabor, Mercy’s stroke program coordinator in Rogers. That’s why a quick diagnosis through TeleStroke is so important.

WORLD’S FIRST VIRTUAL CARE CENTER

TeleStroke treatment and Mercy’s other modes of telemedicine are all coordinated through the world’s first Virtual Care Center in Chesterfield, Missouri. Opened in October 2015, the 125,000-square-foot building is the cornerstone of Mercy’s nationally-recognized program for delivering telemedicine.

Telemedicine is not just about technology, however. Developing the center also required investment in electronic medical records that physicians can access anywhere, as well as a highly trained workforce of caregivers. These resources were combined with cutting edge processes proven to improve patient care.

In addition to the TeleStroke service that was so essential to Trey Auten, some the other key programs delivered through the Virtual Care Center are:

TeleICU – For more than a decade, Mercy has operated the nation’s largest single hub electronic ICU, which employs advanced analytics and tested processes to collaborate with bedside caregivers for optimal patient care.

eSitter – This resource provides 24/7 observation for agitated or at-risk patients using two-way audio-video monitoring to improve patient safety and reduce stress on staff members.

TeleHospitalist – This program helps close gaps in clinician coverage that may sometimes occur overnight and at peak demand times, particularly in rural areas.

TeleSepsis – Using algorithms, data aggregation and centralized monitoring, this initiative is designed to ensure early detection and response to inpatient sepsis cases.

Engagement@Home – Providing tools to engage patients in their own care management, this program allows a multidisciplinary team to care for the health system’s sickest patients in their homes under the direction of their primary care provider.

REMOTE PATIENT MONITORING

Recent legislative changes will enable Mercy to deliver the Engagement@Home program in Arkansas for the first time beginning this year. This groundbreaking program addresses seriously ill patients who must manage multiple chronic conditions and are at high risk for complications and frequent hospitalizations.

Patients enrolled in the program receive a tablet computer, blood pressure cuff, pulse oximeter and weight scale. Using advanced analytics, biometric monitoring and interactive technologies, a care team proactively monitors and engages the patients to provide them with individualized care.
In October 2015, Mercy opened the Virtual Care Center, the first and only facility in the world dedicated to providing telemedical care. The four-story, 125,000-square-foot building is the cornerstone of Mercy’s virtual care program and serves as a nationally recognized center for developing and delivering telehealth.

From the ground up, the Virtual Care Center (VCC) is designed to bring together the best minds to provide patient care and to develop optimized work flow processes and advance technological innovations that will transform health care.

Mercy invested $54 million in building the Virtual Care Center, which today houses 600 specialized medical personnel. As the command center for telemedicine across the system, the VCC is always open – 24/7/365.

The four-story modern structure is both beautiful and functional. Featuring floor-to-ceiling glass walls outside and natural stone, tile and exposed wood inside, it is surrounded by a pond and towering, mature trees.

The first floor includes a briefing area where visitors are introduced to the facility and to Mercy’s vision for virtual care. Conference space, a chapel and a café are also housed on this level.

The next floor is the center of telemedical care, where Mercy Virtual team members use two-way audio-video technology and diagnostic and monitoring tools to virtually interact with and care for patients. Each workstation is set up to allow a virtual care physician, nurse or care navigator to monitor and interact with multiple patients at a time, similar to how a bedside caregiver might monitor a variety of patients within a specific unit.

On the top floor, a bank of monitors displays a wide variety of statistical information on Mercy’s virtual services. This space, known as the “garage,” also serves as an innovation hub where care team members gather to discuss, plan and design the next wave of telehealth innovations and applications.

and keep them healthier and out of the hospital.

During a 24-month assessment, Mercy found Engagement@Home reduced preventable readmissions by 50% and reduced medical costs by 30%. More importantly, 98% of patients indicated satisfaction with the program.

Mercy plans to have Engagement@Home up and running in Arkansas by fall, says Dr. Gavin Helton, medical director for ambulatory medicine at the Virtual Care Center.

Engagement@Home helps address the needs of patients who aren’t well-served by episodic care delivered during office visits.

“We’re bringing the right level of care at the right time, which many times is in the home,” Dr. Helton says. “The key is collaboration with the traditional care team. Using virtual care, we’re able to leverage technology to fill current gaps in care.”

Such gaps often occur when patients are transitioning from one level of care to another, he explains. That could be when patients transfer from the intensive care unit to a regular floor or from the emergency room to home. The Virtual Care Center focuses on being part of a continuum of care that helps create more seamless transitions.

“This makes it a system focused on patients, where their needs are driving what we do,” Dr. Helton adds.

Indeed, patient need was the driving force behind the initial development of TeleStroke. Stroke has become the fifth-leading cause of death in the U.S. and can lead to paralysis and loss of cognitive function in survivors.

There aren’t enough neurologists in the United States to offer the 24-hour coverage needed to ensure patients are diagnosed quickly enough for possible tPA treatment. That’s where the Virtual Care Center and TeleStroke program help fill the gap.

ARKANSAS HOSPITAL ASSOCIATION - 29
Because of quick diagnosis and treatment, Trey Auten has no lasting effects from the stroke he suffered in October. On the other hand, his health scare inspired some lifestyle changes, including following a low-sodium diet that has helped him drop 40 pounds.

“I’m kind of convinced this was a God thing and a wake-up call,” he says. Today, Trey is thriving in his work as a computer programmer, recently celebrated his daughter’s high school graduation and is considering a cautious return to bike riding.

Dr. Syed Hamid pioneered a regional hospitalist program at three rural Arkansas critical access hospitals that are part of Mercy Hospital Fort Smith. These hospitals serve Waldron, Paris and Booneville. Currently, Dr. Hamid is based in Booneville, and he travels each workday to all three hospitals to admit patients and do rounds.

The regional program has helped treat rural patients closer to home and offer a more consistent and higher level of care, Dr. Hamid said. Through Mercy Virtual, this program, which has been so successful for patients in the area, is about to take another step forward.

Now, Mercy Virtual plans to enhance the existing program by introducing a TeleHospitalist initiative this summer, expanding Dr. Hamid’s ability to treat patients even more. TeleHospitalist will expand the availability of Dr. Hamid’s services overnight and on weekends by enabling him to examine patients virtually rather than losing precious time traveling from facility to facility.

He initially had reservations about the TeleHospitalist program but says these concerns were allayed after he trained on its specialized equipment.

“It allows for real-time communication between the patient and me,” Dr. Hamid explains. "I was pleasantly surprised to find the audio and video quality to be excellent. The patients I talk with seem to be very happy with it."

The equipment is very high tech. “For example, there is a stethoscope that lets me hear heart and breath sounds. I could hear just as if I were actually in the room examining these patients,” he said.

Mercy also plans to use the TeleHospitalist program for specialist visits at the Waldron, Paris and Booneville hospitals. Current plans call for cardiology and pulmonology visits that will happen virtually, and more specialties could be added later.
ARKANSAS HFMA WINS AWARD FOR EXCELLENCE

The Healthcare Financial Management Association’s (HFMA) most prestigious chapter award, the Robert M. Shelton Award for Sustained Excellence, was presented to the Arkansas chapter of HFMA at its 2017 annual national institute in Orlando in June. The award is given in recognition of five years of sustained excellence in service to members. The awards committee made a unanimous decision this year that the Arkansas chapter fit that description.

Outgoing Arkansas HFMA President Brian Fowler said the entire chapter’s commitment to excellence and dedication to the advancement of the health care finance profession led to this recognition. In addition to Fowler, who served as president of the Arkansas chapter for the 2016-2017 year, other presidents who served within the five-year window reviewed by the national awards committee are Trisha Smith Walden, Jeannie Bond, Tracy Young and Bryan Jackson.

In expressing his thanks, Fowler said, “I’d of course be remiss not to mention Association Manager Tami Hill. Even though her presidential tenure was long ago, her dedication to the Arkansas chapter and to each of us who have served as president has without a doubt led us to this point.”

With more than 40,000 members, HFMA is the nation’s leading membership organization of healthcare finance executives and leaders. The organization is a respected and innovative thought leader on top trends and challenges facing the healthcare finance industry.
Ten years ago, a group of health quality professionals from different backgrounds and organizations came together to develop ways to improve the health of Arkansans. This group designed the Arkansas Medicaid Inpatient Quality Incentive (IQI) program, which has earned national attention for its innovative approach to improvement through health care community involvement.

Through the program, hospitals receive performance-based bonus payments based upon measurable improvements on selected quality measures determined by Arkansas Medicaid. Officially implemented in March 2007, the program featured a partnership between Arkansas Medicaid, the Arkansas Foundation for Medical Care (AFMC), the Arkansas Hospital Association (AHA) and quality review professionals from member hospitals.

Operation of the IQI program continues today through an advisory board comprised of hospitals and quality partners. Although the IQI program is voluntary, hospitals have embraced the program and its goals from the beginning. Through it, participating hospitals are encouraged to work on improvement activities that will positively affect Arkansas patients.

The hospitals collect and submit data on all quality measures for which they are eligible, and based upon this information, each hospital’s performance is evaluated and assessed. The IQI program’s performance assessment methods include calculating measure rates and performance thresholds, including a measure-validation component. Individual measure performance is assessed on two levels: achievement thresholds and improvement thresholds.

**IQI PERFORMANCE MEASURES**

Performance measures selected for reporting during the program’s first two years focused primarily on heart failure and pneumonia, conditions that are prevalent in the Medicare population, but less so among the Medicaid population.

Because Medicaid is the largest health care payer in Arkansas, as well as the largest payer of births in Arkansas, the IQI Program then introduced quality measures that aligned more closely with Medicaid priorities, focusing on areas of health care that would have the greatest impact on Medicaid beneficiaries’ health outcomes.

Measures introduced in subsequent years focused on hospital improvement efforts such as coordinating patient care across the health care continuum, perinatal care measures, tobacco cessation counseling and treatment, prevention of venous thromboembolism in hospitalized patients, and newborn screening.

**PERINATAL CARE**

Perinatal care measures included objectives to reduce rates of early elective deliveries, reduce low-risk-first-time Caesarean section rates and increase exclusive breast milk feeding during the newborn’s entire hospital stay. Perinatal care performance results have yielded solid improvement from baseline.

- Early elective deliveries have declined more than 97% since the baseline collections began in fall 2009. The rate of early elective deliveries among hospitals participating in the Medicaid IQI program is 1.66%.
- Exclusive breast milk feeding at hospital discharge has increased 31% since the initial baseline measurement in 2011, with a rate above 33%.
- Low-risk Caesarean sections have declined 21% statewide among participating hospitals. The rate is currently at 22.36%, which is below the U.S. government’s Healthy People 2020 target of 23.9%.
Examination of vital records trends in gestational age at birth and birth weights of all Arkansas infants born during the past seven years shows that the IQI Program has an impact on all-payer activity. Increases in births over 39 weeks and decreases in births at 37 to 38 weeks are statistically significant. These changes have resulted in an annual rate of more than 3,000 fewer Arkansas babies born before 39 weeks – nearly 8% of all births in the state. If we assume that 10% of 37 to 38 week deliveries will require neonatal intensive care unit (NICU) care, this translates to an avoidance of nearly 300 newborn admissions to NICU, and considerable savings to the health system and to the state.

**TOBACCO CESSATION**

Tobacco use remains the leading preventable cause of premature disease and death in the United States. Tobacco use causes many different cancers, heart disease and other serious health problems. Since the IQI Program introduced tobacco use screening and treatment measures five years ago, the performance results have been remarkable. Screening of patients admitted to hospitals in Arkansas occurs 99% of the time. A majority of patients identified as tobacco product users receive practical counseling to quit, along with Food and Drug Administration-approved cessation medications.

**NEWBORN SCREENING**

Every state does newborn screening to identify conditions that are present in the newborn period, but not yet clinically evident. Working with hospitals, Arkansas Medicaid and the Arkansas Department of Health (ADH) leveraged the innovative IQI Program to introduce two newborn screening quality measures in the state. These quality measures complement ongoing efforts in birthing facilities to examine their current process for collection and submission of newborns’ blood samples and enhance their ongoing quality improvement efforts. Since introduction of the screening measures in 2013, Arkansas hospitals have attained a nearly 400% improvement in timely submission of newborn screening samples for testing by the ADH lab. Last year alone, hospitals in Arkansas qualified to share more than $4.5 million in performance bonuses for achieving performance thresholds and meeting standards. Since the IQI program began in 2007, Arkansas Medicaid has awarded nearly $40 million to hospitals that have participated in the program and successfully improved care.

For more information about the IQI Program, contact schasteen@afmc.org. Steven Chasteen is AFMC’s Director of Practice Transformation.
Like many hospital systems in Arkansas, Baptist Health was an early adopter of telemedicine. Long known for its electronic intensive care unit service, Baptist Health eICU® care, the system also is expanding telemedicine initiatives as part of its focus on population health. Kourtney Matlock, Associate Vice President for Patient Services, is a key player in this work.

Matlock is a woman on a mission to expand health care access in Arkansas. And she sees offering telehealth programs as a way to expand both access and the long-term health of Arkansans. “Everyone knows Baptist as home of the eICU,” Matlock says. “But our outreach goes far beyond the ICU.”

With her work specifically focusing in the area of Population Health, she has daily opportunities to work on expansion of health care in the state. “Population Health means many things to different people,” Matlock says. “For some, it’s completely centered on costs, and for others, the focus is on the quality of the health care provided.” To Matlock, population health means increasing access to health care for all Arkansans and providing that care to all Arkansas communities, both urban and rural.

“We need to make it easier for people to adhere to their care. If they can ‘see’ physicians and nurse practitioners via telehealth when they can’t see the provider in person, they will still have that one-on-one experience that guides them to better..."
health. The more people have easy access to health care, the healthier they will be. And that’s what we want for ALL Arkansans!”

Matlock says telehealth appeals to all ages, but that connecting people to telehealth networks when they’re kids or in their early adult years will lead to better long-term health. Working with other hospitals and providers is key to making these connections. “It’s our goal at Baptist to increase health care access in tandem with other hospital systems, physicians, a variety of providers…working across corporate lines to make patients the center of Arkansas health care.”

Matlock started her personal focus on population health seven years ago, when she became involved with the state’s first attempt at establishing the “medical home” concept. From that initial project came the Comprehensive Primary Care Initiative (CPCI) sponsored by the Centers for Medicare and Medicaid Services (CMS).

“We need to make it easier for people to adhere to their care. If they can ‘see’ physicians and nurse practitioners via telehealth when they can’t see the provider in person, they will still have that one-on-one experience that guides them to better health. The more people have easy access to health care, the healthier they will be. And that’s what we want for ALL Arkansans!”

CPCI was a national program that launched in 2012, essentially inviting primary care practitioners to join with commercial, state and other federal insurance plans to give more Americans access to quality health care at a lower cost. Under the CPC Initiative, CMS paid primary care practices a care management fee – initially set at an average of $20 per beneficiary per month – to support enhanced, coordinated services. Arkansas Blue Cross and Blue Shield (doing business as Health Advantage), QualChoice, Humana and the Arkansas State Medicaid program also offered an enhanced payment to these primary care practices.

In order to receive the new care management fee from CMS and insurers, primary care practices agreed to provide enhanced services for their patients including: offering longer and more flexible hours, using electronic health records, delivering preventive care, coordinating care with patients’ other health care providers, engaging patients and caregivers in managing their own care, and providing individualized, enhanced care for patients living with multiple chronic diseases and other needs.

