Legislative Update

Join Us in D.C. April 10-13

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As you know, two years ago during the 2009 Arkansas General Assembly, the Hospital Assessment Program became law. It was designed to raise funds for Medicaid – funds that are matched with federal dollars to bring more Medicaid funding to the state.

In its first year this “voluntary tax” brought in more than $120 million in supplemental Medicaid payments for participating hospitals.

During the 2011 General Assembly, the program was fine-tuned and signed into law by Governor Mike Beebe, making sustainable this hospital-generated Medicaid funding mechanism into the future.

I want to personally thank each of you who contacted your legislators, helping us to pass this legislation. Your involvement, your direct contact with your legislators, made clear the necessity for program updates and helped those newly elected to understand the complex program and its importance to the hospitals of Arkansas.

Nearly every state in the union faces Medicaid funding shortfalls. As I write this, Governor Beebe has just met with U.S. Health and Human Services Secretary Kathleen Sebelius, discussing Arkansas’ desire to explore new cost control methods. He asked for a waiver (permission to proceed) to be approved by May 1; if the waiver is issued, our state will tackle the challenge of totally reforming the Medicaid and commercial insurer payment system. The goal is to have details of a new proposal worked out and ready to go July 1, 2012. All eyes will be on Arkansas.

How can you be involved in this process? The governor’s office, Arkansas Medicaid, all healthcare provider associations (including your Arkansas Hospital Association), representatives of providers and insurers are gearing up for discussions. I ask that you stay abreast of the process, and I pledge to keep you informed as new ideas are hammered out. As the process unfolds, your personal involvement and input will be key.

I also want to thank those who have committed their involvement to our annual visit with the Arkansas congressional delegation; this year’s visit will mean deepening Arkansas hospitals’ relationships with our three new representatives, new senator and their staffs, assuring that they each know and understand hospital issues and how proposed cuts to both Medicare and Medicaid will bear dire consequences to local hospitals and communities.

If you haven’t made arrangements to attend the annual meeting of the American Hospital Association with us in Washington, D.C. April 9-13, please consider doing so. Your voice bearing the Arkansas hospital message to the ears of our lawmakers carries more weight than that of any other.

To each of you who work, volunteer, govern and lead in the hospital field, I ask you to get involved and stay involved as federal legislation and new state processes unfold. If you don’t know what you can do to help, just ask.

It’s going to take each of us remaining focused to keep the upheavals ahead in check, and we must work together to find answers that will keep our hospitals open and solvent so we can care for our fellow Arkansans into the future.

Bo Ryall
President and CEO
Arkansas Hospital Association
Jonathan Bates, MD, president/CEO of Arkansas Children’s Hospital in Little Rock, and Gary Bebow, FACHE, administrator/CEO of White River Health System in Batesville, have been named to the Arkansas Department of Human Services’ Medicaid Advisory Committee (MAC). Members will provide comments and opinions to the agency in connection with health-care reform and related health and medical care services issues. Each member will serve a two-year term. Anthony Walters has been named CEO at Springwoods Behavioral Health Hospital in Fayetteville. He succeeds Lucinda DeBruce.

**Education Calendar**

**April 5, Little Rock**  
Mid-Management Leadership Series: Great Leaders Help Others Act on Their Best Intentions

**April 6-8, Hot Springs**  
Healthcare Financial Management Association (HFMA) Quarterly Educational Meeting

**April 10-13, Washington, DC**  
American Hospital Association Annual Meeting

**April 15, Little Rock**  
Arkansas Social Workers in Health Care Workshop

**April 20, Little Rock**  
Administrative Professionals Workshop

**April 21, Little Rock**  
Compliance Forum

**April 22, Little Rock**  
Arkansas Organization for Nurse Executives/Arkansas Association for Healthcare Quality Joint Workshop

**April 27, Little Rock**  
Arkansas Association of Hospital Trustees Workshop

**April 27, Little Rock**  
Hospital Staff Development Workshop

**April 28, Little Rock**  
Arkansas Health Executives Forum Quarterly Luncheon

**April 29, Little Rock**  
Medicare Conditions of Participation Workshop

**May 4-6, Hot Springs**  
Society for Arkansas Healthcare Purchasing and Materials Management Annual Meeting

**May 10-11, Little Rock**  
Arkansas Foundation for Medical Care Quality Conference

**May 11-13, Little Rock**  
Arkansas Association for Hospital Engineering Annual Meeting

**May 25, Little Rock**  
Mid-Management Leadership Series: Nine Success Secrets of World Class Healthcare Managers

**June 2-3, Little Rock**  
Basic Emotional First Aid Training

**June 15-17, Dallas**  
Hospital Executive Leadership Forum

**June 24, Little Rock**  
Mid-Management Leadership Series: The Power of an Engaged Team

**August 25, Little Rock**  
Mid-Management Leadership Series: Successfully Managing Multiple Projects and Priorities

Program information available at [www.arkhospitals.org/events](http://www.arkhospitals.org/events). Webinar and audio conference information available at [www.arkhospitals.org/events](http://www.arkhospitals.org/events).
88th General Assembly:
A Slow Start, but Successful for Hospitals

With a 46-member Freshman Caucus in the House of Representatives and another 13 members serving their first terms in the Senate, this session’s pace began more slowly than any session in recent memory. That is not to say that there was less work being done. In fact, one could argue that the legislative work has been more deliberate than in recent memory.

While the final tally of bills filed reached 2352, at the end of the sixth week, right at 800 bills had been filed; slightly more than half of those filed were appropriations bills for state agencies, boards, and commissions and incomplete bills to modify retirement systems and scope of practice issues – bills required to be filed within 15 days of the beginning of a legislative session.

Almost 20 percent of the bills were filed March 7, the last day allowed to file a bill.

During this session, both the Governor and the legislative leadership are grappling with deficits in unemployment insurance, funding for highways and roads, the growth in spending for corrections, and forecasts of a more than a $300 million deficit in Arkansas’ Medicaid budget by 2013.

In a time of budget constraints, the Arkansas Hospital Association (AHA) wisely spent its efforts on maintaining resources available to Arkansas’ hospitals as well as expanding federal resources available to them through the hospital assessment. We have also been playing defense on proposals for additional administrative requirements that do not directly benefit patients and communities.

For the AHA, this session presented an opportunity to fine-tune the hospital assessment that was implemented two years ago during the 87th General Assembly. With so many Arkansans – especially its elected officials – bent toward “no new taxes,” explaining the difference in the hospital assessment and a tax was no small feat; add to that the complications of articulating how the Medicaid system pays hospitals substandard rates and how hospitals’ rates of uncompensated care have risen over the past few years.

Nonetheless, the bill was filed January 24, 2011, just two short weeks after the session had begun, with enough co-sponsors to assure that it would be successful in committees on both ends of the Capitol. With strong sponsors in Senator Larry Teague and Representative Keith Ingram, a lot of data supporting the bill, tons of grassroots education, and a little luck, it passed both chambers and became law – Act 19 of 2011.

If one followed the events on the legislative Web site, it might not be apparent that there were a few unexpected hurdles to the bill’s passage. The unwritten history of this bill includes a surprise testimony against the bill as well as a last minute request by the Arkansas Department of Finance and Administration to amend the bill to remove a provision that would allow DHS to recover tax proceeds due to hospitals in the event that the hospitals didn’t pay the assessment on time. (This one led to one particular AHA employee running between the Old Supreme Court room in the Capitol, where the committee was being held, and the Big Mac building, where the employees who could actually conduct the business of preparing the amendment – the Bureau of Legislative Research staff – were relocated after its renovation and addition of new committee rooms.) Despite those hurdles and others not named, 27 of Arkansas’ 35 Senators and 78 of the available 98
votes in the House of Representatives voted in favor of the bill. One thing is certain: this group of legislators needs a very valid reason to support a bill. Undoubtedly, Arkansas’ hospitals gave the legislature all of the right reasons to vote for SB134. Congratulations to all of those who will reap the benefits of this measure for years to come!

While it is a lot of work to get a bill enacted into law, it is just as much work to keep a potentially harmful bill from being filed and arguably even more work to ensure that a bill that is already filed gets amended in a way that is positive for hospitals.

Some of the highlights surrounding those activities include thwarting efforts to remove the “no smoking on hospital premises” provision that was included in Act 134 of 2005; ensuring that requests for reporting health facility acquired infections are done so in a protected manner that promotes quality improvement and garners cooperation of hospitals, state agencies, and the Centers for Disease Control and Prevention; and creating a mechanism for hospitals to report patient burns in order to share appropriate, essential information to local law enforcement to assist them in combating methamphetamine laboratories and arson.

Of course, the focus of the AHA’s efforts is primarily on health and the healthcare delivery system. Many items for debate this session relate to whether to expand the scope of advanced practice nurses, dental hygienists, pharmacists, and physicians and physician assistants. Others occur in the context of modifying public health registries, like expanding the childhood immunization registry to include adults and creating a prescription drug monitoring program that includes a registry within the Arkansas Department of Health.

Other issues that the AHA is monitoring this session relate to health insurance modifications, like whether coverage for autism, obesity, and in vitro fertilization will be included in insurance mandates and what laws might be necessary to establish the Health Insurance Exchanges; preparedness legislation, like radio encryption for public health personnel and whether the state will allow a sales-tax-free day for purchasing disaster-preparedness items; and issues surrounding the business operations of hospitals, like potential tax credits for using renewable energy resources and monitoring and reporting proposals for how employers will be required to assist in eliminating the unemployment insurance deficit; and other measures.

As the 88th General Assembly completes its work in the regular session, many issues will still loom overhead. While Arkansas didn’t experience the extreme downturn in the economy experienced by most other states, no one denies that many Arkansans are hurting financially.

The fiscal session in January is just a few short months away. Stay tuned for more information!
Valuable AHA Member Benefits:
Legislative Bulletin and voterVoice!

The AHA’s legislative staff works year-round to provide a valuable and effective advocacy voice for Arkansas hospitals. You can make your views known to your legislators by using voterVoice, a powerful Web-based advocacy tool. To use the voterVoice tool for contacting public officials, go to the AHA Web site, www.arkhospitals.org, and click on Legislative/Regulatory, then click voterVoice.

Throughout the Arkansas legislative session, you can get up-to-date information on what’s happening in both chambers of the General Assembly by visiting www.arkleg.state.ar.us.

To determine the status of a particular bill, go to the General Assembly Web site at www.arkleg.state.ar.us, then click on Bills and Resolutions, click on Bill Status, enter the Bill Number, and click on Run Query.

If you are following legislative matters via the AHA Web site (www.arkhospitals.org), go to Legislative/Regulatory and click on Arkansas General Assembly. There you will be linked directly to the main pages for the 88th General Assembly, and will see what meetings and votes are scheduled for the day.

Also, check the AHA Web site, www.arkhospitals.org, and click on Legislative/Regulatory to view the latest Legislative Bulletin. Produced by AHA Vice President for Government Relations Jodiane Tritt regularly throughout the session, the Legislative Bulletin is your quick-read update on what’s happening with healthcare issues, proposed bills and legislative action at the Capitol.

NEED MORE BUYING POWER?

In a time when all hospitals are looking for ways to reduce costs, AHA Services, Inc. is helping Arkansas hospitals save thousands of dollars.

With buying power in areas like insurance, equipment, staffing services and many others, AHASI negotiates group discounts as a service to AHA members.

Call Tina Creel or Liz Carder and boost your buying power today.
Reminder: AHA Annual Meeting in Washington, D.C. is April 10-13

Hospital executives, managers and trustees who plan to attend the American Hospital Association’s (AHA) 2011 Annual Membership Meeting April 10-13 in Washington, D.C. need to register immediately.

This meeting will provide an excellent opportunity to learn first-hand about AHA’s advocacy agenda for the 112th Congress. Of utmost urgency is your ability to visit personally with members of Arkansas’ congressional delegation about the expected impact of federal legislative and regulatory issues on local Arkansas hospitals and communities.

These visits will be as important in 2011 as for any year in recent memory, given that Arkansas’ D.C. delegation includes three new congressmen and a new senator, who has moved over from the House of Representatives to now represent all Arkansas hospitals.

As it has for the previous three years, the Arkansas Hospital Association will reimburse each CEO of a member hospital up to $1,000 to help offset the costs of attending the meeting. However, to receive the stipend, attendees must participate in all Arkansas activities, including the visits with our congressional leaders.

Meeting and registration information is available online at the AHA Web site, [http://www.aha.org/aha/advocacy/annual-meeting/11-registration.html](http://www.aha.org/aha/advocacy/annual-meeting/11-registration.html).

Those making plans to attend the meeting should fax a copy of their meeting registration form to Beth Ingram with the Arkansas Hospital Association at (501) 224-0519 to receive special mailings detailing Arkansas events. Or, e-mail your attendance plans to bingram@arkhospitals.org.

Arkansas Trauma Call Center Now Operational

The Arkansas Department of Health (ADH) implemented its Arkansas Trauma Call Center (ATCC) January 3, 2011.

The ATCC is a major component of the state’s new trauma care system and is operated under contract with Little Rock-based Metropolitan Emergency Medical Services (MEMS).

The call center is manned with operators whose responsibility is to advise ambulance services regarding the transport of major and moderate trauma patients to hospitals with the appropriate medical capabilities, and the appropriate hospital-to-hospital transfers of trauma patients.

Initially, the ATCC will facilitate hospital-to-hospital transfers only, but it will begin routing all major and moderate trauma transports after all ambulance services receive AWIN radios. The Arkansas Department of Health (ADH) expected this to occur in March 2011.

ADH hosted a video conference each Tuesday morning in January and February to discuss trauma system implementation. The initial call on January 3 was dedicated to an update on the online dashboard being used for trauma care purposes.