“For that type of system to work, Care Coordinators are pivotal,” Matlock says. In fact, at the outset, she hired a cadre of more than 20 Care Coordinators to assure that all patients were connected with their caregivers, who were working together across traditional medical silos to increase population health and help grow access to care.

At CPCI’s launch there were 69 Arkansas practices participating in the program, 15 of which were Baptist locations; now, there are 120 Arkansas provider units taking part in phase 2 of the program, CPC+, 21 of which under the Baptist umbrella. Matlock, through her role at Baptist, offers case management input and oversight over the CPC+ clinics.

“Now, we’re engaged in CPC+, with double the number of states, and double the number of practices per state participating in the widened concept of the medical home. I’m pleased to see the government saw value in putting money into care coordination.”

A significant reduction of ED utilization has occurred as patients experienced care through their own primary care physician; patients are discovering that their own PCP’s office offers a better place to be seen. Care is coordinated, and other benefits abound.

“After hours care is a big component,” Matlock says. “The care cost per patient went down significantly when we opened after hours clinics.”

And with the CPC+ network, specialty telemedicine is becoming readily available.

“Many times, physicians and patients can be connected via iPad, phone, or simply by computer. Telehealth carts are not always necessary,” Matlock says. “And through our telehealth network, we have lots of opportunity to do a better job with psych patients. Let’s face it; we simply don’t have enough providers. There are not enough advanced practice registered nurses (APRNs) or physicians coming out of school wanting to do psych. Telehealth allows us to stretch our providers. We reduce travel time between locations for our doctors and
increase the number of people who can be seen each day. We also integrate Behavioral Medicine into the PCP office, which is where we should be identifying the needs initially."

Like others in the industry, Matlock agrees that the new telemedicine law enacted at this year’s General Assembly will increase the ability of Arkansas providers to participate in telehealth/telemedicine. “In the rural setting, outpatient telehealth can be billed the same as face-to-face encounters," she says. “The hosting clinic can bill for its special telecommunication use, and the physician can bill as normal. It’s a win-win-win for patient, facility and physician."

Matlock sees health care delivered through telehealth channels as growing exponentially in the coming years. “We’re going to need a whole team of APRNs doing nothing but telehealth. Again, it’s a win-win; patients ‘see’ a caregiver, and access can be immediate."

“To me, eCare Coordination is like a group of coaches calling plays from their box seats above the field," Matlock says. “Our centralized care coordination team are the health coaches assessing gaps in care and cost opportunities. And each of us as patients? We’re the ones playing the game on the field."

Her ideas are only growing as telehealth expands. “My goal is that we offer specific eHealth programs through telehealth channels throughout the state, and that all Arkansans achieve the easy access to health care, including psych treatment and medical specialties, no matter where they live." These goals have become part of Kourtney Matlock’s mission – a mission that will result in better, more accessible care for our friends, neighbors and ourselves.

THE BAPTIST HEALTH CARE eHEALTH SERVICES

eICU
Around the clock, instant access is offered to an experienced team of Critical Care physicians and RNs supported by clinical decision support software to watch over a facility’s sickest patients.

eSepsis
Supported by critical care physicians, experienced eICU RNs provide continuous surveillance in the emergency department to rapidly identify severe sepsis and septic shock for early intervention, best practice adherence, and improved outcomes.

eSNF
Supported by an acute care team, the service provides monitoring and virtual rapid response to support patients in a skilled nursing facility in order to reduce readmissions and improve outcomes.

ePsych
Emergency department, inpatient and outpatient clinical consults are provided by mental health providers.

eCare Coordination
Care coordination is offered through an interdisciplinary team (Care Coordinators, Social Workers & Nutritionists) for clinics wanting to improve population health efforts for patients.

eNutrition Services
Nutrition services are provided in the clinic or hospital setting, including the emergency department.

eCardiology
Cardiologists provide emergency department, inpatient and outpatient clinic consults Monday through Friday.

eTranslation Services
Translation services are offered via telehealth for 12 languages, with 48 additional languages offered by telephone.

eLactation
Through this service, a lactation consultation can be done electronically with an RN IBCLC certified lactation consultant to help new mothers overcome the barriers to successful breastfeeding. Consultations are offered in the inpatient and outpatient setting, as well as from the patients’ homes.

NICU Live Streaming
The Baptist Health NICU Live Streaming system uses a camera placed at the baby’s bedside so that parents and other family members who can’t be at the NICU can view the baby 24 hours a day by logging into a secure account from their laptop, tablet or smart phone. This system helps promote bonding between parents and their premature babies, who sometimes have to stay in the hospital for weeks or months.

Remote Monitoring
Offered to patients suffering from congestive heart failure and to those with diabetes, this service provides real-time ongoing monitoring of vitals, as well as face-to-face telehealth consults via an integrated tablet with the focus of reducing patient costs and improving compliance.
WHEN TELEMEDICINE AND A COMMITMENT TO EXCELLENCE MERGE

by Kay Kendall, BaldrigeCoach CEO

With telemedicine as a focus in this issue of Arkansas Hospitals, I wondered about its possible connection with the Baldrige Excellence Framework. So I reached out to the senior leaders of two of our healthcare clients – Methodist Health System (Methodist) and Kindred Nursing and Rehabilitation Center-Mountain Valley (Mountain Valley) – for inspiration.
At first glance, these two organizations could not appear more dissimilar. Methodist provides quality, integrated health care to individuals and families throughout the large Dallas-Fort Worth metroplex. It includes four large hospitals as well as 27 health care centers as part of the Methodist Medical Group. Its workforce includes 8,000 active employees, 1,200 volunteers and 400 students. On the other hand, Mountain Valley provides five-star long-term care and short-term rehabilitation in the remote community of Kellogg, Idaho, with its population of just over 2,000 people. Its workforce includes 90 employees who provide care in the small, 68-bed facility.

Despite first impressions, however, the two organizations have many things in common. Both have received numerous recognitions for the high-quality care they provide. The senior leaders of both organizations are committed to a journey to performance excellence. And they’re both award winners: Methodist earned the highest-level award from the Texas Award for Performance Excellence program in 2014. Mountain Valley earned the Gold Award from the AHCA/NCAL Quality Award Program (the Baldrige-based program for the long-term care industry) in 2011, and was named a Baldrige Award recipient in 2016 – the first long-term care facility to receive this prestigious national award.

Both organizations have also found that telemedicine offers them ways to provide increased access to care for patients and their families. Methodist was added to the Mayo Clinic Care Network in September 2014. This relationship has offered an asynchronous form of telemedicine with clinical questions directed to Mayo Clinic specialists. It also has provided Methodist patients with a second opinion on cancer diagnoses. In addition, Methodist contracts with a neurology group as an on-call service to their Emergency Rooms (ERs). Through telemedicine, on-call neurologists confer regarding the diagnosis of a possible stroke. If validated, life-saving drugs can be administered quickly in the ER.

Another innovative use of telemedicine at Methodist is a text-based platform that provides continuity of care for up to seven days after discharge from the ER. Through a secure information exchange, physicians can respond to questions within four minutes and make decisions about whether the patient needs additional care, a return to the hospital or other follow-up. In the event a patient is discharged with an unclear diagnosis, the physician can continue to follow up for several hours after discharge to determine if the patient’s condition requires additional evaluation.

Until recently, Texas law presented multiple barriers to a wide-ranging adoption of telemedicine. Since the recent passing of Texas Senate Bill 1107, Methodist is optimistic that it will be able to adopt a broader approach to telemedicine that is responsive to the increasing expectation in America for real-time access and real-time communication with health care providers.

For Mountain Valley, telemedicine offers access to specialists who are physically located in Coeur D’Alene nearly 40 miles away, or locations even further out. The organization first began using telemedicine to consult with a nurse practitioner certified in wound care. One initial difficulty was overcoming the weakness of Wi-Fi signal strength in the rural valley. Once conquered, this opened the door for the organization’s expansion of services to offer telepsych care through collaboration with physicians practicing in a dedicated behavioral unit 60 miles away. As Mountain Valley added smart TVs to the residents’ rooms, they also gained the ability to virtually include families who are away from the facility in discussions while physicians are making their rounds.

In an innovative collaboration with the Shoshone Medical Center – the small hospital located across the street from Mountain Valley – they explored using a telemedicine program between the two entities to reduce residents’ visits to the ER. Now a resident with an acute condition can be evaluated via telemedicine in the ER to determine if a transfer to the hospital is warranted. In the short time this new program has been in place, Mountain Valley and the Shoshone Medical Center have seen an 11% reduction in hospital readmissions, and Mountain Valley has seen a 22% reduction in ER visits by their residents.

The definition of “innovation” in the Glossary of the Baldrige Excellence Framework includes the concept of creating new value for stakeholders. “Innovation benefits from a supportive environment, a process for identifying strategic opportunities, and a willingness to pursue intelligent risks.” Both of the role model organizations described here demonstrate that innovation is the intersection of telemedicine and a commitment to excellence.
## ARKANSAS HOSPITALS: Key Numbers to Know

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>106</td>
<td>Hospitals of all types are located in Arkansas.</td>
</tr>
<tr>
<td>101</td>
<td>Total hospitals and other healthcare organizations are members of the Arkansas Hospital Association.</td>
</tr>
<tr>
<td>44</td>
<td>Arkansas community hospitals have fewer than 100 beds.</td>
</tr>
<tr>
<td>29</td>
<td>Arkansas hospitals are designated by the federal government as Critical Access Hospitals, having no more than 25 acute care beds.</td>
</tr>
<tr>
<td>40</td>
<td>Arkansas counties are served by a single hospital. Nineteen of those counties are served by a single Critical Access Hospital.</td>
</tr>
<tr>
<td>36</td>
<td>Arkansas counties are home to hospitals that are among the top five employers in the county. In 21 of those counties, a hospital is among the top three employers.</td>
</tr>
<tr>
<td>24</td>
<td>Arkansas counties and cities believe their hospitals to be important enough that their citizens have voted to provide local tax support to the hospital.</td>
</tr>
<tr>
<td>22</td>
<td>Arkansas counties – almost 30% of all counties in the state – do not have a local community hospital.</td>
</tr>
<tr>
<td>56%</td>
<td>Of AHA member hospitals are charitable, not-for-profit organizations, while 30% of the hospitals are owned and operated by private, for-profit companies, and 14% are public hospitals owned and operated a city, county, state or federal government.</td>
</tr>
<tr>
<td>16,302</td>
<td>Arkansans sought inpatient or outpatient care from Arkansas’s hospitals each day in 2015 for illnesses, injuries and other conditions requiring medical attention.</td>
</tr>
<tr>
<td>36,206</td>
<td>Newborns were delivered in Arkansas hospitals in 2015. The Arkansas Medicaid program covered almost 65% of them.</td>
</tr>
<tr>
<td>45,226</td>
<td>Arkansans are employed in full- and part-time capacities by hospitals across the state, which have a combined annual payroll of $2.8 billion that helps to support about 8% of all non-farm jobs in the state through direct and indirect purchases of goods and services.</td>
</tr>
<tr>
<td>40,700</td>
<td>Other jobs in local communities across Arkansas are supported through hospital employees’ personal purchases of groceries, clothing, cars, appliances, housing and many other goods and services.</td>
</tr>
<tr>
<td>$370 million</td>
<td>Was spent in 2015 by Arkansas hospitals in providing uncompensated care for patients who could not afford to pay for the cost of their services.</td>
</tr>
<tr>
<td>$11.4 billion</td>
<td>Is the estimated overall annual economic impact Arkansas hospitals provided for the state, based on direct spending on goods and services, their impact on other businesses throughout the economy, jobs and employees’ spending.</td>
</tr>
</tbody>
</table>
A SNAPSHOT OF ARKANSAS HOSPITAL ASSOCIATION MEMBERS

Hospitals licensed in Arkansas

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Med-Surg Hospitals</td>
<td>75</td>
</tr>
<tr>
<td>Psychiatric Hospitals</td>
<td>10</td>
</tr>
<tr>
<td>Rehabilitation Hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Long-term Care Hospitals</td>
<td>5</td>
</tr>
<tr>
<td>Veterans Affairs Hospitals</td>
<td>2</td>
</tr>
<tr>
<td>Urban (24)</td>
<td></td>
</tr>
<tr>
<td>Rural (20)</td>
<td></td>
</tr>
<tr>
<td>Pediatric Hospitals (1)</td>
<td></td>
</tr>
<tr>
<td>Cardiac Care Hospitals (1)</td>
<td></td>
</tr>
<tr>
<td>Women’s Hospitals (1)</td>
<td></td>
</tr>
<tr>
<td>Critical Access Hospitals (28)</td>
<td>96</td>
</tr>
<tr>
<td>Number of out-of-state border city hospitals</td>
<td>+2</td>
</tr>
<tr>
<td>Non-hospital member organizations</td>
<td>+3</td>
</tr>
<tr>
<td>Total AHA-member organizations</td>
<td>101</td>
</tr>
</tbody>
</table>

Source: American Hospital Association, AHA Statistics, 2017

MEMBER ORGANIZATIONS BY TYPE

General Med-Surg Hospitals (44)
Arkansas Methodist Medical Center
Baptist Health Medical Center-Conway
Baptist Health Medical Center-Hot Spring County
Baptist Health Medical Center-Little Rock
Baptist Health Medical Center-NLR
Baptist Health Medical Center-Stuttgart
Baxter Regional Medical Center
Chambers Memorial Hospital
CHI St. Vincent Hot Springs
CHI St. Vincent Infirmary
CHI St. Vincent North
Conway Regional Health System
Drew Memorial Hospital
Five Rivers Medical Center
Forrest City Medical Center
Great River Medical Center
Helena Regional Medical Center
Jefferson Regional Medical Center
Johnson Regional Medical Center
Levi Hospital
Magnolia Regional Medical Center
Medical Center of South Arkansas
Mena Regional Health System
Mercy Hospital Northwest Arkansas
Mercy Hospital Fort Smith
National Park Medical Center
NEA Baptist Memorial Hospital
North Arkansas Regional Medical Center
North Metro Medical Center
Northwest Health Physicians’ Specialty Hospital
Northwest Medical Center-Bentonville
Northwest Medical Center-Springdale
Ouachita County Medical Center
Saint Mary’s Regional Medical Center
Saline Memorial Hospital
Siloam Springs Memorial Hospital
Sparks Regional Medical Center
Sparks Medical Center-Van Buren
St. Bernards Medical Center
UAMS Medical Center
Unity Health-Harris Medical Center
Unity Health-White Medical Center
Washington Regional Medical Center
White River Medical Center

Inpatient Psych Hospitals (10)
Arkansas State Hospital
Methodist Behavioral Hospital
Pinnacle Pointe Hospital
OakRidge Behavioral Center
Rivendell Behavioral Health Services
Riverview Behavioral Health
Springwoods Behavioral Health
The BridgeWay
Valley Behavioral Health System
Vantage Point of NWA

Inpatient Rehab Hospitals (4)
Baptist Health Rehabilitation Institute
Conway Regional Rehabilitation Hospital
HEALTHSOUTH Rehabilitation Hospital of Fayetteville
St. Vincent Rehabilitation Hospital