The new trauma dashboard replaces the one that hospitals had been updating by calling in to MEMS. For the system to operate correctly, participating hospitals now must continually update the status of their capabilities on the new online trauma dashboard.
Making the transition to supervisor/manager/leader is a significant step for nearly everyone who takes it. In today’s healthcare environment, accepting a leadership role is far more challenging and complex than ever before.

First, there is the challenge of simply getting oriented to what it means to be a manager or leader. This is closely followed by the realization that you carry the responsibility for meeting the demands of your organization for high quality and productivity as well as compliance and financial outcomes. You also quickly learn that these accountabilities must be balanced with an excellent grasp of human relations skills in working closely and collaborating with others.

In its sixth year, the Arkansas Hospital Association’s (AHA) Mid-Management Healthcare Leadership Series continues to add focus to critical leadership skills and competencies with new workshop topics and facilitators. The all-new series is designed to assist mid-level managers and supervisors in expanding their core leadership skills and can be especially helpful for those who have been promoted into management positions.

The series will offer six one-day workshops (to be held at the AHA headquarters building) and a choice of three Webinar courses. Series dates, topics and speakers include:

- **APRIL 5** Great Leaders Help Others Act on Their Best Intentions: Effective Leadership in Healthcare Organizations (Susan Keane Baker)
- **APRIL 21** Legal Issues for Healthcare Leaders (Lynda Johnson) Webinar
- **MAY 17** CSI Workplace: Customer Service Internally = Profit (Chris Zervas) Webinar
- **MAY 25** Nine Success Secrets of World Class Healthcare Managers (Jeff Standridge)
- **JUNE 24** The Power of Leading an Engaged Team (Chris Zervas and Brian Brandt)
- **JULY 26** Feedback Without Fallout: Coaching for World Class Performance (Jeff Standridge) Webinar
- **AUG. 25** Successfully Managing Multiple Projects and Priorities (Harry Chambers)
- **SEPT. 16** Making the Business Case for Quality Improvement (Bill Ward)
- **OCT. 5** How to Achieve Top Gun Success for Hospitals (Ed Rush) To be held in conjunction with the AHA Annual Meeting

A program brochure is available on the AHA Web site at [www.arkhospitals.org/events](http://www.arkhospitals.org/events). Please contact Beth Ingram or Anna Sroczynski at 501-224-7878 for additional information. ●

**AHA Congratulates 2010 Mid-Management Series Graduates**

The Arkansas Hospital Association offered its fifth annual Mid-Management Leadership Series from April through October of 2010. The series featured individual programs targeted specifically for individuals new to hospital supervisory or mid-level management positions. Other individuals attended the programs as refresher courses.
The series was designed to educate employees for middle-management positions or toward advancement along their career paths. Course topics included leaping from staff to management, the legal aspects of management, accountability, executive leadership for managers and leading through reform without losing workforce. Participants also were required to take an online careLearning course on improving employee performance and evaluating leadership style.

The AHA congratulates the following Arkansas hospital representatives on their achievement of earning the 2010 Mid-Management Leadership Certificate by completing at least five of the seven programs (and a careLearning program):

- **Jennifer Lord**
  Business Office Supervisor
  Fulton County Hospital

- **Christy Davis**
  Nurse Manager
  White County Medical Center

- **Monica Estes**
  Asst. Director of Nursing
  Fulton County Hospital

- **Ralph Garlitos**
  Physical Therapist Manager
  CHRISTUS St. Michael Health System

- **Bridget Reynolds**
  Materials Mgmt. Supervisor
  Fulton County Hospital

- **Janelle Wray**
  Housekeeping Team Leader
  Fulton County Hospital

- **Marva LaGrant**
  Clinical Nurse Manager
  Jefferson Regional Medical Center

**HRSA Encourages Federally Qualified Health Centers to Collaborate**

The Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care, which oversees the federal health center program, issued a “program assistance letter” November 23 encouraging Federally Qualified Health Centers (FQHC) to collaborate with other healthcare safety-net providers through contracts and cooperative arrangements.

HRSA noted in its letter that the Health Center Program statute found within the Public Health Service (PHS) Act specifically requires health centers to demonstrate that they have made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other healthcare providers in their catchment area.

The agency also is placing an increased emphasis on collaboration within its FQHC funding opportunities. The Patient Protection and Affordable Care Act, for example, provides $9.5 billion in New Access Point (NAP) grants for health centers that collaborate to provide new access points for delivery of care to low-income patients.

NAP applications will be assessed “on the extent to which they demonstrate formal and informal collaboration and coordination of services with other healthcare providers.”


**New ACA Rules to Fight Healthcare Fraud**

On Monday, January 24, the Department of Health and Human Services announced new rules authorized by the Affordable Care Act (ACA) that will help stop healthcare fraud.

Specifically, the final rule:
- Creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud (for example, durable medical equipment suppliers) will be subject to a more thorough screening process.
- Requires a new enrollment process for Medicaid and CHIP providers. Under the Affordable Care Act, states will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding the government. Providers that have been kicked out of Medicare or another state’s Medicaid or CHIP will be barred from all Medicaid and CHIP programs.
- Temporarily stops enrollment of new providers and suppliers. Medicare and state agencies will be on the lookout for trends that may indicate healthcare fraud — including using advanced predictive modeling software, such as that used to detect credit-card fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.

AHA Diamond Awards: Call for Entries

2011 Diamond Award
Call for Entries

The 2011 Arkansas Hospital Association (AHA) Diamond Awards Call for Entries has been announced. The open nominations are co-sponsored by the AHA and the Arkansas Society for Healthcare Marketing and Public Relations. Last year, 11 hospitals received awards presented at the AHA’s Annual Awards Dinner held in conjunction with the AHA Annual Meeting and Trade Show. This year’s recipients will receive their awards during the October 6, 2011 Awards Dinner at the Peabody Hotel in Little Rock.

The 2011 Diamond Awards recognize excellence and encourage improvement in the quality, effectiveness and impact of healthcare marketing and public relations in the state of Arkansas. Awards will be presented in several categories, such as advertising, annual report, Internet Web site, publications, special video production and writing.

Diamond Awards (for hospitals with 0-99 beds, 100-249 beds and 250 or more beds) will be presented in each category. Entries will be judged by a panel of judges not affiliated with any Arkansas hospital.

Nominations and entries, accompanied by appropriate documentation, must arrive at AHA headquarters no later than April 29, 2011. A brochure providing details of the awards competition was mailed to hospital CEOs and marketing and public relations directors and is available at http://www.arkhospitals.org/events/annual-meeting, selecting “2011 Diamond Awards Brochure.”

Medical Board Streamlines Licensure Process

The Arkansas State Medical Board (ASMB) recently informed the Arkansas Hospital Association (AHA) of steps being taken to streamline the physician licensure process and reduce the time from receipt of an application to approval of the license.

ASMB has adopted several new processes that will allow applicants for licenses to submit their information in a variety of methods not previously qualified as “acceptable.” Applicants will continue to be subject to a complete audit, but it will be a much faster review, reducing the licensure process by several weeks, in most cases.

The ASMB licensing staff will continue to review existing internal requirements, as well as the physician’s responsibilities in the license application process, and how each can be tailored toward further eliminating duplication of effort and reduction of turn-around-time in the license and Centralized Credentials Verification System (CCVS) process.

The biggest problem encountered by the licensure and CCVS divisions continues to be the submission of incomplete information in the application process.

The AHA has expressed its appreciation to the ASMB licensure staff for all their hard work to make the licensure process more efficient for physicians coming to Arkansas.
Accountable Care Organizations in the Rural Setting

Accountable care organizations (ACOs) are touted as a way to curb rising costs and improve quality. However, many questions remain unanswered about ACOs. How do ACOs relate to medical homes or other means of coordinating care? What are options for “bundled payment” for hospitals, physicians and other providers of care? Do ACOs even make sense in a rural setting? How can providers in rural areas attain ACO features such as collaboration with public health and health-related community organizations, exceptional information technology, accurate and open measurement and reporting of quality and financial information, and appropriate payment mechanisms and incentives? Thomas R. Miller, Ph.D., assistant professor of health policy and management, School of Rural Public Health, Texas A&M Health Science Center, will examine current ACO criteria and organizational implications. Opportunities and limitations for ACOs in rural settings are identified along with strategies to improve an organization’s positioning.

Accountable Care Organizations – Fact or Fantasy?

Everyone in the healthcare field wants to learn about ACOs; some actually claim to be ACOs. Consulting and law firms will charge hundreds of thousands of dollars to get you ready for ACOs, but is that reality? Attorney Dan Mulholland, J.D, Horty, Springer and Mattern, will explain just what the law says about ACOs, discuss the questions that remain unanswered about them, and warn hospitals and doctors about jumping the gun.

Health Insurance Reform: Best Practices in Adapting to Local Regulations, Markets and Trends (1.5 hours credit ACHE Category I)

Through a panel of healthcare executives and a representative of the Arkansas Insurance Department, this session will focus on regulatory implications related to the health insurance coverage provisions of the Affordable Care Act, state and local policies that impact the operations of local hospitals and healthcare organizations (as providers and employers), and how organizations are affected by insurance regulation and its impact on employment trends.
During 2010, the Arkansas Hospital Association Political Action Committee (AHAPAC) received $22,945 in contributions, primarily from hospital executives and employees throughout the state.

These donations, which are shared between the Arkansas Hospital Association and the American Hospital Association, make possible the financial support those organizations are able to provide to political candidates seeking state or federal elective offices.

Contributions of any amount, from all contributors to the AHAPAC, are seriously needed and deeply appreciated. However, special acknowledgement is given to individuals who contribute at certain threshold levels. Those individuals qualify for recognition as members of the American Hospital Association’s Ben Franklin Club, Chairman’s Circle or its Capitol Club.

Ben Franklin Club membership is awarded for individuals who contributed $1,000 or more to AHAPAC. Chairman’s Circle membership is awarded for individuals who contributed $500 or more to AHAPAC during the year, while the Capitol Club membership is earned with a $350 donation.

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2010 Arkansas PAC Contributions Recognized

**Listed below are individuals from Arkansas who qualified for membership in each of these groups in 2010.**

**BEN FRANKLIN CLUB:**
- Kevin J. Clement, Siloam Springs Memorial Hospital
- Robin Lake, Harrison
- Phil Matthews, President Emeritus, Arkansas Hospital Association
- Raymond W. Montgomery, II, FACHE, White County Medical Center
- Bo Ryall, Arkansas Hospital Association

**CHAIRMAN’S CIRCLE:**
- Don Adams, Arkansas Hospital Association
- Jonathan R. Bates, MD, Arkansas Children’s Hospital
- Roger Busfield, Jr., PhD, LFACHE, President Emeritus, Arkansas Hospital Association
- James David Cicero, Ouachita County Medical Center
- Tina Creel, AHA Services, Inc.
- Paul Cunningham, Arkansas Hospital Association
- Bob Gant, Conway Regional Health System
- Russell D. Harrington, Jr., FACHE, Baptist Health
- Beth Ingram, Arkansas Hospital Association
- Tim Johnsen, St. Joseph’s Mercy Health Center
- Jeffrey A. Johnston, St. Edward Mercy Medical Center
- Scott Peek, Chambers Memorial Hospital
- Ron Peterson, FACHE, Baxter Regional Medical Center
- Nancy Robertson, Robertson Cook Communications, Inc.
- Ronald K. Rooney, FACHE, Arkansas Methodist Medical Center
- Stephen Smart, DDS, Medical Center of South Arkansas
- Melody Trimble, FACHE, Sparks Health System
- Douglas Weeks, FACHE, Baptist Health Medical Center-Little Rock
- Elisa M. White, Arkansas Hospital Association

**CAPITOL CLUB:**
- Robert P. Atkinson, FACHE, President Emeritus, Jefferson Regional Medical Center
- Gary L. Bebow, FACHE, White River Health System
- Paul Betz, FACHE, NEA Baptist Memorial Hospital
- Darren Caldwell, DeWitt Hospital
- Kristy Estrem, FACHE, St. John’s Hospital-Berryville
- Christy Hockaday, FACHE, St. Anthony’s Medical Center
- Walter E. Johnson, Jr., Jefferson Regional Medical Center
- Edward L. Lacy, FACHE, Baptist Health Medical Center-Heber Springs
- James M. Lambert, FACHE, Conway Regional Health System
- Debbie Love, Arkansas Hospital Association
- Mark Lowman, Baptist Health Medical Center-Little Rock
- James L. Magee, Piggott Community Hospital
- Harold E. Mitchell, Jr., CPA, Bradley County Medical Center
- Larry Morse, CHE, Johnson Regional Medical Center
- Barry Pipkin, Universal Health Services
- Kirk Reamey, III, FACHE, Ozark Health Medical Center
- Rosi Smith, Arkansas Children’s Hospital
- John Tucker, FACHE, Five Rivers Medical Center
Thanks to a $495,926 USDA telemedicine grant, the Mercy healthcare network (Sisters of Mercy Health System) will be able to provide 900 people in some of the nation’s hardest-to-reach rural areas medical care unlike any they’ve known before.

Through the three-year Tele-home Project, Mercy – a network of hospitals and physician offices in Arkansas, Kansas, Missouri and Oklahoma – will target patients with the most chronic ailments, including diabetes, heart disease and respiratory disease. The grant monies will fund monitoring devices so patients can electronically transmit results from home via computer or telephone line directly to their physician.

Mercy facilities participating in the grant project include: Berryville, Ozark, Paris, and Waldron, in Arkansas, and Cassville and Mountain View, Missouri. Some of these communities are 100 miles from the nearest urban area, sometimes over mountainous rural roads. In addition, all six of the communities exceed national poverty rates.