Critical Access Hospitals (28)
Ashley County Medical Center
Baptist Health Medical Center-Arkadelphia
Baptist Health Medical Center-Heber Springs
Bradley County Medical Center
CHI St. Vincent Morrilton
Chicot Memorial Medical Center
Community Medical Center of Izard County
CrossRidge Community Hospital
Dallas County Medical Center
Delta Memorial Hospital
DeWitt Hospital
Eureka Springs Hospital
Fulton County Hospital
Howard Memorial Hospital
Lawrence Memorial Hospital
Little River Memorial Hospital
McGehee Hospital
Mercy Hospital Berryville
Mercy Hospital Booneville
Mercy Hospital Ozark
Mercy Hospital Paris
Mercy Hospital Waldron
Ozark Health Medical Center
Ozarks Community Hospital
Piggott Community Hospital
River Valley Medical Center
SMC Regional Medical Center
Stone County Medical Center

Veterans Affairs Hospitals (2)
Central Arkansas Veterans Healthcare System
Veterans Healthcare System of the Ozarks

Long Term Care Hospitals (5)
Advanced Care Hospital of White County
Baptist Health Extended Care Hospital
Dubuis Hospital of Fort Smith
CHRISTUS Dubuis Hospital of Hot Springs
Cornerstone Hospital of Little Rock

Special Focus Hospitals (3)
Arkansas Children’s Hospital
Arkansas Heart Hospital
Willow Creek Women’s Hospital

Out of State Border City Hospitals (2)
CHRISTUS St. Michael Health System
Regional One Health

Non-Hospital Facilities (3)
19th Medical Group, LRAFB
Arkansas Hospice
CARTI
<table>
<thead>
<tr>
<th>CITY</th>
<th>HOSPITAL</th>
<th>CONTROL</th>
<th>TYPE OF HOSPITAL</th>
<th>MEDICARE PMT. STATUS</th>
<th>LICENSED BEDS</th>
<th>ADDITIONAL DPS/SERVICES OFFERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkadelphia</td>
<td>Baptist Health Med. Ctr.-Arkadelphia</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Ashdown</td>
<td>Little River Memorial Hospital</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH/ICF</td>
</tr>
<tr>
<td>Batesville</td>
<td>White River Medical Center</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Benton</td>
<td>River dell Behavioral Health</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Benton</td>
<td>Saline Memorial Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>167</td>
<td>Psych/Rehab/HH</td>
</tr>
<tr>
<td>Bentonville</td>
<td>Northwest Med. Ctr.-Bentonville</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>128</td>
<td>HH</td>
</tr>
<tr>
<td>Berryville</td>
<td>Mercy Hospital Berryville</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>25</td>
<td>HH/ICF</td>
</tr>
<tr>
<td>Blytheville</td>
<td>Great River Medical Center</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>Rural</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Booneville</td>
<td>Mercy Hospital Booneville</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Calico Rock</td>
<td>Community Medical Center of Izard County</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Camden</td>
<td>Ouachita County Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Rural/SCH</td>
<td>98</td>
<td>SB/SNF/Psych/Rehab/HH</td>
</tr>
<tr>
<td>Clarksville</td>
<td>Johnson Regional Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Rural/MDH</td>
<td>80</td>
<td>SB/SNF/Psych/Rehab/HH</td>
</tr>
<tr>
<td>Clinton</td>
<td>Ozark Health Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Conway</td>
<td>Baptist Health Medical Center-Conway</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Conway</td>
<td>Conway Regional Health System</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>154</td>
<td>Psych/Rehab/HH</td>
</tr>
<tr>
<td>Conway</td>
<td>Conway Regional Rehabilitation Hospital</td>
<td>Corporate</td>
<td>Rehabilitation</td>
<td>IRF</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Crossett</td>
<td>Ashley County Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>33</td>
<td>SB/Psych/HH</td>
</tr>
<tr>
<td>Danville</td>
<td>Chambers Memorial Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Rural</td>
<td>41</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Dardanelle</td>
<td>River Valley Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/Psych/HH</td>
</tr>
<tr>
<td>DeWitt</td>
<td>Do WH Hospital &amp; Nursing Home</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/ICF</td>
</tr>
<tr>
<td>Dumas</td>
<td>Delta Memorial Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>25</td>
<td>HH/ICF</td>
</tr>
<tr>
<td>El Dorado</td>
<td>Medical Center of South Arkansas</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>RRC/SCH</td>
<td>166</td>
<td>Rehab</td>
</tr>
<tr>
<td>Eureka Springs</td>
<td>Eureka Springs Hospital</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>22</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Fayetteville</td>
<td>HEALTHSOUTH Rehab. of Fayetteville</td>
<td>Corporate</td>
<td>Rehabilitation</td>
<td>IRF</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Fayetteville</td>
<td>NW Health Physicians’ Specialty</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Fayetteville</td>
<td>Springwoods Behavioral Health</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Fayetteville</td>
<td>Washington Regional Medical Ctr.</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>366</td>
<td>HH</td>
</tr>
<tr>
<td>Fayetteville</td>
<td>Veterans Healthcare Ctr. of the Ozarks</td>
<td>Federal</td>
<td>Veterans Affairs</td>
<td>Psych</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>Fayetteville</td>
<td>Vantage Point of NWA</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Fordyce</td>
<td>Dallas County Medical Center</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Forrest City</td>
<td>Forrest City Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Rural/SCH</td>
<td>118</td>
<td>Psych/HH</td>
</tr>
<tr>
<td>Fort Smith</td>
<td>Dubuis Hospital of Fort Smith</td>
<td>PNP</td>
<td>Long Term Care</td>
<td>LTCH</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Fort Smith</td>
<td>Sparks Regional Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>492</td>
<td>HH</td>
</tr>
<tr>
<td>Fort Smith</td>
<td>Mercy Hospital Fort Smith</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>354</td>
<td>S NF/Rehab/HH</td>
</tr>
<tr>
<td>Gravette</td>
<td>Ozarks Community Hospital</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>25</td>
<td>SB/OP Geriopsy/Wound Clinic</td>
</tr>
<tr>
<td>Harrison</td>
<td>North Arkansas Regional Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>RRC/SCH</td>
<td>174</td>
<td>HH/Psych/DPU</td>
</tr>
<tr>
<td>Heber Springs</td>
<td>Baptist Health Medical Ctr.-Heber Springs</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Helena</td>
<td>Helena Regional Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Rural</td>
<td>155</td>
<td>SB/Rehab/HH</td>
</tr>
<tr>
<td>Hot Springs</td>
<td>CHRISTUS Dubuis Hospital of Hot Springs</td>
<td>PNP</td>
<td>Long Term Care</td>
<td>LTCH</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Hot Springs</td>
<td>Levi Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>81</td>
<td>Psych/Rehab</td>
</tr>
<tr>
<td>Hot Springs</td>
<td>National Park Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>RRC</td>
<td>166</td>
<td>Rehab</td>
</tr>
<tr>
<td>Hot Springs</td>
<td>CHI St. Vincent Hospital Hot Springs</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>282</td>
<td>Psych/Rehab/HH</td>
</tr>
<tr>
<td>Jacksonville</td>
<td>North Metro Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Johnson</td>
<td>Willow Creek Women’s Hospital</td>
<td>Corporate</td>
<td>Med-Surg (OB/Gyn)</td>
<td>Urban</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Jonesboro</td>
<td>NEA Baptist Memorial Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>216</td>
<td>Rehab</td>
</tr>
<tr>
<td>Jonesboro</td>
<td>St. Bernards Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>RRC</td>
<td>438</td>
<td>Psych/HH</td>
</tr>
<tr>
<td>Lake Village</td>
<td>Chicot Memorial Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Little Rock</td>
<td>19th Medical Group</td>
<td>DoD</td>
<td>Infirmary</td>
<td>CAH</td>
<td>0</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Arkansas Children’s Hospital</td>
<td>PNP</td>
<td>Med-Surg (Ped)</td>
<td>CAH</td>
<td>359</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Arkansas Heart Hospital</td>
<td>Corporate</td>
<td>Med-Surg (Cardiac)</td>
<td>CAH</td>
<td>112</td>
<td>SB/HH</td>
</tr>
<tr>
<td>CITY</td>
<td>HOSPITAL</td>
<td>CONTROL</td>
<td>TYPE OF HOSPITAL</td>
<td>MEDICARE PMT. STATUS</td>
<td>LICENSED BEDS</td>
<td>ADDITIONAL DPUS/SERVICES OFFERED</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------</td>
<td>---------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Arkansas State Hospital</td>
<td>State</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>345</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Baptist Health Extended Care Hospital</td>
<td>PNP</td>
<td>Long Term Care</td>
<td>LTC</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>Little Rock</td>
<td>Baptist Health Med. Ctr. - Little Rock</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>597</td>
<td>SNF/Psych/HH</td>
</tr>
<tr>
<td>Little Rock</td>
<td>Baptist Health Rehabilitation Institute</td>
<td>PNP</td>
<td>Rehabilitation</td>
<td>IRF</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Little Rock</td>
<td>CARTI</td>
<td>PNP</td>
<td>OP Cancer Center</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Little Rock</td>
<td>Central AR Veterans Healthcare System</td>
<td>PNP</td>
<td>Long Term Care</td>
<td>LTC</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Little Rock</td>
<td>Cornerstone Hospital of Little Rock</td>
<td>Corporate</td>
<td>Long Term Care</td>
<td>LTC</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Little Rock</td>
<td>CHI St. Vincent Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>615</td>
<td></td>
</tr>
<tr>
<td>Little Rock</td>
<td>UAMS Medical Center</td>
<td>State</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>450</td>
<td></td>
</tr>
<tr>
<td>Magnolia</td>
<td>Magnolia Regional Medical Center</td>
<td>City</td>
<td>Medical-Surgical</td>
<td>Rural/SCH</td>
<td>49</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Malvern</td>
<td>Baptist Health Med. Ctr.- Hot Springs</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Rural/MDH</td>
<td>72</td>
<td>Psych/HH</td>
</tr>
<tr>
<td>Maumelle</td>
<td>Methodist Hospital</td>
<td>PNP</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>60</td>
<td>SB/HH</td>
</tr>
<tr>
<td>McGehee</td>
<td>McGehee Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Memphis, TN</td>
<td>Regional One Health</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban (TN)</td>
<td>620</td>
<td></td>
</tr>
<tr>
<td>Mena</td>
<td>Mena Regional Health System</td>
<td>City</td>
<td>Medical-Surgical</td>
<td>Rural/SCH</td>
<td>65</td>
<td>SB/Psych/Rehab</td>
</tr>
<tr>
<td>Monticello</td>
<td>Draw Medical Hospital</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>Rural/SCH</td>
<td>49</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Morrilton</td>
<td>CHI St. Vincent Morrilton</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Mountain Home</td>
<td>Baxter Regional Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>RRC/SCH</td>
<td>368</td>
<td>Psych/Rehab/HH</td>
</tr>
<tr>
<td>Mountain View</td>
<td>Stone County Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>20</td>
<td>SB</td>
</tr>
<tr>
<td>Nashville</td>
<td>Howard Memorial Hospital</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Rural</td>
<td>133</td>
<td>SB/Psych</td>
</tr>
<tr>
<td>Newport</td>
<td>Unity Health-Harris Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>North Little Rock</td>
<td>Arkansas Hospice</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Inpatient Hospice</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>North Little Rock</td>
<td>Baptist Health Med. Ctr.- NLR</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>220</td>
<td>Rehab/HH</td>
</tr>
<tr>
<td>North Little Rock</td>
<td>The BridgeWay</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>127</td>
<td></td>
</tr>
<tr>
<td>Osceola</td>
<td>SMC Regional Medical Center</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/Psych</td>
</tr>
<tr>
<td>Oark</td>
<td>Mercy Hospital Oark</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB</td>
</tr>
<tr>
<td>Paragould</td>
<td>Arkansas Methodist Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>RRC</td>
<td>129</td>
<td>SB/Rehab/HH</td>
</tr>
<tr>
<td>Paris</td>
<td>Mercy Hospital Paris</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>16</td>
<td>SB</td>
</tr>
<tr>
<td>Pigott</td>
<td>Piggott Community Hospital</td>
<td>City</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
<tr>
<td>Pine Bluff</td>
<td>Jefferson Regional Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban/SCH</td>
<td>471</td>
<td>SNF/Psych/Rehab/HH</td>
</tr>
<tr>
<td>Pocahontas</td>
<td>Five Rivers Medical Center Arkansas</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Rural/SCH</td>
<td>50</td>
<td>Psych/HH</td>
</tr>
<tr>
<td>Rogers</td>
<td>Mercy Hospital of Northwest</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>220</td>
<td>Psych/HH</td>
</tr>
<tr>
<td>Russellville</td>
<td>Saint Mary's Regional Medical Center</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>RRC</td>
<td>170</td>
<td>Psych/Rehab</td>
</tr>
<tr>
<td>Salem</td>
<td>Fulton County Hospital</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB</td>
</tr>
<tr>
<td>Searcy</td>
<td>Advanced Care Hospital of White County</td>
<td>PNP</td>
<td>Long Term Care</td>
<td>LTC</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Searcy</td>
<td>Unity Health-White County Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>RRC/SCH</td>
<td>438</td>
<td>Psych/Rehab/HH</td>
</tr>
<tr>
<td>Sherwood</td>
<td>CHI St. Vincent North</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>69</td>
<td>HH</td>
</tr>
<tr>
<td>Sherwood</td>
<td>St. Vincent Rehabilitation Hospital</td>
<td>Corporate</td>
<td>Rehabilitation</td>
<td>IRF</td>
<td>93</td>
<td></td>
</tr>
<tr>
<td>Siloam Springs</td>
<td>Siloam Springs Regional Hospital</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>73</td>
<td>SB</td>
</tr>
<tr>
<td>Springdale</td>
<td>Northwest Medical Center Springdale</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>222</td>
<td>Psych/Rehab/HH</td>
</tr>
<tr>
<td>Stuttgart</td>
<td>Baptist Health Medical Center-Stuttgart</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Rural/MDH</td>
<td>49</td>
<td>SB</td>
</tr>
<tr>
<td>Texarkana</td>
<td>Riverview Behavioral Health</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Texarkana, TX</td>
<td>CHRISTUS St. Michael Health System</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>Urban (TX)</td>
<td>312</td>
<td></td>
</tr>
<tr>
<td>Van Buren</td>
<td>Sparks Medical Center-Van Buren</td>
<td>Corporate</td>
<td>Medical-Surgical</td>
<td>Urban</td>
<td>103</td>
<td></td>
</tr>
<tr>
<td>Waldron</td>
<td>Mercy Hospital Waldron</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>24</td>
<td>SB/ICF</td>
</tr>
<tr>
<td>Walnut Ridge</td>
<td>Lawrence Memorial Hospital</td>
<td>County</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/ICF</td>
</tr>
<tr>
<td>Warren</td>
<td>Bradley County Medical Center</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>33</td>
<td>SB/Psych/HH</td>
</tr>
<tr>
<td>West Memphis</td>
<td>Oak Ridge Behavioral Center</td>
<td>Corporate</td>
<td>Psychiatric</td>
<td>IP Psych</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Wynne</td>
<td>Cross Ridge Community Hospital</td>
<td>PNP</td>
<td>Medical-Surgical</td>
<td>CAH</td>
<td>25</td>
<td>SB/HH</td>
</tr>
</tbody>
</table>

PNP = Private Non-Profit; CAH = Critical Access Hospital; RRC = Rural Referral Center; SCH = Sole Community Hospital; MDH = Medicare Dependent Hospital; SB = Swing Beds; DPU = Distinct Part Unit; HH = Home Health; ICF = Intermediate Care Facility
AHA-MEMBER ORGANIZATIONS
BY CONGRESSIONAL DISTRICT

1st Congressional District
· Arkansas Methodist Medical Center
· Baptist Health Medical Center-Heber Springs
· Baptist Health Medical Center-Stuttgart
· Baxter Regional Medical Center
· Chicot Memorial Medical Center
· Community Medical Center of Izard County
· CrossRidge Community Hospital
· Delta Memorial Hospital
· DeWitt Hospital
· Five Rivers Medical Center
· Forrest City Medical Center
· Fulton County Hospital
· Great River Medical Center
· Lawrence Memorial Hospital
· McGehee Hospital
· NEA Baptist Memorial Hospital
· OakRidge Behavioral Center
· Piggott Community Hospital
· SMC Regional Medical Center
· St. Bernards Medical Center
· Stone County Medical Center
· Unity Health-Harris Medical Center
· White River Health System

Total = 24

2nd Congressional District
· 19th Medical Group
· Advanced Care Hospital of White County
· Arkansas Children’s Hospital
· Arkansas Heart Hospital
· Arkansas Hospice
· Arkansas State Hospital
· Baptist Health Extended Care Hospital
· Baptist Health Medical Center-Conway
· Baptist Health Medical Center-Little Rock
· Baptist Health Medical Center-North Little Rock
· Baptist Health Rehabilitation Institute
· CARTI
· Central Arkansas Veterans Healthcare System
· CHI St. Vincent Infirmary
· CHI St. Vincent Morrilton
· CHI St. Vincent North
· Conway Regional Health System
· Conway Regional Rehabilitation Hospital
· Cornerstone Hospital of Little Rock
· Methodist Behavioral Hospital
· North Metro Medical Center
· Ozark Health Medical Center
· Pinnacle Pointe Behavioral Healthcare System
· Rivendell Behavioral Health Services
· Saline Memorial Hospital
· St. Vincent Rehabilitation Hospital
· The BridgeWay
· UAMS Medical Center
· Unity Health-White County Medical Center

Total = 29

3rd Congressional District
· Dubuis Hospital of Fort Smith
· Eureka Springs Hospital
· HEALTHSOUTH Rehabilitation Hospital of Fayetteville
· Mercy Hospital Berryville
· Mercy Hospital Fort Smith
· Mercy Hospital Northwest Arkansas
· North Arkansas Regional Medical Center
· Northwest Health Physicians’ Specialty Hospital
· Northwest Medical Center-Bentonville
· Northwest Medical Center-Springdale
· Ozarks Community Hospital
· Saint Mary’s Regional Medical Center
· Siloam Springs Regional Hospital
· Sparks Medical Ctr.-Van Buren
· Sparks Regional Medical Center
· Springwoods Behavioral Health Hospital
· Valley Behavioral Health System
· Vantage Point of NWA
· Veterans Health Care System of the Ozarks
· Washington Regional Medical Center
· Willow Creek Women’s Hospital

Total = 21

4th Congressional District
· Ashley County Medical Center
· Baptist Health Medical Center-Arkadelphia
· Baptist Health Medical Center-Hot Springs County
· Bradley County Medical Center
· Chambers Memorial Hospital
· CHRISTUS Dubuis Hospital of Hot Springs
· CHI St. Vincent Hospital Hot Springs
· Drew Memorial Hospital
· Howard Memorial Hospital
· Jefferson Regional Medical Center
· Johnson Regional Medical Center
· Levi Hospital
· Little River Memorial Hospital
· Magnolia Regional Medical Center
· Medical Center of South Arkansas
· Mena Regional Health System
· Mercy Hospital Booneville
· Mercy Hospital Ozark
· Mercy Hospital Paris
· Mercy Hospital Waldron
· National Park Medical Center
· Ouachita County Medical Center
· River Valley Medical Center
· Riverview Behavioral Health

Total = 25

Additional AHA Member Hospitals Include:
· CHRISTUS St. Michael Health System, Texarkana, TX
· Regional One Health, Memphis, TN
## AHA HOSPITALS OPERATED BY FOR-PROFIT MULTI-HOSPITAL SYSTEMS

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Acadia Health</th>
<th>Allegiance Health Management</th>
<th>Capella Health</th>
<th>Community Health Systems</th>
<th>Cornerstone Healthcare Group</th>
<th>HealthSouth Corp.</th>
<th>Ozark Community Hospital Health System</th>
<th>Quorum Health</th>
<th>Universal Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornerstone Hospital of Little Rock</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eureka Springs Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forrest City Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEALTHSOUTH Rehab. Hospital of Fayetteville</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helena Regional Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Center of South Arkansas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Park Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Metro Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northwest Health Physicians’ Specialty Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northwest Medical Center-Bentonville</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northwest Medical Center-Springdale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ozarks Community Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pinnacle Pointe Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rivendell Behavioral Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>River Valley Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Riverview Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saint Mary’s Regional Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saline Memorial Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siloam Springs Memorial Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sparks Medical Center-Van Buren</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sparks Regional Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Springwoods Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Vincent Rehabilitation Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The BridgeWay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valley Behavioral Health System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vantage Point of NWA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willow Creek Women’s Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## AHA Non-Profit Multi-Hospital Systems

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Baptist Health</th>
<th>Catholic Health Initiatives</th>
<th>CHRISTUS</th>
<th>Mercy Health</th>
<th>St. Bernards Health System</th>
<th>Unity Health</th>
<th>White River Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Care Hospital of White County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Extended Care Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-Arkadelphia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-Conway</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-Heber Springs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-Hot Spring County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-Little Rock</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-North Little Rock</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Medical Center-Stuttgart</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baptist Health Rehabilitation Institute</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHI St. Vincent Hot Springs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHI St. Vincent Infirmary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHI St. Vincent Morrilton</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHI St. Vincent North</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHRISTUS Dubuis Hospital of Hot Springs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHRISTUS St. Michael Health System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CrossRidge Community Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dubuis Hospital of Fort Smith</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawrence Memorial Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Berryville</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Booneville</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Fort Smith</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Northwest Arkansas</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Ozark</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Paris</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercy Hospital Waldron</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEA Baptist Memorial Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Bernards Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stone County Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unity Health-Harris Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unity Health-White County Medical Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White River Health System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. **Beds Available**: 2015 - 9.438 (4.78%)

2. **Admissions**: 2015 - 3,419,087 (20.31%)

3. **Patient Days**: 2015 - 3,414,948 (53.7%)

4. **Inpatient Surgeries**: 2015 - 102,964 (11.32%)

5. **Outpatient Surgeries**: 2015 - 160,223 (9.85%)

6. **Total Surgeries**: 2015 - 263,187 (6.52%)

7. **Outpatient As % of Total Surgeries**: 2015 - 60.88% (10.76%)

8. **FTE Employees**: 2015 - 44,681 (3.53%)

9. **FTEs Per Adjusted Occupied Bed**: 2015 - 0.453 (4.45%)

10. **Gross Revenue, Inpatient**: 2015 - $11,456,007,960 (19.49%)

11. **Net Patient Revenue**: 2015 - $4,656,921,660 (22.44%)

12. **Other Operating Revenue**: 2015 - $2,715,203,458 (22.97%)

13. **Total Expense**: 2015 - $5,299,543,986 (20.30%)

14. **Patient Revenue Margin**: 2015 - 0.84% (1.51%)

15. **Total Margin**: 2015 - 5.72% (6.77%)

16. **Payment Per Adjusted Inpatient Day**: 2015 - $5,645.43 (23.43%)

17. **Expense Per Adjusted Inpatient Day**: 2015 - $1,533.42 (13.00%)

18. **Payroll Per Adjusted Inpatient Day**: 2015 - $646.53 (11.03%)

19. **Payroll As % of Total Expense**: 2015 - 42.2% (13.49%)

20. **Bad Debt and Charity As % of Total Charge**: 2015 - 8.0% (6.8%)

21. **Total Deductions As % of Total Charge**: 2015 - 21.66% (23.43%)

22. **Outpatient Revenue As % of Total Patient Revenue**: 2015 - 60.88% (10.76%)

23. **Admissions Per Bed**: 2015 - 38.6 (4.95%)

24. **Patient Days Per 1,000 Population**: 2015 - 640.9 (4.49%)

25. **Admissions Per 1,000 Population**: 2015 - 12.37 (4.73%)

26. **Population (000s)**: 2015 - 2,938 (1.36%)
### ARKANSAS HOSPITALS RECEIVING LOCAL TAX SUPPORT, 2017

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Sales Tax</th>
<th>Rate</th>
<th>Millage</th>
<th>Year Approved</th>
<th>Annual Amount Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashley County Medical Center</td>
<td>Yes</td>
<td>0.25%</td>
<td></td>
<td>2009</td>
<td>$600,000</td>
</tr>
<tr>
<td>Baptist Health Medical Center-Hot Spring Co.</td>
<td>Yes</td>
<td>0.5%</td>
<td></td>
<td>2009</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>Baptist Health Medical Center-Stuttgart</td>
<td>Yes</td>
<td>1.0%</td>
<td></td>
<td>2009</td>
<td>$2,200,000</td>
</tr>
<tr>
<td>Bradley County Medical Center</td>
<td>Yes</td>
<td>1.00%</td>
<td>.4 mil</td>
<td>2009</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>Chicot Memorial Hospital **</td>
<td>Yes</td>
<td>1.00%</td>
<td>.5 mil</td>
<td>2003</td>
<td>$1,100,000</td>
</tr>
<tr>
<td>CrossRidge Community Hospital</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2000</td>
<td>$2,100,000</td>
</tr>
<tr>
<td>Dallas County Medical Center</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2005</td>
<td>$840,000</td>
</tr>
<tr>
<td>Delta Memorial Hospital *</td>
<td>Yes</td>
<td>2.00%</td>
<td></td>
<td>2004</td>
<td>$360,000</td>
</tr>
<tr>
<td>DeWitt Hospital</td>
<td>Yes</td>
<td>1.5%</td>
<td></td>
<td>2003</td>
<td>$850,000</td>
</tr>
<tr>
<td>Drew Memorial Hospital</td>
<td>Yes</td>
<td>0.25%</td>
<td></td>
<td>2015</td>
<td>$670,000</td>
</tr>
<tr>
<td>Five Rivers Medical Center</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2007</td>
<td>$750,000</td>
</tr>
<tr>
<td>Fulton County Hospital</td>
<td>Yes</td>
<td>0.50%</td>
<td></td>
<td>2007</td>
<td>$288,000</td>
</tr>
<tr>
<td>Johnson Regional Medical Center</td>
<td>No</td>
<td></td>
<td>.3 mil</td>
<td>1977</td>
<td>$65,000</td>
</tr>
<tr>
<td>Lawrence Memorial Hospital</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2014</td>
<td>$1,560,000</td>
</tr>
<tr>
<td>Little River Memorial Hospital</td>
<td>Yes</td>
<td>NA</td>
<td></td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Magnolia Regional Medical Center (A)</td>
<td>Yes</td>
<td>1.25%</td>
<td></td>
<td>2007</td>
<td>$2,600,000</td>
</tr>
<tr>
<td>Magnolia Regional Medical Center (B)</td>
<td>Yes</td>
<td>0.25%</td>
<td></td>
<td>2004</td>
<td>$540,000</td>
</tr>
<tr>
<td>Mercy Hospital Booneville</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2003</td>
<td>$360,000</td>
</tr>
<tr>
<td>Mercy Hospital Ozark</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2001</td>
<td>$350,000</td>
</tr>
<tr>
<td>Mercy Hospital Paris</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>McGehee Hospital</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>1999</td>
<td>$600,000</td>
</tr>
<tr>
<td>Mississippi County Hospital System</td>
<td>Yes</td>
<td>0.50%</td>
<td>1 mil</td>
<td>2015/1952</td>
<td>$2,732,000</td>
</tr>
<tr>
<td>Ouachita County Medical Center ***</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2015</td>
<td>$2,400,000</td>
</tr>
<tr>
<td>Piggott Community Hospital</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2010</td>
<td>$360,000</td>
</tr>
<tr>
<td>CHI St. Vincent Morrilton</td>
<td>Yes</td>
<td>0.25%</td>
<td>.25 mil</td>
<td>2008</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Ozark Health Medical Center</td>
<td>Yes</td>
<td>1.00%</td>
<td></td>
<td>2000</td>
<td>NA</td>
</tr>
</tbody>
</table>

*A 2% sales tax was approved in 2004/2005 to build the hospital building. Due to refinancing, a portion of that 2% now goes to support other city buildings. Another refinancing in 2015 allowed some savings to be allocated to maintenance and equipment for the hospital for a 5-year period. That is expected to generate about $360,000 annually.

**Annually receives approximately $1.1 million on a bond issue that was used to build the new building; plus $1.1 million received from a sales and use tax; plus $264,000 from a 1/2 millage property tax.

***50% for maintenance, 50% for bond debt retirement

NA = Information not available

Source: Self-reported information provided to the Arkansas Hospital Association
### COMMUNITY HOSPITAL SUMMARY FINANCIAL DATA