“We intentionally chose areas where there is the greatest medical need,” said Tom Hale, MD, executive medical director of Mercy’s Center for Innovative Care (CIC). “We continue to find ways to innovate so we can provide better patient care.”

Mercy’s CIC, the driver behind the Tele-home Project, creatively combines people and technology to extend Mercy’s reach and services well beyond the walls of doctors’ offices, hospital campuses and other traditional facilities. By studying the impact of new approaches and then putting new technologies to the test, Mercy’s CIC ultimately hopes to provide better care through more convenient and lower-cost locations.

“I recently had a patient come in with a blood sugar level way above normal and I couldn’t figure out why it was so high, because she was taking two oral medications and insulin to control her diabetes,” said April Revis, APN, a family nurse practitioner at Mercy’s Scott County Rural Health Clinic. The clinic, located in Waldron, Arkansas, is more than 45 miles from the closest urban area.

“After talking with her, I discovered it had become difficult for her to see well enough to draw up her insulin, so she stopped taking it,” Revis said. “If we had been using tele-home monitoring and tracking the rise in her blood sugar, we would have been able to get her help long before there was a problem.”

Extensive research shows behaviors change when someone is paying close attention to them. Simply tracking hypertensive patients nationwide with remote blood pressure monitors could potentially save $100 billion a year in unnecessary healthcare costs.

“In addition to traditional care, Mercy is providing a new version of the house call for the digital age. Because of our integrated electronic health record, we can track patient care across four states 24/7 whether you are in a hospital, clinic, ER – and now, from your home – with monitoring devices,” said Tim Smith, MD, vice president of research for Mercy’s CIC. “By regularly tracking glucose levels, blood pressure, oxygen levels and more, our patients reap the benefits.”

Patient benefits include:
- Reduced travel time
- Greater access to medical personnel
- More accurate referrals
- Quicker consultation time
- Reduced costs
- Improved understanding of chronic illness

Through the Tele-home Project, Mercy will test the waters for even greater patient connectivity by moving beyond an electronic health record to providing patients with personal health records (PHR). Eventually, the goal is for all Mercy patients, not just those in rural areas, to have the ability to input data such as glucose readings, blood pressure and other measurements with integrated home monitoring devices to better their health.

Already in place today in many communities, MyMercy, a free online service, gives Mercy patients the ability to track health history, schedule appointments, contact a doctor and renew prescriptions via a personal 

continued on page 16
After being up and running for just three months, more than 85,000 people across Arkansas, Kansas, Missouri and Oklahoma had already signed up for MyMercy. It will be available in the Hot Springs and Fort Smith areas in the coming months.

“Mercy is raising healthcare to a new level,” said Dr. Smith. “We are providing patients with ways to be more involved in their own care and the potential benefits to patients are mind boggling.”

Arkansas hospitals connected with Mercy are St. Joseph's Mercy Health Center in Hot Springs, St. Edward Mercy Medical Center in Fort Smith, Mercy Medical Center in Rogers, Mercy Hospital/Turner Memorial in Ozark, Mercy Hospital of Scott County in Waldron, North Logan Mercy Hospital in Paris, and St. John's Hospital - Berryville.

Mercy – Sisters of Mercy Health System – is the eighth largest Catholic healthcare system in the U.S. and serves more than 3 million people annually. Mercy includes 28 hospitals, more than 200 outpatient facilities, 45,000 co-workers and 1,300 integrated physicians in Arkansas, Kansas, Missouri and Oklahoma. Mercy also has outreach ministries in Louisiana, Mississippi and Texas. For more about Mercy, visit www.mercy.net.
April 27 is Deadline for 2011 Governor’s Quality Award Applications

The deadline for 2011 award applications to the Governor’s Quality Award Program is fast approaching. All applications should be postmarked by Wednesday, April 27, 2011.

The Governor’s Quality Award program was developed to provide opportunities for all organizations in the state to measure their progress in the journey of performance excellence. The award is to be used by businesses, hospitals and healthcare systems, government agencies, schools, churches and all types of organizations, including for-profit, not-for-profit, small, large, growing, mature, etc. – in short, any organization interested in improving quality, productivity and financial effectiveness.

The basis of the process is a philosophy that to manage effectively we must measure effectively and provide feedback on our progress. We must honestly and objectively look at where we are now compared with where we have been and, to some degree, compare ourselves with others in order to learn from them.

The Governor’s Quality Award program is intended to create a system for measuring progress and growth, not to promote a sense of competition. The goal is for Arkansas to have hundreds of winners as all participants grow and progress toward individual and organizational goals of success. According to the Governor’s Quality Award Web site, “While we grow, we will teach and support each other as our state improves in economic strength.”

The Governor’s Quality Award program was developed by a team of volunteers with a variety of backgrounds and employers. The team chose to use the Malcolm Baldrige National Quality Award as a basis for the Arkansas process. This process combines the advantages of using the most current, comprehensive, and widely accepted criteria available to assess progress toward long-term improvement of organizations in a process that uses a four-step award program.

ADDITIONAL PROGRAM OFFERINGS HELP APPLICANT ORGANIZATIONS

- Applicant Training is an excellent opportunity to learn how to use the Malcolm Baldrige Criteria for both application to the GQA Program and self-assessment of an organization’s total quality management processes.
- Regional and industry-specific Challenge seminars are annually provided in manufacturing, healthcare and business/finance. These seminars are at no charge to applicants. The seminar programs are designed to address relevant issues in each industry and focus on improving performance excellence in those areas.
- Benchmark Tours are provided to applicants annually. The Benchmark Tours are at companies that have been involved in the GQA Program at the highest award levels and want to share their best practices with other applicants.
- The annual Examiner Training teaches trained professionals how to assess applications for the GQA Program. The training offers up to 5.1 ASQ recertification credits. Examiners receive information on how to use the criteria in assessment and in their own organizations.

For more information on the program or the process, please visit http://www.arkansas-quality.org.

Physicians Exempted from Red Flags Rule

Both chambers of Congress in late 2010 passed legislation that exempts most physicians and other professionals from complying with the Federal Trade Commission’s (FTC) “Red Flags Rule,” which requires creditors to create written anti-identify theft programs.

The legislation, titled the “Red Flag Program Clarification Act of 2010,” was signed by President Barack Obama December 18, and clarifies that creditors who must be concerned with identity-theft prevention and detection programs are those who use consumer reports in credit transactions and provide information to consumer reporting agencies.

Providers who bill patients after delivering services should not be classified the same way as creditors such as banks and retailers, according to the new definition.

The legislation supports arguments made by the American Medical Association and American Osteopathic Association, which sued the FTC in 2010, claiming that the Red Flags Rule undermines trust between physicians and patients and that the Health Insurance Portability and Accountability Act already contains identity-theft safeguards.
Department of Justice Recovers $3 Billion in False Claims Cases in FY 2010

The Department of Justice (DOJ) recovered $2.5 billion in healthcare fraud recoveries for fiscal year (FY) 2010 – the largest in history – and $3 billion in total civil fraud claims, according to information released late in 2010.

The DOJ recovered more than $2.3 billion via the False Claims Act’s *qui tam* provisions. These provisions award whistleblowers between 15% and 30% of the proceeds of a successful suit. In FY 2010, whistleblowers collected $385 million.

The DOJ also entered into a $2.3 billion settlement with Pfizer Inc., which is the largest healthcare fraud settlement in history. The $2.3 billion includes $669 million recovered under the federal False Claims Act, $1.3 billion in criminal fines and forfeitures, and $331 million in recoveries for state Medicaid programs and the District of Columbia.

Pharmaceutical companies and medical device industries accounted for $1.6 billion in settlements, including the $669 million from Pfizer Inc., $302 million from AstraZeneca, and $192.7 from Novartis Pharmaceutical Corporation.

A $108 million settlement with The Health Alliance of Greater Cincinnati and one of its former member hospitals, The Christ Hospital, was the largest Anti-Kickback Statute settlement for the conduct of a single hospital.

Attorney General Announces Arkansas’ Share of Pharmaceutical Settlement

Attorney General Dustin McDaniel in late fall, 2010 announced that Arkansas has joined with other states and the federal government to reach an agreement in principle with pharmaceutical manufacturer GlaxoSmithKline (GSK) to settle allegations that the company introduced adulterated drugs into interstate commerce.

As a result, GSK will pay the states and the federal government $600 million in civil damages and penalties for Medicaid and other federally funded healthcare programs. Arkansas’ share of the settlement will be $690,220.49.

Additionally, the GSK subsidiary SB Pharmaco of Puerto Rico, where the drugs were manufactured, has agreed to plead guilty to a felony violation of the U.S. Food, Drug, and Cosmetic Act, and has agreed to pay $150 million in criminal fines and forfeitures.

“I am pleased with the efforts of the states working collectively to reach this settlement, which will rightfully reimburse the Arkansas Medicaid program for these improper actions,” McDaniel said.

The civil settlement resolves allegations of poor manufacturing practices in the GSK facility located in Cidra, Puerto Rico. The investigation grew out of a false claims lawsuit that alleged GSK knowingly manufactured, distributed and sold four products – Paxil CR, Avandamet, Kytril and Bactroban – whose strength, purity and/or quality fell below the standards required by the FDA.

This settlement agreement reimburses the federal government and the states for the amounts paid by the Medicaid program as a result of GSK’s conduct. Additionally, GSK has agreed to the terms of a Corporate Integrity Agreement (CIA) with the Department of Health and Human Services, Office of the Inspector General, which will require scrutiny of GSK’s future manufacturing practices.
SAVE THE DATES! MAY 10-11, 2011

THE LANDSCAPE OF HEALTH CARE IS CHANGING.

MAY 10–11, 2011

DOUBLETREE HOTEL LITTLE ROCK, AR
On February 14, the White House released its budget proposal for fiscal year (FY) 2012. The proposal does not include major reductions to hospitals under Medicare or restructuring of the Medicare program. However, it does include significant Medicaid payment reductions to providers, reductions which are of great concern. The $62 billion in cuts over 10 years fund a two-year extension of physicians’ Medicare payments at the current level. The cuts are as follows.

**Medicaid ($28.8 billion):** Among other changes, reduces the ability of the states to use Medicaid provider taxes beginning in 2015 and rebases Medicaid disproportionate share hospital payments in 2021.

**Children’s Graduate Medical Education (GME) ($318 million):** Eliminates GME payments for children’s hospitals.

**Program Integrity ($13.9 billion):** Expands the Centers for Medicare & Medicaid Services’ program integrity authority, including strengthening third-party liability under Medicaid, recovering payments made in error to Medicare Advantage plans, and dedicates a portion of funds recovered by Recovery Audit Contractors to efforts to prevent improper payments and fraud.

**Program Efficiencies ($6.4 billion):** Makes a series of changes to the Quality Improvement Organization (QIO) program to improve efficiency, such as expanding the pool of eligible contractors, lengthening the QIO contract period and examining the geographic scope of QIO contracts.

**Pharmaceuticals ($12.8 billion):** Among other changes, makes a series of changes to shorten the time period in which drug manufacturers maintain exclusivity for new drugs and prohibits drug companies from delaying generic forms of pharmaceuticals. “While we are pleased that the president’s budget does not include any new major reductions to hospitals under Medicare or restructuring of the Medicare program. However, it does include significant Medicaid payment reductions to providers, reductions which are of great concern. The $62 billion in cuts over 10 years fund a two-year extension of physicians’ Medicare payments at the current level. The cuts are as follows.

**White House Releases FY 2012 Budget Proposal
Proposal Would Cut Medicare/Medicaid Spending by $62 Billion to Fund Two-Year Doc Fix**

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Overall, the White House estimates the cuts contained in the $3.7 trillion dollar spending proposal will reduce the national deficit by $1.1 trillion over the next 10 years. The deficit is projected to reach $1.6 trillion this year. The budget proposal can be found at [http://www.whitehouse.gov/omb/budget](http://www.whitehouse.gov/omb/budget).

**Hospital Resource Guide on Understanding and Managing Variation is Released**

The *Health Care Leader Action Guide: Understanding and Managing Variation*, the latest resource produced under *Hospitals in Pursuit of Excellence*, was released as a resource tool for hospitals February 8.

This new HPOE guide builds upon the report of the American Hospital Association’s Task Force on Variation in Health Care Spending that was released in late January. Its purpose is to provide hospitals with a resource to help reduce inappropriate variation within their own organizations and in conjunction with care partners.

The guide includes practical steps to understanding and managing variation and a list of best practices and case studies as examples and resources for hospital leaders to use for implementing key interventions.

The guide may be downloaded at [http://www.hret.org/quality/projects/healthcare-leader-action-guide-understanding-managing-variation.shtml](http://www.hret.org/quality/projects/healthcare-leader-action-guide-understanding-managing-variation.shtml). Also available at that site are the original task force report and other resources and information concerning variation specific to hospital use.
Patients often fear removal of a brain tumor more than the threatening consequences of its persistence. Intricately lodged in the critical tissues of the brain, intra- and extra-axial tumors pose unique treatment challenges. Fortunately, the expert neuro-oncology team of the Arkansas Neuroscience Institute at St. Vincent meets unique challenges with unique care.

Led by Ali F. Krisht, M.D. – an internationally recognized authority in the management of complex cranial brain tumors – our experienced team provides state-of-the-art treatment options for patients and collaborates with other subspecialists to ensure the highest level of comprehensive treatment.

The Arkansas Neuroscience Institute at St. Vincent is a resource dedicated to serving you and your patients. For referrals, call 501-552-6400 today.