**Arkansas and Surrounding States, 2015***

<table>
<thead>
<tr>
<th></th>
<th>ARKANSAS</th>
<th>LOUISIANA</th>
<th>MISSISSIPPI</th>
<th>MISSOURI</th>
<th>OKLAHOMA</th>
<th>TENNESSEE</th>
<th>TEXAS</th>
<th>UNITED STATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals charged this amount for the inpatient and outpatient care they provided in 2015:</td>
<td>$23,254,353,505</td>
<td>$42,370,510,175</td>
<td>$28,239,309,946</td>
<td>$64,000,572,293</td>
<td>$32,720,858,328</td>
<td>$68,537,247,268</td>
<td>$251,502,315,374</td>
<td>$3,016,398,683,161</td>
</tr>
<tr>
<td>But, patients and payer groups didn’t pay the full amount of billed charges for various reasons. Government programs like Medicare and Medicaid, workers’ comp programs and others never pay the full hospital bill. Managed care plans and other insurers typically pay discounted amounts only and individual patients often can’t afford to pay some or any of the out-of-pocket costs related to their hospital bills. For those reasons, hospitals had to forfeit this much of their billed charges:</td>
<td>16,788,731,845</td>
<td>30,578,707,526</td>
<td>20,830,266,436</td>
<td>44,162,427,882</td>
<td>24,054,668,319</td>
<td>51,407,644,782</td>
<td>191,251,783,422</td>
<td>235,390,102,320</td>
</tr>
<tr>
<td>As a result, actual payments to hospitals were:</td>
<td>6,465,621,660</td>
<td>11,791,802,649</td>
<td>7,408,843,510</td>
<td>19,838,144,411</td>
<td>8,666,190,009</td>
<td>17,329,602,486</td>
<td>60,250,531,952</td>
<td>866,008,570,841</td>
</tr>
<tr>
<td>At the same time, hospitals spent this much providing patient care services...</td>
<td>6,299,543,986</td>
<td>11,678,829,432</td>
<td>7,225,388,181</td>
<td>20,150,390,956</td>
<td>8,276,760,096</td>
<td>16,056,401,723</td>
<td>58,537,520,459</td>
<td>851,514,523,144</td>
</tr>
<tr>
<td>...to patients needing care for this many adjusted patient days while being served:</td>
<td>3,700,208</td>
<td>6,151,123</td>
<td>4,933,732</td>
<td>8,492,160</td>
<td>4,133,595</td>
<td>8,763,076</td>
<td>24,328,175</td>
<td>333,111,172</td>
</tr>
<tr>
<td>So, the revenue excess (loss) was:</td>
<td>$166,077,674</td>
<td>$114,973,217</td>
<td>$183,455,329</td>
<td>$(312,246,543)</td>
<td>$389,429,913</td>
<td>$(1,083,200,763)</td>
<td>$1,913,011,493</td>
<td>$14,494,047,697</td>
</tr>
<tr>
<td>In other words, hospitals made (or lost) this much on each of the equivalent days of care they provided to inpatients and outpatients:</td>
<td>$44,88</td>
<td>$18,69</td>
<td>$3718</td>
<td>$(36,77)</td>
<td>$94.21</td>
<td>$123.61</td>
<td>$78.63</td>
<td>$43.51</td>
</tr>
<tr>
<td>Yielding a &quot;patient service&quot; margin of:</td>
<td>2.57%</td>
<td>0.98%</td>
<td>2.48%</td>
<td>-1.57%</td>
<td>4.49%</td>
<td>6.32%</td>
<td>3.18%</td>
<td>1.67%</td>
</tr>
<tr>
<td>In addition, hospitals also received revenues from other operating sources, such as cafeteria and gift shop sales, adding this much to their revenues:</td>
<td>$249,634,077</td>
<td>$799,145,785</td>
<td>$299,447,552</td>
<td>$1,348,433,494</td>
<td>$295,455,124</td>
<td>$596,387,736</td>
<td>$5,439,798,405</td>
<td>$5,374,900,904</td>
</tr>
<tr>
<td>Which raised total operating income to:</td>
<td>$415,711,751</td>
<td>$914,119,002</td>
<td>$482,902,881</td>
<td>$936,886,049</td>
<td>$684,885,037</td>
<td>$1,670,588,499</td>
<td>$7,352,809,898</td>
<td>$6,766,848,601</td>
</tr>
<tr>
<td>As a result, the &quot;operating margin&quot; rose to:</td>
<td>6.19%</td>
<td>7.26%</td>
<td>6.26%</td>
<td>4.44%</td>
<td>7.64%</td>
<td>9.48%</td>
<td>11.19%</td>
<td>7.36%</td>
</tr>
<tr>
<td>Hospitals also collected other types of revenue from sources including contributions, tax appropriations, investments and the rental of office space. Those amounted to:</td>
<td>$417,704,386</td>
<td>$41,289,716</td>
<td>$82,305,898</td>
<td>$237,425,463</td>
<td>$82,917,369</td>
<td>$122,822,365</td>
<td>$678,343,891</td>
<td>$5,657,063,784</td>
</tr>
<tr>
<td>That resulted in total funds available to reinvest in new equipment, update facilities, expand programs and repay debt equaling:</td>
<td>$457,416,157</td>
<td>$955,408,718</td>
<td>$565,008,779</td>
<td>$1,173,612,412</td>
<td>$767,802,406</td>
<td>$1,802,410,864</td>
<td>$8,121,537,789</td>
<td>$75,306,012,385</td>
</tr>
<tr>
<td>For a return on investment totaling:</td>
<td>6.77%</td>
<td>7.56%</td>
<td>7.25%</td>
<td>5.50%</td>
<td>8.49%</td>
<td>10.30%</td>
<td>12.22%</td>
<td>7.93%</td>
</tr>
</tbody>
</table>

*Source: American Hospital Association, Hospital Statistics, 2017 (reflects most recent data available)*
### COMPARATIVE FINANCIAL INDICATORS

<table>
<thead>
<tr>
<th>RANK</th>
<th>AVERAGE CHARGE PER HOSPITAL STAY</th>
<th>AVERAGE OPERATING COST PER HOSPITAL STAY</th>
<th>AVERAGE PAYMENT PER HOSPITAL STAY</th>
<th>MARGIN ON PATIENT CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>California</td>
<td>District of Columbia</td>
<td>Alaska</td>
<td>16.56%</td>
</tr>
<tr>
<td>2</td>
<td>Colorado</td>
<td>District of Columbia</td>
<td>Utah</td>
<td>14.34%</td>
</tr>
<tr>
<td>3</td>
<td>Alabama</td>
<td>New York</td>
<td>Colorado</td>
<td>8.93%</td>
</tr>
<tr>
<td>4</td>
<td>District of Columbia</td>
<td>California</td>
<td>Indiana</td>
<td>7.69%</td>
</tr>
<tr>
<td>5</td>
<td>New Jersey</td>
<td>Washington</td>
<td>New Mexico</td>
<td>7.33%</td>
</tr>
<tr>
<td>6</td>
<td>Nevada</td>
<td>Hawaii</td>
<td>Nebraska</td>
<td>6.94%</td>
</tr>
<tr>
<td>7</td>
<td>Pennsylvania</td>
<td>Colorado</td>
<td>South Carolina</td>
<td>6.82%</td>
</tr>
<tr>
<td>8</td>
<td>Texas</td>
<td>Massachusetts</td>
<td>Tennessee</td>
<td>6.32%</td>
</tr>
<tr>
<td>9</td>
<td>Florida</td>
<td>Minnesota</td>
<td>Virginia</td>
<td>6.09%</td>
</tr>
<tr>
<td>10</td>
<td>Washington</td>
<td>Oregon</td>
<td>Idaho</td>
<td>5.81%</td>
</tr>
<tr>
<td>11</td>
<td>Arizona</td>
<td>Maine</td>
<td>North Carolina</td>
<td>5.69%</td>
</tr>
<tr>
<td>12</td>
<td>WSC Region*</td>
<td>Delaware</td>
<td>Florida</td>
<td>5.46%</td>
</tr>
<tr>
<td>13</td>
<td>New York</td>
<td>Idaho</td>
<td>Wisconsin</td>
<td>5.44%</td>
</tr>
<tr>
<td>14</td>
<td>U.S.**</td>
<td>South Dakota</td>
<td>Kentucky</td>
<td>5.05%</td>
</tr>
<tr>
<td>15</td>
<td>Utah</td>
<td>Connecticut</td>
<td>Nevada</td>
<td>4.96%</td>
</tr>
<tr>
<td>16</td>
<td>Ohio</td>
<td>Montana</td>
<td>Montana</td>
<td>4.88%</td>
</tr>
<tr>
<td>17</td>
<td>Indiana</td>
<td>Wyoming</td>
<td>Oklahoma</td>
<td>4.49%</td>
</tr>
<tr>
<td>18</td>
<td>New Mexico</td>
<td>New Hampshire</td>
<td>Delaware</td>
<td>4.41%</td>
</tr>
<tr>
<td>19</td>
<td>Illinois</td>
<td>Wisconsin</td>
<td>New Hampshire</td>
<td>4.22%</td>
</tr>
<tr>
<td>20</td>
<td>South Carolina</td>
<td>Pennsylvania</td>
<td>South Dakota</td>
<td>3.97%</td>
</tr>
<tr>
<td>21</td>
<td>Connecticut</td>
<td>Ohio</td>
<td>Wyoming</td>
<td>3.51%</td>
</tr>
<tr>
<td>22</td>
<td>Oklahoma</td>
<td>Rhode Island</td>
<td>Texas</td>
<td>3.15%</td>
</tr>
<tr>
<td>23</td>
<td>Tennessee</td>
<td>Vermont</td>
<td>WSC Region*</td>
<td>2.96%</td>
</tr>
<tr>
<td>24</td>
<td>Georgia</td>
<td>U.S.**</td>
<td>Pennsylvania</td>
<td>2.57%</td>
</tr>
<tr>
<td>25</td>
<td>Kansas</td>
<td>New Jersey</td>
<td>Mississippi</td>
<td>2.48%</td>
</tr>
<tr>
<td>26</td>
<td>Hawaii</td>
<td>Indiana</td>
<td>Vermont</td>
<td>2.35%</td>
</tr>
<tr>
<td>27</td>
<td>Virginia</td>
<td>Maryland</td>
<td>New Mexico</td>
<td>2.29%</td>
</tr>
<tr>
<td>28</td>
<td>South Dakota</td>
<td>Nebraska</td>
<td>New Jersey</td>
<td>2.04%</td>
</tr>
<tr>
<td>29</td>
<td>Minnesota</td>
<td>North Dakota</td>
<td>New Hampshire</td>
<td>1.99%</td>
</tr>
<tr>
<td>30</td>
<td>Alabama</td>
<td>North Dakota</td>
<td>Texas</td>
<td>1.91%</td>
</tr>
<tr>
<td>31</td>
<td>Idaho</td>
<td>Texas</td>
<td>Maryland</td>
<td>1.90%</td>
</tr>
<tr>
<td>32</td>
<td>Mississippi</td>
<td>New Mexico</td>
<td>Rhode Island</td>
<td>1.67%</td>
</tr>
<tr>
<td>33</td>
<td>Missouri</td>
<td>Missouri</td>
<td>Illinois</td>
<td>1.47%</td>
</tr>
<tr>
<td>34</td>
<td>New Hampshire</td>
<td>Illinois</td>
<td>WSC Region*</td>
<td>1.21%</td>
</tr>
<tr>
<td>35</td>
<td>Kentucky</td>
<td>WSC Region*</td>
<td>Virginia</td>
<td>1.16%</td>
</tr>
<tr>
<td>36</td>
<td>North Carolina</td>
<td>Arizona</td>
<td>Missouri</td>
<td>1.07%</td>
</tr>
<tr>
<td>37</td>
<td>Nebraska</td>
<td>Michigan</td>
<td>Arizona</td>
<td>1.05%</td>
</tr>
<tr>
<td>38</td>
<td>Wisconsin</td>
<td>Kansas</td>
<td>North Carolina</td>
<td>1.02%</td>
</tr>
<tr>
<td>39</td>
<td>Massachusetts</td>
<td>Virginia</td>
<td>Kansas</td>
<td>0.98%</td>
</tr>
<tr>
<td>40</td>
<td>Rhode Island</td>
<td>Georgia</td>
<td>Michigan</td>
<td>0.77%</td>
</tr>
<tr>
<td>41</td>
<td>Louisiana</td>
<td>North Carolina</td>
<td>Michigan</td>
<td>0.63%</td>
</tr>
<tr>
<td>42</td>
<td>Delaware</td>
<td>Nevada</td>
<td>Nevada</td>
<td>0.10%</td>
</tr>
<tr>
<td>43</td>
<td>Oregon</td>
<td>Iowa</td>
<td>Oklahoma</td>
<td>0.14%</td>
</tr>
<tr>
<td>44</td>
<td>Michigan</td>
<td>Oklahoma</td>
<td>South Carolina</td>
<td>0.34%</td>
</tr>
<tr>
<td>45</td>
<td>Maine</td>
<td>South Carolina</td>
<td>Connecticut</td>
<td>0.38%</td>
</tr>
<tr>
<td>46</td>
<td>Arkansas</td>
<td>Florida</td>
<td>Iowa</td>
<td>0.89%</td>
</tr>
<tr>
<td>47</td>
<td>Vermont</td>
<td>West Virginia</td>
<td>Tennessee</td>
<td>1.57%</td>
</tr>
<tr>
<td>48</td>
<td>Montana</td>
<td>Mississippi</td>
<td>Kentucky</td>
<td>1.57%</td>
</tr>
<tr>
<td>49</td>
<td>Iowa</td>
<td>Tennessee</td>
<td>West Virginia</td>
<td>4.30%</td>
</tr>
<tr>
<td>50</td>
<td>North Dakota</td>
<td>Mississippi</td>
<td>Kentucky</td>
<td>4.30%</td>
</tr>
<tr>
<td>51</td>
<td>Wyoming</td>
<td>Kentucky</td>
<td>Louisiana</td>
<td>6.49%</td>
</tr>
<tr>
<td>52</td>
<td>West Virginia</td>
<td>Arkansas</td>
<td>Rhode Island</td>
<td>7.83%</td>
</tr>
<tr>
<td>53</td>
<td>Maryland</td>
<td>Alabama</td>
<td>Massachusetts</td>
<td>12.76%</td>
</tr>
</tbody>
</table>

*Average for the West South Central Region, CMS Region VI, which includes Arkansas, Louisiana, New Mexico, Oklahoma and Texas

**Average for the entire United States

Source: American Hospital Association, Hospital Statistics, 2017
### INPATIENT CHARGES BY PAYER CATEGORY

<table>
<thead>
<tr>
<th>PAYER CATEGORIES</th>
<th>NUMBER OF DISCHARGES</th>
<th>% DISCHARGES</th>
<th>TOTAL CHARGES</th>
<th>AVERAGE CHARGE PER STAY</th>
<th>% TOTAL CHARGES</th>
<th>MEAN STAY (DAYS)</th>
<th>AVERAGE CHARGE PER DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>164,927</td>
<td>41.70%</td>
<td>$5,750,627,236</td>
<td>$34,868</td>
<td>49.30%</td>
<td>6</td>
<td>$5,811</td>
</tr>
<tr>
<td>HMO/Comm. Ins.</td>
<td>36,496</td>
<td>9.20%</td>
<td>$1,058,739,794</td>
<td>$29,109</td>
<td>9.10%</td>
<td>4.63</td>
<td>$6,266</td>
</tr>
<tr>
<td>Medicaid</td>
<td>80,770</td>
<td>20.40%</td>
<td>$1,787,877,395</td>
<td>$22,135</td>
<td>15.30%</td>
<td>5.34</td>
<td>$4,145</td>
</tr>
<tr>
<td>Self-Pay/No Charge</td>
<td>16,182</td>
<td>4.10%</td>
<td>$315,720,186</td>
<td>$19,477</td>
<td>2.70%</td>
<td>5.39</td>
<td>$3,753</td>
</tr>
<tr>
<td>Other Gov. Programs</td>
<td>4,417</td>
<td>1.10%</td>
<td>$140,782,234</td>
<td>$31,873</td>
<td>1.20%</td>
<td>4.42</td>
<td>$7,211</td>
</tr>
<tr>
<td>Other/Unknown*</td>
<td>92,345</td>
<td>23.40%</td>
<td>$2,607,733,372</td>
<td>$28,239</td>
<td>22.40%</td>
<td>4.32</td>
<td>$6,537</td>
</tr>
<tr>
<td>ALL CATEGORIES</td>
<td>395,137</td>
<td>100.00%</td>
<td>$11,660,930,217</td>
<td>$29,511</td>
<td>100.00%</td>
<td>5.3</td>
<td>$5,573</td>
</tr>
</tbody>
</table>

*Includes Arkansas Private Option patients

Source: Arkansas Department of Health, Hospital Discharge Database, 2015 data (most recent available)

### EMERGENCY DEPARTMENT CHARGES BY PAYER

<table>
<thead>
<tr>
<th>PAYER CATEGORIES</th>
<th>NUMBER OF ED DISCHARGES*</th>
<th>% OF ED DISCHARGES</th>
<th>TOTAL CHARGES</th>
<th>AVERAGE CHARGES PER STAY</th>
<th>% TOTAL CHARGES</th>
<th>% OF ED</th>
<th>TOTAL CHARGES</th>
<th>AVERAGE CHARGES PER STAY</th>
<th>% OF ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>233,610</td>
<td>19.30%</td>
<td>$714,606,838</td>
<td>$3,059</td>
<td>26.20%</td>
<td>26.20%</td>
<td>$714,606,838</td>
<td>$3,059</td>
<td>26.20%</td>
</tr>
<tr>
<td>HMO/Comm. Ins.</td>
<td>99,110</td>
<td>8.20%</td>
<td>$289,867,239</td>
<td>$2,925</td>
<td>10.60%</td>
<td>10.60%</td>
<td>$289,867,239</td>
<td>$2,925</td>
<td>10.60%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>362,259</td>
<td>30.00%</td>
<td>$621,762,053</td>
<td>$1,716</td>
<td>12.80%</td>
<td>12.80%</td>
<td>$621,762,053</td>
<td>$1,716</td>
<td>12.80%</td>
</tr>
<tr>
<td>Self-Pay/No Charge</td>
<td>139,616</td>
<td>11.60%</td>
<td>$275,201,387</td>
<td>$1,971</td>
<td>15.10%</td>
<td>15.10%</td>
<td>$275,201,387</td>
<td>$1,971</td>
<td>15.10%</td>
</tr>
<tr>
<td>Other Gov. Programs</td>
<td>172,980</td>
<td>14.00%</td>
<td>$43,801,086</td>
<td>$2,436</td>
<td>1.60%</td>
<td>1.60%</td>
<td>$43,801,086</td>
<td>$2,436</td>
<td>1.60%</td>
</tr>
<tr>
<td>Other/Unknown**</td>
<td>355,955</td>
<td>29.50%</td>
<td>$781,689,238</td>
<td>$2,196</td>
<td>18.70%</td>
<td>18.70%</td>
<td>$781,689,238</td>
<td>$2,196</td>
<td>18.70%</td>
</tr>
<tr>
<td>ALL CATEGORIES</td>
<td>1,208,530</td>
<td>100.00%</td>
<td>$2,726,927,841</td>
<td>$2,256</td>
<td>100.00%</td>
<td>100.00%</td>
<td>$2,726,927,841</td>
<td>$2,256</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

*Excludes non-emergency visits

**Includes Arkansas Private Option Patients

Source: Arkansas Department of Health, Hospital Discharge Database, 2015 data (most recent available)

### IMPACT OF SELF-PAY (UNINSURED) EMERGENCY VISITS ON ARKANSAS HOSPITALS

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Self-Pay/No Charge Patients Admitted</td>
<td>297,241</td>
<td>168,779</td>
<td>139,616</td>
</tr>
<tr>
<td>Self-Pay/No Charge As % of All Patients Admitted</td>
<td>25.56%</td>
<td>13.92%</td>
<td>11.55%</td>
</tr>
<tr>
<td>Total Uncovered Charges ($ Millions)</td>
<td>$516</td>
<td>$303</td>
<td>$275</td>
</tr>
<tr>
<td>Total Uncovered Costs ($ Millions)</td>
<td>$126</td>
<td>$69</td>
<td>$60</td>
</tr>
</tbody>
</table>

Source: Arkansas Department of Health, Hospital Discharge Data Program (reflects most recent data available)
## Impact of Self-Pay (Uninsured) Inpatients on Arkansas Hospitals, 2006-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Number Self-Pay/No Charge Patients Admitted</th>
<th>Self-Pay/No Charge As % of All Patients Admitted</th>
<th>Total Uncovered S/P Charges ($ Millions)</th>
<th>Total Uncovered S/P Costs ($ Millions)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>27,963</td>
<td>6.50%</td>
<td>439</td>
<td>162</td>
</tr>
<tr>
<td>2007</td>
<td>30,296</td>
<td>7.08%</td>
<td>485</td>
<td>174</td>
</tr>
<tr>
<td>2008</td>
<td>30,121</td>
<td>7.08%</td>
<td>518</td>
<td>185</td>
</tr>
<tr>
<td>2009</td>
<td>30,199</td>
<td>7.23%</td>
<td>593</td>
<td>201</td>
</tr>
<tr>
<td>2010</td>
<td>28,142</td>
<td>6.82%</td>
<td>583</td>
<td>201</td>
</tr>
<tr>
<td>2011</td>
<td>28,676</td>
<td>6.99%</td>
<td>618</td>
<td>218</td>
</tr>
<tr>
<td>2012</td>
<td>27,241</td>
<td>7.46%</td>
<td>610</td>
<td>216</td>
</tr>
<tr>
<td>2013</td>
<td>29,240</td>
<td>4.21%</td>
<td>694</td>
<td>216</td>
</tr>
<tr>
<td>2014</td>
<td>16,632</td>
<td>4.10%</td>
<td>368</td>
<td>126</td>
</tr>
<tr>
<td>2015</td>
<td>16,182</td>
<td></td>
<td>315</td>
<td>104</td>
</tr>
</tbody>
</table>

Source: Arkansas Department of Health, Hospital Discharge Data Program (reflects most recent data available)

*Estimate based on statewide cost-to-charge ratio

## Arkansas Hospitals

### Uncompensated Care Costs, 2006-2015

| Year | Gross Revenues (Billed Charges) | Net Revenues ($ Collected) | Other Operating Revenue | Gross + Other Revenue | Total Operating Costs | Cost-to-Charge Ratio *
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>12,002,276,866</td>
<td>4,429,611,024</td>
<td>154,744,439</td>
<td>12,157,021,305</td>
<td>4,437,596,804</td>
<td>31.59%</td>
</tr>
<tr>
<td>2007</td>
<td>12,805,540,523</td>
<td>4,584,908,031</td>
<td>162,165,731</td>
<td>12,967,706,354</td>
<td>4,585,732,810</td>
<td>30.52%</td>
</tr>
<tr>
<td>2008</td>
<td>11,818,610,265</td>
<td>4,801,656,026</td>
<td>169,341,834</td>
<td>13,988,333,459</td>
<td>4,921,858,438</td>
<td>30.22%</td>
</tr>
<tr>
<td>2009</td>
<td>15,211,301,888</td>
<td>5,056,912,363</td>
<td>193,995,646</td>
<td>15,455,304,013</td>
<td>5,501,736,250</td>
<td>28.53%</td>
</tr>
<tr>
<td>2010</td>
<td>16,295,092,727</td>
<td>5,288,563,017</td>
<td>221,896,629</td>
<td>16,510,059,646</td>
<td>5,246,234,974</td>
<td>26.70%</td>
</tr>
<tr>
<td>2011</td>
<td>13,787,817,253</td>
<td>5,280,968,970</td>
<td>220,871,438</td>
<td>17,608,888,491</td>
<td>5,336,539,234</td>
<td>25.15%</td>
</tr>
<tr>
<td>2012</td>
<td>18,369,475,018</td>
<td>5,899,244,204</td>
<td>256,662,838</td>
<td>18,625,637,656</td>
<td>5,795,240,612</td>
<td>25.85%</td>
</tr>
<tr>
<td>2013</td>
<td>19,905,752,056</td>
<td>5,770,659,253</td>
<td>265,134,349</td>
<td>20,174,886,395</td>
<td>5,917,263,241</td>
<td>24.42%</td>
</tr>
<tr>
<td>2014</td>
<td>21,208,360,769</td>
<td>5,903,068,665</td>
<td>308,493,708</td>
<td>21,516,854,477</td>
<td>5,975,998,987</td>
<td>22.73%</td>
</tr>
<tr>
<td>2015</td>
<td>23,254,353,505</td>
<td>5,465,621,660</td>
<td>249,634,077</td>
<td>23,503,987,582</td>
<td>6,299,543,986</td>
<td>21.94%</td>
</tr>
</tbody>
</table>

Source: American Hospital Association, Hospital Statistics, 2017 (reflects most current data available)
MEDICAID ESSENTIAL FOR ARKANSAS

More than 60% of Arkansas children are covered by Medicaid (including ARKids A and B), according to a newly-released study conducted by the Georgetown University Center for Children and Families and the University of North Carolina’s NC Rural Health Research Program.

Arkansas leads the nation in the number of children covered under the program, followed by Mississippi, New Mexico, Florida and South Carolina.

The study used United States Census Bureau data to analyze Medicaid coverage of adults and children in rural areas between 2008 and 2015. Among other key findings, the study confirmed that Medicaid covers a larger share of children and families in small towns and rural areas than in large metropolitan areas.

It also found that the Affordable Care Act’s Medicaid expansion is having a disproportionately positive impact on small towns and rural areas, with the rate of uninsured adults in expansion states decreasing by 11 percentage points in rural areas of these states overall.
SAVE THE DATE

THE NEW PLAYBOOK FOR HEALTHCARE

AHA’s 87th Annual Meeting & Trade Show
October 4-6, 2017
Little Rock Marriott
ARKANSAS TRAUMA SYSTEM REDUCES PREVENTABLE DEATHS

The state’s trauma system reduced the rate of preventable trauma deaths by about half over five years, and taxpayers saw a nine fold return on their investment in the system, according to a study led by faculty at the University of Arkansas for Medical Sciences (UAMS).

The study, "Does the Institution of a Statewide Trauma System Reduce Preventable Mortality and Yield a Positive Return on Investment for Taxpayers?" compared figures from before and after the Arkansas Trauma System’s implementation in 2010. It appeared in the Journal of the American College of Surgeons in April.

Before the trauma system, the preventable death rate was 30 percent. Afterward, it dropped to 16 percent. In raw numbers, the rate drop resulted in 79 lives saved over a 12-month period.

The study found that the number of lives saved represented a $186 million annual positive impact on the Arkansas economy, compared to $20 million per year in public funding for the system.

The study was funded by the Arkansas Department of Health.

POLICY PERSPECTIVE
When many close family members are involved in the health care industry, there’s a good chance you’ll find yourself working in the field as well. That’s what happened to Scott Barrilleaux, CEO at Drew Memorial Health System in Monticello.

His two older sisters each hold PhDs, one in nursing and the other in statistics. And his brother-in-law is a health care attorney. “I have had exposure to the health care industry for years, and it seemed natural for me to follow that same path myself.”

So, in the mid-1990s, he went to work for a company that sold rehabilitation and durable medical equipment. “It was work I enjoyed, but an unusual set of circumstances led me down another path in the medical field – the path of hospital administration.”

Barrilleaux had been considering entry into the Tulane University master’s program in health care administration. One day while playing golf, his group came upon another group, and they started playing together.

“We were involved in friendly conversation, and one of the guys asked what I did for a living. I told him about my work, and that I was considering the Tulane University program,” Barrilleaux says. “He told me he highly recommended the program, because he was the program director!”

Barrilleaux entered the program and was nearing completion of the course of study when his employer decided to close the doors of his business. Each employee was given three months’ notice, so Barrilleaux decided to use this time to explore how to break into a career as a hospital administrator.

It is often said, “if you can see it, you can be it,” and Scott Barrilleaux is living proof that this is true. He set a goal, then went to work making it happen.

“I visited with the chair of the American College of Healthcare Executives in my home state of Louisiana, and he said he would give me the names of people to talk with,” Barrilleaux says. “I’m going to give you three names,” the exec said. “I am willing to tell you how to get there, but not how to drive.”

Barrilleaux talked with the hospital CEOs shared by the ACHE exec. He asked how to find a job as an administrator. One of the leaders knew that the hospital at Kinder, Louisiana was ready to begin interviewing for a new CEO. Barrilleaux got the position.

That was in 2002. He took his determination in finding a job as an administrator and transferred this energy into being a successful hospital leader. Barrilleaux took his first hospital from a $4 million operation to a $14 million operation. The secret to his success? Dedication to helping hospitals and the communities they serve. “I love what I do,” he says. “I love building systems that help a hospital staff make a real difference.”

Barrilleaux has since served five other hospitals: Neshoba County General Hospital in Philadelphia, Mississippi; Logan County Medical Center in Guthrie, Oklahoma; Homer Memorial in Homer, Louisiana; Madison Parish Hospital in Tallulah, Louisiana; and now, three years at Drew Memorial Hospital in Monticello.

He is most proud of the expansion occurring currently at Drew Memorial. “Before I came to Monticello, there was a desire by the community to build a new surgery center. One of the first things we did was to do a market analysis to find out what type of brick and mortar operation would make the most sense for the community,” he says. Growth is important, but growth through smart investments that meet the community’s needs is even more important.

After confirming the community need, they did, indeed, decide to build a new surgery center – one to replace
What are you currently reading for enjoyment?
My wife and I read Scripture a lot; it’s important to our life and our faith. I also read the news, but that isn’t always so enjoyable…

What would you do if you weren’t in health care?
I would probably be in my grandfather’s family business. Back in the days after World War II, he returned to Louisiana and was one of the only men in our parish who was French-speaking. He founded a plumbing business and soon had all the French-speaking families as customers. That business has grown and is still operating today.

Where is home?
I grew up in Thibodaux, Louisiana, and much of my family is still there. I love living in Monticello. The community is fantastic, plus it’s just a 6-hour drive to get back to Thibodaux and some of my Mom’s home cooking!

What’s the best advice you ever received?
One of the gentlemen I visited with on my quest to break into the world of hospital administration shared this: When you’re working with your Board and an important vote is coming up, always enter the room knowing exactly where the votes are before you even start the meeting. This has helped me over the years when it was time to introduce something new or challenging. It was great advice.

the original built in 1975. Also included in the expansion are a new obstetrics area, outpatient clinic space and a complete overhaul of the hospital’s lab. “The slab has now been poured and there’s sheet rocking going on,” he says. “This is a very exciting time for our community.” The new facility will open in the summer of 2018.

The hospital is also undergoing a new branding campaign. “We are officially changing our name to Drew Memorial Health System,” Barrilleaux says. “Though we’re phasing in the name change, it will all be in place by the time of our grand opening next year.” The new name appropriately reflects the commitment of the Drew Memorial team to improving the health of its community.

Family led Scott Barrilleaux to health care, but dedication to improvement led him to administration and to the community he serves today.
MEDICAL SCHOOL AT ASU IS TELEHEALTH TRAILBLAZER

by Jillian McGehee, Editor
Arkansas's second and newest medical school, at the tender age of one, offers something other medical schools in America do not – an unprecedented focus on teaching the technologies and relationship techniques distinctive to the world of telemedicine.

The New York Institute of Technology College of Osteopathic Medicine (NYITCOM) at Arkansas State University in Jonesboro (Arkansas’s new osteopathic med school housed at ASU) just completed its first year of operation. Important to its mission is preparing future physicians who are ready to comfortably work within the newest patient contact technologies born of the digital age, says the school’s dean, Dr. Shane Speights.

Osteopathic physicians, who are fully licensed and practice in every medical specialty, offer a unique approach to patient care by looking at the whole person. They reach diagnoses through a holistic approach not based solely on a patient’s presenting symptoms.

ASU’s osteopathic medical school opened its doors in August 2016; its parent, NYITCOM, was established in 1977. Leaders at the institute early on put in place a strong medical curriculum designed to produce excellent physicians and researchers, Speights said.

“But you also have to prepare physicians who are ready to work within the technologies and patient care methods evolving today,” he says. Speights leads faculty and students in academic co-curricular activities including telemedicine and engaging in community outreach with hospitals and physicians in Jonesboro and the greater Delta region.

Earning his medical degree from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Speights is an Arkansas native and no stranger to Northeast Arkansas. He completed his residency training at the University of Arkansas for Medical Sciences (UAMS) Northeast Center in Jonesboro, which is one of eight UAMS regional centers located throughout the state. His residency in Family Medicine was completed at St. Bernards Medical Center, Jonesboro.

**FILLING A NEED**

The osteopathic school is especially important to Northeast Arkansas as it seeks to fulfill health needs of patients in the Delta and surrounding states through the art of telemedicine, Speights notes.