StVincentHealth.com/ANI
Healthcare spending in the United States grew 4.0 percent in 2009, to $2.5 trillion, or $8,086 per person, the slowest rate of growth in the 50-year history of the National Health Expenditure Accounts (NHEA), due in great part to the economic recession, according to a January report from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary.

The report, prepared annually, summarizes recent trends in health spending based on the most current data sources. Available historically since 1960, the NHEA represents the official estimates of total healthcare spending in the United States and measures annual health spending by the types of goods and services delivered (hospital care, physician services, retail prescription drugs, etc.), by the programs and payers that pay for that care (private health insurance, Medicare, Medicaid, etc.), and by the sponsors who are ultimately responsible for financing that care (private businesses, households, and governments).

The 4.0 percent growth in 2009 was down from 4.7 percent in 2008, the second slowest rate of growth in the history of the NHEA, as the recession led to slower growth in private health insurance expenditures and out-of-pocket spending by consumers, and to a reduction in capital investments. Despite the slowdown, healthcare spending growth continued to outpace overall economic growth, which declined 1.7 percent in 2009 as measured by nominal Gross Domestic Product (GDP).

However, health spending as a share of the nation’s GDP continued to climb, reaching 17.6 percent in 2009, up 1.0 percentage point from 2008, the largest one-year increase in the history of the NHEA.

In comparison to other recent recessions, the health spending share of GDP increased 0.7 percentage point in 1991 and 2001, and 0.8 percentage point in 1982.

According to the report, the recession, which began in December 2007 and ended in June 2009, affected health spending as many consumers decreased their use of goods and services partially due to lost employer-based private health insurance coverage and reduced household income. This led to a deceleration in private health insurance spending, which increased only 1.3 percent in 2009 compared to 3.5 percent in 2008, that was due primarily to a 3.2 percent drop in enrollment. At the same time, as more people became eligible for and enrolled in Medicaid, growth in that program’s spending accelerated to 9.0 percent in 2009 following 4.9 percent growth in 2008.

With approximately $34 billion in enhanced federal aid for states (provided by the American Recovery and Reinvestment Act of 2009), federal Medicaid spending increased 22.0 percent and its share of total Medicaid spending reached 66 percent (from a 59 percent share in 2008). In contrast, state Medicaid spending declined 9.8 percent, the largest decline in the program’s history. The economic downturn also affected consumer out-of-pocket spending, which slowed to 0.4 percent growth in 2009, as spending for dental services, nursing care facilities and continuing care retirement communities, and physician and clinical services declined. A 2.7 percent reduction in expenditures for capital investments also contributed to the slowdown in health spending. In 2009, private and state and local government providers decreased their investment in structures and equipment by 4.3 percent and 1.1 percent, respectively.

Key statistics on the growth of healthcare spending in the new report include:

- Hospital spending increased 5.1 percent to $759.1 billion in 2009 compared to 5.2 percent growth in 2008.
- Physician and clinical services spending increased 4.0 percent in 2009 to $505.9 billion, a deceleration from 5.2 percent growth in 2008.
- Retail prescription drug spending grew 5.3 percent in 2009 to $249.9 billion, after 3.1 percent growth in 2008.
- Spending for freestanding nursing care facilities and continuing care retirement communities increased 3.1 percent in 2009 to $137.0 billion, a deceleration from growth of 5.0 percent in 2008.
- Spending for home healthcare services provided by freestanding facilities grew 10.0 percent to $68.3 billion following growth of 7.5 percent in 2008.
- Total healthcare spending by health insurance payers, which includes the Medicare and Medicaid programs, increased 5.1 percent in 2009, a slight deceleration from 5.3 percent growth in 2008.
- Private health insurance premiums grew 1.3 percent in 2009, a deceleration from 3.5 percent growth in 2008 and the slowest rate of growth in the history of the NHEA.
- Out-of-pocket spending grew 0.4 percent in 2009 compared to 3.1 percent growth in 2008.

To read the complete report, visit http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.
American Hospital Association Reports on Variation in Healthcare Spending

Variation in care does exist, and hospital leaders and other stakeholders must work together to do a better job of providing patients with optimal care and reducing inappropriate variation in healthcare spending. But not all variation is inappropriate; nor can it be entirely controlled by the nation’s healthcare system, American Hospital Association (AHA) board member Scott Malaney in late January told an Institute of Medicine (IOM) committee studying the issue.

Malaney is chairman of the AHA’s Task Force on Variation on Health Care Spending, and he shared findings from the task force’s new report with the IOM committee. In 2013, the committee is charged with recommending to the Health and Human Services secretary Medicare payment changes to promote “high-value” care.

In developing its recommendations, Malaney urged the IOM committee to recognize that some degree of variation is appropriate and to be expected. He noted that there are differences in patients’ underlying health that may suggest the need for differing approaches to care and that patients may have different preferences for what services they want to receive. Moreover, Malaney said hospitals and other providers face different costs, for example, due to different labor costs across markets, mission-related expenses for teaching and research, and the added costs of providing services in remote rural areas.

And he made the case that not all variation relates to the nation’s healthcare system. Broader social factors affect health status and spending, such as poverty rates, local culture and demographics.

While hospitals are not the only source of variation in spending, they “represent the setting where the greatest percentage of care dollars are spent – including physician and other professional fees – and reducing variation in hospital care will be critical to reducing variation overall,” Malaney told the IOM’s Committee on Geographic Variation in Health Care Spending. To reduce variation in spending on hospital care, he said hospital leaders must collaborate with the physicians who direct much of the care provided in their facilities.

Variation in spending occurs not only across geographic regions of the country, but also within regions, states and even across healthcare professionals within an organization, said Malaney, who is president and CEO of Blanchard Valley Health System in Findlay, Ohio. “The implication of these findings is that care must be taken to ensure that measures of performance don’t penalize good performers in poor performing areas and vice versa,” he said.

The AHA convened its task force on variation in healthcare spending in 2009. It commissioned an extensive review of literature on the subject, along with two research projects, and heard from a number of experts in the field before releasing its January 11 report and recommendations. Citing those recommendations, Malaney said the AHA supports approaches to efficiently measure and reward high-quality performance, but doesn’t believe geography is the correct way to do it.

That variation also exists across other “performance dimensions,” like quality, access, prevention and treatment, cost, equity and health behavior points to the importance of involving a broad range of stakeholders, including the public health community, employers, schools and payers to tackle the problem, Malaney said.

The AHA’s task force report calls upon the hospital field to address variation within their organizations, and to work with physicians and others in the healthcare community to reduce it across the continuum of care.

To give hospitals the tools they need to succeed, the report recommends investing federal dollars to make timely and comprehensive data readily available to providers and researchers, and to develop and distribute practice standards, guidelines and research on comparative effectiveness that can help providers curb variations in spending. The AHA also expects its Hospitals in Pursuit of Excellence initiative to play a leading role in helping hospital members identify and reduce inappropriate variations in spending.