Telemedicine is important anywhere, he says, adding that, for example, it can ease the frustrations of patients in New York who might have trouble getting places because of intense traffic. In the Delta, patients may experience other challenges, such as being unable to afford travel to a specialty clinic located half a state away from a patient's hometown.

“The thing we ask ourselves is, ‘How do we make health services more accessible for patients?’” he says.

**PREPARING FUTURE PHYSICIANS**

NYITCOM begins the telemedicine experience by introducing first-year medical students to the equipment itself, and the beginning concepts of how to interact with patients through screen-based technologies. “We start to remove barriers to the utilization of telemedicine that first year,” Speights says.

Each successive area of medical study incorporates telemedicine. Some specialties are more suited than others to having the patient/physician relationship occur by way of the Internet, but every specialty can make use of telemedicine as a tool where physicians interact with their patients to provide information and education, he says. “It’s the engaging of patients in discussion with their physicians that often makes the difference in a patient’s care,” Speights explains. In his own practice, he has utilized telemedicine to save his patients driving an hour or more for an office visit. “Physicians don’t necessarily have to physically be in front of a patient to provide that critical information and education.”

Telemedicine can save not only patients’ time, but also medical dollars for both the provider and the patient, Speights says. “Surgery follow-up (where the surgery was performed in a city distant from the patient’s home) is a good example of this,” he explains. “Telemedicine allows any post-surgical patient to travel mere minutes to their local clinic or hospital where they can remotely talk with their surgeon, who may be located hours away in another city, using today’s telemedicine technology.”
That’s what we’re teaching our students: how to communicate and maintain patient/physician relationships remotely through the skilled use of telemedicine."

“As our students progress through their medical school careers,” Speights says, “we require them to complete rural rotations and work within our telehealth communities to help them advance their skills in telemedicine.”

**FACING OBSTACLES**

“In current practice, the biggest obstacle with telemedicine is not with the patients,” Speights says. “It’s with the doctors. They see telemedicine as cutting into their rhythm; this is largely because they weren’t trained to use it effectively.”

He comments that too often, he will walk into rural hospitals and see the physical components of telemedicine sitting idle. “The technology is in place, but adoption of its use can be slow,” Speights says.

“We’re trying to overcome perceived hurdles by introducing telemedicine as a truly personal approach to the practice of medicine,” he says. “Medicine is rapidly evolving and being able to keep pace is a difficult challenge, but this method of practice can make all the difference when a community is short of physicians, or patients live in isolated communities.”

“Older adults typically are the highest utilizers of health care,” Speights notes. “You’ll hear this age group isn’t welcoming the new technology, but our experience shows that a huge percentage of retirees readily accept it and are routinely using it.”

Indeed, studies show that older adults embrace telemedicine technologies and telehealth advancements now more than ever before.

A dozen years ago, a 2005 AARP study looking at the then-newer field of telemedicine and its acceptance by older populations debunked the notion that older adults don’t go online. “This may have once been true, but it’s rapidly changing,” the study indicates. “As Boomers grow into the AARP demographic, use of the Internet won’t just be an option, it will be the first choice of health communication tools.”

Six years ago, Humana Cares launched an extensive remote care management program where 2,000 of its members with congestive heart failure (100% of whom were aged 65 or older) were given remote care monitoring devices that included daily biometric monitoring and member education. Near the conclusion of the pilot, participants expressed high satisfaction with the technology and, in fact, were reluctant to give it up. Kate Marcus, clinical operations manager for Humana Cares, said at the time, “As we are removing these devices from the home, we are seeing how connected the members are to their devices and how connected they are to their [program] nurses.”

**CHARGING ON**

Many such studies and successive programs with telehealth at their core support Speights’ suggestion that teaching medical students the proper uses and intricacies of telemedicine is imperative in today’s health care world.

The new ASU-based NYITCOM school of osteopathic medicine provides one of many paths for Arkansans to pursue as they seek careers in medicine. “A lot of people who grow up here don’t want to leave. This school gives people a new option, and it makes health care better for everyone,” Speights says.

Dr. Speights would like to acknowledge that the NYITCOM-ASU campus would not have been established and running successfully today without the support of Jonesboro’s St. Bernards hospital, the local Chamber of Commerce and the surrounding and profoundly accommodating community. Please visit www.nyit.edu/medicine for more information about its innovative approach to telemedicine and the teaching of future physicians.
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 levels. 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

BancorpSouth Insurance Services, Inc.

PROFESSIONAL LIABILITY | PROPERTY | LOSS CONTROL | TPA SERVICES
(501)664-7705 • www.bsrli.com

BancorpSouth Insurance Services, Inc. is a wholly owned subsidiary of BancorpSouth Bank. Insurance products are not a deposit • not FDIC insured • Not insured by any federal government agency • Not guaranteed by the bank • May go down in value.

DATA DRIVES DECISIONS™

WHAT’S THE SUREST ROUTE TO THE MOST COMPETITIVE BENEFITS STRATEGY?

With relevant data, you have reliable markers on the road to confident decision making. Gallagher’s Benefits Strategy & Benchmarking Survey gives you access to data from over 3,000 employers, and multiple insights for effectively implementing your employee benefits.

Let us help you map a measurable, sustainable strategy for containing costs and competing for the right talent.

BENEFITS & HR CONSULTING

Arthur J. Gallagher & Co.

To learn more, contact:
Merlin Hagan, Chris Newkirk or Jeff Goff
Gallagher Benefit Services, Inc.
6325 Ranch Drive, Little Rock, AR 72223
T: 501.485.3075 • F: 501.485.3076

ARKANSAS HOSPITAL ASSOCIATION • 53
Barriers have challenged the widespread adoption of telemedicine, even as the use of telehealth technologies for clinical diagnosis and treatment, care management, and health education has moved from an experimental venture to an integral part of our health system. Among those barriers are technological and financial issues, certainly, but legal concerns have also been a major obstacle to expansion.
As recently as 2015, Arkansas was ranked by national organizations as among the most restrictive telemedicine environments in the nation. But action by the Arkansas General Assembly this spring may help to expand the availability of telehealth in the state.

**TELEMEDICINE DEFINED**

The definition of telemedicine may vary from state to state, and this definition often impacts state health policy. The Arkansas General Assembly now has provided a comprehensive definition in Act 203 of 2017, which goes into effect in early August.

Unlike the more narrow definition in prior law, Act 203 defines telemedicine as “the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient.”

The Act also explicitly includes “remote patient monitoring” and “store-and-forward technology” within the definition of telemedicine. Remote patient monitoring is the use of telehealth technology to gather health data and monitor patients outside of the usual clinical settings. It can be particularly useful for patients with chronic conditions such as diabetes. Store-and-forward technology is an alternative to “real time” audio/video interaction that involves sending health information (such as a questionnaire, image, test result, video, etc.) to the clinician for study and evaluation. Store-and-forward can take the place of a face-to-face interaction, or it may come before or after a consultation.

**PATIENT-PROVIDER RELATIONSHIP**

Much of the telemedicine debate in Arkansas has centered around the requirements for establishing a physician-patient relationship sufficient to support telemedicine services.

Prior to September 2016, Arkansas medical regulations required an initial in-person physical examination in order to establish a valid physician-patient relationship. Telemedicine services could not be provided without the existence of a previously existing physician-patient relationship.

Effective September 6, 2016, the
Arkansas Medical Board amended its rules to allow an initial patient-physician relationship to be established through the use of real time audio and visual telemedicine technology that provides information “at least equal to” the information that would have been obtained by an in-person examination.

Then, in the 2017 legislative session, the Arkansas General Assembly passed Act 203 of 2017, which amended the state’s telemedicine laws to provide even broader availability of telehealth across the state. While prior law only addressed physician-provided telemedicine, the new law authorizes telemedicine services by other licensed providers.

As recently as 2015, Arkansas was ranked by national organizations as among the most restrictive telemedicine environments in the nation. But action by the Arkansas General Assembly this spring may help to expand the availability of telehealth in the state.

The Arkansas Medical Board regulations remain significant, however, because other providers’ licensing boards are prohibited from issuing regulations that allow formation of a provider-patient relationship under circumstances that are less restrictive than those set forth by the Arkansas Medical Board.

Notably, the 2017 law maintains restrictions on certain mechanisms used in other states to establish physician-patient relationships. For example, some national companies use a care model that lets them receive a patient’s medical history, then allow the patient to talk by
phone with a doctor the patient has not met about minor health issues.

Arkansas Act 203 states that a provider cannot form a relationship with a patient using an internet questionnaire, email, patient-generated medical history, audio-only communication (such as a telephone), text, fax or any combination of these. While Arkansas no longer is the most restrictive environment for telemedicine, this provision is still more restrictive than the laws found in many other states.

**ORIGINATING SITE**

In addition to clarifying the requirements for establishing a patient-provider relationship, Act 203 also cleared the way for home-based telemedicine services. Prior Arkansas law prohibited patients from receiving telemedicine services outside of clinics or other health care facilities, but Act 203 modified the definition of “originating site” to allow services to be provided wherever the patient is located at the time of the telehealth consultation.

The Act also has implications for school-based telemedicine programs, requiring school-based programs that treat Medicaid recipients to use either the child’s regular primary care physician or a physician with a cross-coverage arrangement with the regular physician, or to have authorization from the child’s regular primary care physician.

**CONTINUED EVOLUTION**

While Act 203 certainly will help bring Arkansas law more in line with the laws applicable in other states (and hopefully permanently move us out of the “most restrictive state” category), our statutes probably will see further changes in future legislative sessions. As technology develops, both patient and provider demand are likely to spur increased use of telehealth. And the law will have to keep up.
For you to provide proper care to your patients, you need a reliable infrastructure that’s fully protected and completely secure. And since care can happen in a variety of locations, it’s vital that your entire IT and Telephone Network is built to work.

Network Services Group

www.nsgdv.com • 501-758-6058

National Ambulance Accreditation
Commission on the Accreditation of Ambulance Services

Need help with a transfer?
Call our Dispatch (877) 672-4595

Have EMS questions?
Call our Business Office (870) 734-3366

“Serving your communities like our family”

www.southernparamedic.com
Take a nature break and support conservation in The Natural State.

ARKANSAS Wildlife

$12 one year  $20 two years  $25 three years

Six issues per year – including the July-July calendar. Call 800-283-2664 or visit www.ArkansasWildlife.com

Perfect for any office!
SAVE YOUR HOSPITAL SO MUCH MONEY,
THE BOARD GIVES YOU A STANDING OVATION.

With more vendors, options and increased savings, there are plenty of reasons to let us guide you. Call us today, and we’ll make you the rockstar around the hospital.

Welch, Couch & Company, PA is a full service accounting firm offering a wide range of services to the healthcare industry.

- Financial Statement and Employee Benefit Plan Audits
- Medicare and Medicaid Cost Report Preparation
- Reimbursement and Compliance Issue Consulting
- Critical Access Hospital Consulting
- Revenue Cycle Analysis
- Feasibility Studies
- IRS Form 990 Preparation
- Strategic Planning for Acquisitions, Sales, Mergers and Expansions

At Welch, Couch & Company, PA, we have made a commitment to providing professional services to the healthcare industry. Our experienced professionals work closely with clients and their staff to ensure they are receiving the level of service you should expect out of your CPA firm.

Batesville, Arkansas
Bill Couch, CPA, FHFMA
870.793.5231
www.welchcouch.com
CONFRONTING UNCERTAINTY

Health Reform and Rural Providers

by Michael Topchik, national leader, the Chartis Center for Rural Health

The uncertainty surrounding the future of the ACA/AHCA will likely continue to be unsettling for rural providers – especially when the potential for changes in legislation threatens financial viability and stability.

The repeal and replacement of the ACA/AHCA continues to be wrangled in Washington and in town halls across the country. Key elements of this proposed legislation would impact rural providers either directly or indirectly, including:

- Reversal of ACA’s cuts in federal disproportionate share hospital (DSH) Medicaid payments;
- An increase in the uninsured; and
- Rolling back Medicaid expansion and adding potential long-term funding constraints through Medicaid restructuring.

The uncertainty surrounding the future of the ACA/AHCA will likely continue to be unsettling for rural providers – especially when the potential for changes in legislation threatens financial viability and stability. The Chartis Center for Rural Health (CCRH) and iVantage Health Analytics have taken a close look at the rural health safety net and the impact of the potential policy changes on rural providers – and their communities. Earlier this year, we published the Rural Relevance Study to offer a unique lens into the state of rural health care, the value the safety net provides and the opportunities for the future.
As part of the 2017 study, CCRH explored the intersection of rural provider performance and the socioeconomic challenges and health disparities faced by rural communities. Our population health assessment measures the health status of rural populations by evaluating health outcomes, quality of care, access to care, health behaviors, and social, economic, and environmental determinants of health.

Using nearly 70 metrics, the CCRH quantified the health status of each rural provider’s community.

**Comparison of Population Health in Rural and Non-Rural Hospital Communities**

*Population Health metrics are percentile ranked for all acute care rural and non-rural providers by hospital service area such that lower ranks indicate greater population challenges.

**Lower percentile scores indicate higher density (i.e. providers serving a greater proportion of individuals over 65 receive lower scores).**

Our research validates the hypothesis that rural health care providers serve populations which are not only socioeconomically disadvantaged but also suffer from numerous health disparities and poorer outcomes than non-rural communities.

The closure of 80 rural hospitals across the country since 2010 underscores the challenges faced by rural providers, and research indicates that many more are struggling to stay open. This is an indication that the rural health safety net continues to unravel, putting the mission to care for rural populations in jeopardy in a number of states. In fact, forty-one percent of U.S. rural hospitals operate at a negative margin. Taking a closer look at the rural landscape here in Arkansas provides valuable information about the current fragility of our rural providers.

In addition to the current market forces that affect rural health operating margins, there are a number of policy changes already impacting the financial health of rural providers and a few which remain in question given the new administration in

**Current Fragility of our Rural Providers**

- 50 RURAL PROVIDERS (CAH & PPS)
- 1 MEDIAN RURAL OPERATING MARGIN (%)
- 21 RURALS WITH NEGATIVE OPERATING MARGIN
- Y MEDICAID EXPANSION
Washington. Across rural health care, the average payer mix of rural providers shows that 61% comes from government, compared with 45% for non-rural providers. Medicare payments to rural hospitals and physicians are dramatically less than those to their urban counterparts for equivalent services.

Thus, study findings suggest that policies such as sequestration, bad debt cuts, potential changes in Critical Access Hospital reimbursements, and rural PPS Coding Offset will not only negatively impact rural hospital revenues, but may have broader consequences for rural populations.

Here in Arkansas, the impact of these potential legislative policies on rural providers and their communities would be significant:

$116,229,716
Loss in Revenue
(10 years)

6,235
Loss in Jobs
(10 years)

$732,955,188
GDP Loss
(10 years)

In summary, the rural health safety net across the country serves a population that is older, poorer and sicker with less access to care than their non-rural counterparts. This population has a higher proportional demand for health care given baseline health disparities. The rural health safety net is anchored by rural hospitals that offer critical access to quality care. Through federal and state policies and rural-relevant reimbursements, this safety net has been designed to provide access to populations which are geographically dispersed and often underserved. Yet this safety net continues to be threatened by potential policy changes at both state and federal levels.

Against this context, rural providers here in Arkansas and across the country should act now to prepare for changes ahead. Developing a comprehensive understanding of an organization’s current performance, position and exposure is critical, as is aligning leadership around the most likely scenarios ahead. As has been the case for the last six years, the Rural Relevance Study offers a snapshot into the state of rural health care, the value the safety net provides and the challenges and opportunities for the future.

To download a copy of the study, visit http://www.ivantageindex.com/2017-rural-relevance-study.

And to learn more about how your hospital is performing, with a customized performance snapshot, please contact us at inquiry@ivantagehealth.com.

iVantage Health Analytics and the Chartis Center for Rural Health (CCRH) are part of the Chartis Group. Access to their services is offered through an endorsement agreement with AHA Services, Inc. The CCRH offers knowledge and expertise, performance management solutions, research and education to help rural providers improve health care delivery in their communities. For more information, contact Tina Creel at 501.224.7878 or tcreel@arkhospitals.org.
In May, the National Academies of Sciences, Engineering, and Medicine released an expert consensus report, Global Health and the Future Role of the United States, which identifies global health priorities and 14 recommendations for the U.S. government and other stakeholders to consider.

"By investing in global health over the next 20 years, there is a chance to save the lives of millions of children and adults," said Valentin Fuster, physician-in-chief at Mount Sinai Hospital, who co-chaired the committee that authored the report.

"The health and well-being of other countries both directly and indirectly affect the health, safety, and economic security of American. The U.S. government should maintain its leadership position in global health as a matter of urgent national interest and as a global public benefit that enhances America’s international standing."

Total Health Management.
Healthy People
Healthy Business
Healthy Futures

Implementing stability, precision and quantification to ensure better patient outcomes while significantly reducing employer and member healthcare benefit costs.

HealthSCOPE BENEFITS
www.healthscopebenefits.com


JOIN US
AS WE PARTNER WITH
ay
ABOUT YOU

TO CREATE
ARKANSAS HOSPITALS
THE OFFICIAL PUBLICATION
OF THE ARKANSAS
HOSPITAL ASSOCIATION.

Administrative Consultant Service provides consultation to improve the clinical and financial outcomes of healthcare. ACS services are designed to promote clinical efficiency and effectiveness along with ethical reporting of diagnoses and procedures through education, improved documentation, and coding accuracy. With more than 30 years of trusted experience as a boutique corporation, we are able to create a CDI program designed to meet the specific needs of your facility.

Administrative Consultant Service
info@acsteam.net
405.878.0118

www.acsteam.net
The regular session of the 91st General Assembly began on Monday, January 9, 2017, and adjourned sine die on Monday, May 1, 2017, with 1127 new Acts. Immediately upon adjournment of the regular session, a special session convened – the First Extraordinary Session of 2017 – and ended after three short days. These 2017 sessions yielded many acts that will impact hospitals and the patients and communities they are so fortunate to serve. But for this legislative report, we have compiled a short list of new Acts from the regular session – our version of the Legislative Top Ten – as well as a list of the bills discussed in the Special Session.

Not on the list, but vitally important, is the Revenue Stabilization Act (RSA), which outlines Arkansas’s general revenue budget and works in concert with the appropriation bills that are enacted during the session. The RSA is the delineation of actual money that can be used within each appropriation. Arkansas’s general revenue budget for fiscal year 2018 is $5.49 billion, a $163 million increase over the current fiscal year.

This year’s RSA includes an increase of $113 million for the Department of Human Services. It also sets aside $15.8 million for the rainy-day fund, which is the fund used by the governor for emergencies, special needs and priorities that aren’t included in the general revenue budget. Within the RSA,
priorities are outlined as category "A," which are the items deemed essential and paid for first, and categories "B" and "C." Once category A is funded, the programs in category B get funded, and then category C.

As revenue forecasts come in each month, those allocations are funded in line with the RSA's priorities. Any revenues left over after expenditures made per the RSA requirements will be "surplus" funds and can be used in future budgets.

While the AHA watches the entire state budget like a hawk during the session, it is imperative that particular attention is given to the Medicaid budget and appropriation. The Medicaid appropriation is included in SB 196 of 2017. As we all are well aware, that appropriation requires a 75% approval by each legislative chamber. When the bill was introduced in the Senate, it failed to receive the 27 required votes two times before it finally passed. In the House of Representatives, the 75% threshold was finally met on the bill’s second vote. Not only does this appropriation cover the Arkansas Works program that funds health insurance for many individuals in our state, it also includes appropriations for care for children, the aged, the disabled and the mentally ill.

The special session was set aside to focus on continued Medicaid reforms. In special sessions, it is common that companion bills are filed by topic. Companion bills are those that are introduced in either the House or Senate and have identical or similar language to another bill introduced in the other chamber. In this special session, HB 1001 and its companion SB 1, were filed to make technical corrections to the ethics amendment (Article 19 in the Arkansas Constitution). A list of bills filed is, as follows:

HB 1001/SB 1 make technical corrections and incorporate three Acts of 2017 that pertain to ethics laws into Article 19 of the Arkansas Constitution.


HB 1003/SB 3 require the Department of Human Services to submit a state plan that seeks a federal waiver to amend the benefits of the Arkansas Works program by establishing a work requirement, reducing income-based eligibility and making other changes.

HB 1004/SB 4 seek to prohibit the Arkansas Health Insurance Marketplace from developing technology for a state-based marketplace platform and dissolve the current marketplace oversight committee, placing oversight and study authority with the Legislative Council.

HB 1005/SB 5 seek to move $105 million from the Health Century Trust Fund, originally created by the Master Tobacco Settlement, to an account for long-term reserve funding and repeal the provision that limited the Long Term Reserve Fund to $125 million.
The Arkansas Works companion bills, HB 1003/SB 3, likely contain the greatest potential impact to Arkansas’s hospitals and health care system overall. More than 300,000 Arkansans have received insurance coverage through the Arkansas Works program (and its predecessor, the Arkansas Private Option).

Currently, Arkansans below 138% of the federal poverty level are eligible for insurance coverage on the insurance marketplace. With the changes created by this bill, the Arkansas Works program will cover only those Arkansans with incomes below 100% of the federal poverty level and will permit those between 100% and 138% of the federal poverty level to receive subsidies to purchase insurance on the federal insurance exchange.

The Department of Human Services estimates that approximately 60,000 Arkansans will no longer be eligible for the Arkansas Works program under these conditions. The bill also imposes a work requirement on a select group of able-bodied individuals.

The Arkansas Hospital Association (AHA) expressed concerns to the governor’s staff and the Department of Human Services that the process of moving Arkansans from Arkansas Works to the federal exchange can increase the already burdensome levels of uncompensated care that hospitals deliver to patients who cannot pay for their care. The Director of the Department of Human Services, Cindy Gillespie, subsequently penned a letter to Bo Ryall, President of the Arkansas Hospital Association, stating that the Department is willing to work toward mitigating damages of uncompensated care – not only from the potential population moving from Arkansas Works to the federal exchange, but also uncompensated care that hospitals experience as they serve other populations.

The AHA also discussed concerns about other serious Medicaid reimbursement issues with Director Gillespie. AHA staff are optimistic that the regulations implemented pursuant to HB 1003/SB 3 will be crafted in a way to mitigate uncompensated care and continue to improve the patient experience.

In his opening comments to the joint session of the House and Senate that kicked off the special session, Governor Hutchinson acknowledged that his office is committed to working diligently with Arkansas providers and insurance carriers to make sure that the transition is smooth and that the impact – especially on our rural hospitals – is negligible. In fact, a hospital working group with DHS has been formed and held its first meeting on May 23.

HB 1005/SB 5 also has the potential to negatively impact healthcare in Arkansas. Since the state’s 1998 settlement with tobacco companies, Arkansas has had the Arkansas Health Century Trust Fund as a back-up for the programs originally funded from the settlement, as well as for the Medicaid program. Arkansas was one of few states that used its tobacco settlement funds solely for health care.

Once this bill is enacted, the Healthy Century Trust Fund will convert to a reserve fund that is intended to improve the state’s bond rating from AA to AAA, which might make it easier to obtain better interest rates on bonds. The Legislative Council or Joint Budget Committee would be required to approve accessing the fund with a super-majority, two-thirds vote.

Once the session concluded, House Speaker Jeremy Gillam opened a House caucus meeting to approve HR1001, a proposal to create a process for bringing forth articles of impeachment against a public official. Testimony on the floor stated that, currently, any individual member of the House with approval of the Speaker could move to begin the impeachment process. Under these rules as adopted in a 73-13 vote, at least 34 House members could sign a resolution calling for an impeachment of an elected official, and the House Speaker would be able to refer the matter to a committee for investigation. There would also be a process whereby committee members could disagree with the majority opinion of the committee and could bring forth a minority opinion that the House could consider prior to referring the matter to the Senate for trial.

Just as the state concluded its legislative business, rumors that Congress would take up a measure to repeal the Affordable Care Act were running rampant. In fact, the United States House of Representatives has done just that and has passed the American Health Care Act (AHCA), which includes potentially dire circumstances for patients and hospitals. AHA staff and member hospitals are continuing to advocate at both the state and national levels for the health of our hospitals and our citizens.
1. PROVIDER-LED ORGANIZED CARE ACT

HB 1706 (Pilkington) creates the Provider-Led Organized Care Act, which allows for certain behavioral health, mentally ill, and disabled patients to be covered by Medicaid Managed Care partnerships with Arkansas providers. Many meetings are taking place to create the regulations that will guide this program.

HB 1954 (Collins) states that if the anticipated savings from HB 1706 do not come to fruition, then the Department of Human Services has the authority to stop the program and come up with an alternative to ensure savings.

2. PEER REVIEW

SB 611 (Bledsoe) made changes to peer review in Arkansas and was strongly supported by the Arkansas Medical Society. As originally filed, the Arkansas Hospital Association opposed the measure, but after strong amendments were made to the bill, the AHA withdrew its opposition. Those changes protect peer review by (among other things): (1) ensuring that collegial interventions and other physician-to-physician reviews can be used to solve problems prior to a physician’s credentials being put at risk, (2) protecting standard quality assurance and utilization review and (3) keeping physicians, rather than lawyers, in control of peer review.

3. TORT REFORM REFERRED TO THE PEOPLE

SJR 8 (Irvin) will allow a tort reform amendment to be presented to voters on the November 2018 General Election ballot. The proposed amendment caps attorneys’ contingency fees and limits non-economic and punitive damages.

4. PRESCRIPTION MONITORING

SB 339 (Hutchinson) will require that any prescriber check the prescription drug monitoring program database every time he or she prescribes a Schedule II or III opioid and the first time that he or she prescribes a benzodiazepine. The Arkansas Department of Health will be able to add exemptions to this requirement.

5. TELEMEDICINE IMPROVEMENTS

SB 146 (Bledsoe) establishes improved standards for the practice of telemedicine and offers a platform for expanding the use of telemedicine in the state.

6. VOLUNTARY REGISTRY OF SURGICAL TECHS

SB 167 (Sanders) allows for a voluntary registry of certified surgical technologists with the Arkansas State Medical Board. There is no requirement for a certified surgical technologist to be registered in order to work for hospitals, ambulatory surgery centers or other healthcare institutions.

7. TRAUMA ADVISORY COUNCIL CHANGES

SB 612 (Irvin) changed the make-up and role of the Trauma Advisory Council from a 20-member committee to a 10-member advisory council and waived certain educational requirements that hospitals must meet to maintain trauma level designations.

8. END-OF-LIFE CARE

SB 356 (Irvin) creates physician orders for life sustaining treatment (POLST) for patients who are terminally ill and expected to live no more than one year.

SB 676 (Irvin) made some corrections to the language used in the Healthcare Decisions Act and repealed older Arkansas laws so that the older and newer laws work better together to ensure patients’ wishes are followed in the healthcare setting.

HB 1851 (Hammer) allows a hospice nurse to declare the death of a hospice patient who passes away in a hospital.

9. MEDICAID REIMBURSEMENT FOR URGENT CARE

HB 1264 (Pilkington) allows for reimbursement from the Medicaid program for care delivered in an urgent care center owned or operated by a hospital if the patient does not have a primary care physician.

10. DHS TO STUDY DRG PAYMENT METHODOLOGY

HB 1016 (Farrer) requires the Department of Human Services to study the feasibility of changing from per diem payments to a Designated Related Group (DRG) payment structure for care delivered to Medicaid patients in hospitals.

Plus a bonus … GUNS IN HOSPITALS

SB 724 (Dismang) ensures that hospitals posting appropriate signs do not have to allow guns on their premises. SB 37 (Clark) will still prohibit employers from restricting a licensed employee’s ability to possess a legally owned handgun in the employer’s parking lot in a motor vehicle.

The AHA, in collaboration with the Mitchell Williams law firm, will be distributing a full legislative report to all hospital CEOs. To request a copy, please email Jodiane Tritt at jtritt@arkhospitals.org.
Contact SHARE Today for a SHARE Analytics DEMO!

SHARE State Health Alliance for Records Exchange

The fastest, most secure way to get patient health records from one provider to another

SHARE allows your facility to securely access more than 2+ million patients with health records being exchanged by Arkansas’ health care providers. SHARE gathers your patient’s clinical data from all participating health care providers to instantly give you a holistic view of your patients’ health history, treatment and progress. That’s powerful information that can transform the way that a provider plans, delivers, and coordinates health care.

With SHARE You Can:

✓ Exchange clinical patient information in an efficient, timely and cost-effective manner
✓ Connect to hospitals, physicians, nurses, labs, long-term care entities and others involved in patient care
✓ Receive alerts using patient attribution processes so you know when your patients are released from the hospital
✓ Avoid duplicate testing and procedures through records sharing
✓ Make referrals in real time

Join SHARE Today and provide proactive, efficient, comprehensive, team-based care!

Hospital Services/Products

✓ HIE Integration of Clinical Data (HL-7 and CCD/A): Send data in to the HIE and that data can be sent to provider’s EMR systems
✓ Hospital Information System CCD/A Exchange: Integration supports Query and Response
✓ Direct Secure Messaging Integration with Hospital Information System (HIS) or Electronic Medical Records system (EMR) using XDR integration with DirectTrust Certified system for sending CCDs exchange at transitions of care: Automated with HIS to send CCDs to Providers at patient discharge without manual input
✓ Orders Gateway
✓ Immunization Registry Reporting
✓ Virtual Health Record: Viewing Consolidated Patient Records with Integrated Direct Secure Messaging
✓ DirectTrust Certified Secure Messaging using Web-based System
✓ Send Event Notifications: Admit/Discharge to Providers and Facilities
✓ SHARE Analytics
✓ No Cost ADT Interface
✓ Receive Readmissions Notifications (30 Day and 90 Day options)
✓ Public Health Reporting (Syndromic, Electronic Lab Results, Registries)

Web: SHAREarkansas.com Twitter: @SHAREarkansas Facebook: @SHAREarkansas Email: info@sharearkansas.com
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 PHO’s, Clinically Integrated Networks and ACO’s, 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
- Finance Law
- 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.

Contact Bill Marshall at 501-372-1322 • bmarshall@billmarshalllaw.com • www.billmarshalllaw.com
WE BUILD places to teach, heal, entertain and work
WE INSTALL, move and assemble industrial machinery to keep work going
WE DIG dirt to make way for roads, places to park and room to play
WE ASSESS and abate harmful substances to keep people safe
WE MAINTAIN and remodel buildings to keep things running smoothly
WE RENT equipment to get the job done