The task force report said Medicare policies should spur action on the problem, ensure accountability and reward success. It said performance measures should reflect demographic factors, health status, costs of providing care and related expenses – like teaching and research – and other issues beyond providers’ control. The report also calls for eliminating barriers that stand in the way of clinical integration.

For more on the task force’s report, go to the “Issues” section of www.aha.org and click on “Variation in Health Care.” For more on Malaney’s January 17 testimony, go to the “Advocacy” section of www.aha.org and click on “Testimony.”
ACA and Healthcare Reform in Arkansas

Looking back on the events surrounding healthcare over the past 18 months, it would be nice to think that things would get easier in 2011.

But, as the most sinister of Tony Soprano’s New Jersey cohorts might say, complete with appropriate hand gestures, “Fuhgedaboudit!”

Expect this year to be anything but a cakewalk. In fact, things are likely to get tougher. Despite an affirmative House vote in mid-January on a bill designed by Republican leaders “to repeal the job-crushing healthcare law,” repeal failed in the Senate. The House vote will likely survive only as a political statement.

After all, what are the chances President Obama would sign a law meant to dismantle the signature legislation thus far of his presidency, containing the most sweeping change to federal health law in more than 40 years?

That’s not to say the law won’t need to withstand an array of tactics aimed at delaying implementation.

Technically, the Affordable Care Act (ACA) is on go and will remain so, at least until the courts mandate material changes or a new president from another party is elected, whichever comes first.

That translates into a lot of heavy lifting in the near term for all parties involved, not so much for things that will occur this year, but for the things set to come online in 2012 and beyond.

Arkansas State Insurance Commissioner Jay Bradford understands. In January, Bradford told members of the Arkansas Hospital Association’s (AHA) Metropolitan Hospital District that his office has all engines running full ahead to establish a state Health Insurance Exchange. These individual state exchanges, virtual insurance cyber malls, are a gateway through which many Americans will need to find and buy health insurance.

Exchanges are a centerpiece of the critical health coverage reforms found in the ACA and must be in place by 2014.

The Commissioner and his staff are busy figuring out the when, where, why and how for components of the exchange related to Internet operating systems, consumer assistance responsibilities and regulatory oversight.

The Arkansas Department of Human Services isn’t far behind. One of the residual effects of the Insurance Exchange will be a sizeable increase in state Medicaid rolls, since Medicaid will be the default health plan for people seeking health coverage and whose income is below certain limits.

There’s more. Just over a year from now, the Medicaid office must be ready to implement new enrollment procedures, pay as much or more than Medicare to certain primary care physicians and deal with the consequences of fewer DSH dollars.

The first step toward that end has been to establish and appoint members to a new Medicaid Advisory Committee (MAC), which is charged with providing guidance to the agency in connection with its healthcare reform responsibilities.

Gary Bebow, CEO of Batesville’s White River Health System, and Dr. Jonathan R. Bates, CEO of Arkansas Children’s Hospital, are MAC members, so a hospital perspective will be included in the MAC’s conversations.

The MAC’s input may also help to guide Medicaid’s actions for complying with Governor Mike Beebe’s expressed intent to reduce program spending for the budget’s sake. There’s a sense of immediacy, given the currently predicted funding issues that will show up by state fiscal year 2013, not to mention up to 250,000 Arkansans who could be added to the state’s Medicaid rolls beginning in 2014 due to healthcare reform coverage requirements.

Medicaid officials a year ago laid out plans to explore a DRG-based payment system for hospitals. Look for them to begin experimenting with other changes that piggyback on the various ACA mandates scheduled to unfold during 2012 and 2013 to reduce Medicare hospital spending.

Concepts such as bundled payments, episodic payments, value-based purchasing and some form of Accountable Care Organizations (ACOs) could be the menu for Medicaid, too, plus penalties for hospital-acquired conditions and excessive infection rates.

With one eye on all this peripheral activity that will affect them sooner or later as healthcare providers and/or employers, Arkansas’ hospital community has its own set of ACA concerns to deal with this year.

They really have no choice. It’s either prepare for life under reform, which covers everything from Medicare ACOs to an expansion of transparency initiatives and reduced payments that will begin to unfold during 2012 and 2013, or, in New Jersey jargon, prepare to get whacked.
Labor costs usually tend to be a hospital’s largest expense and growth in net revenue per staffed bed is no longer staying ahead of growth in labor costs. In addition, physician, nurse and clinician shortages are expected to increase in coming years. Healthcare providers that develop efficient recruitment processes maximize their current talent staff and build employee and physician loyalty will gain a competitive advantage as demand for healthcare services grows.

To develop innovative strategies that ensure adequate staffing and minimize the time and money spent filling vacancies, healthcare providers can tap into Amerinet’s executive resources portfolio, which offers savings on services for staffing, physician and employee engagement, retention, and talent management.

Amerinet’s Workforce Management Solutions, powered by Workforce Prescriptions, Inc. offers executives a complete line of resources designed to reduce the patient’s length of stay, address labor cost issues and improve recruiting and retention practices.

Through a unique array of solutions to meet the individual needs of each healthcare provider, Workforce Prescriptions delivers unprecedented results that include:

- A guarantee of $1,000,000 in annual labor reductions
- An average recapture level of $3.5 million per year
- A minimum length of stay reduction of 4 hours
- An average length of stay reduction of 12 hours
- Financial Opportunity Audit – Allows healthcare organizations to gain an understanding of where they may be able to impact financial outcomes through changes to pay practices, staffing levels, service matching, medical staff alignment, care model effective-

Among the tools in the “workforce management toolbox” is a program that uses a pay practice audit of current payroll and pay practices to identify the use of premium pay by type of pay and use by individual and cost center. It includes reports that detail what is being used, why it is being used and how to reduce dependence. In the average adult acute hospital, recapture ranges from $1 million to $15 million per year.

Workforce Management Solutions also offers several types of audits including:

- **HR Audit** – Investigates the functionality and output of HR in nine key areas and 43 sub-areas. The service includes various reports and survey opportunities.
- **Length of Stay Audit** – Uncovers the top 4-6 issues inhibiting throughput and creating excess days of uncompensated care. Adult acute entities average 20 hours of average length of stay reduction.
- Forms automation, which saves customers thousands of man-hours per month by converting paper forms into electronic versions, is also provided.

For more information on Amerinet and Workforce Management Solutions, please contact Jim Foran, director, Member Solutions at jim.foran@amerinet-gpo.com or 877-711-5700 ext. 8611 or Tina Creel, AHA Services, Inc., 501-224-7878 or email her at tcreel@ahaservicesinc.com.
Compliance Tip: Support Your Compliance Program with a Compliance Committee

Creating and facilitating a compliance program is no easy task, so the responsibilities should not rest solely on the compliance officer’s shoulders. Designate a compliance committee to assist the officer in the implementation and monitoring of your compliance program.

To ensure an organized program, the committee should:

- Understand the content and operation of your compliance program
- Review actions taken to ensure consistency with standards and expectations
- Discuss necessary disciplinary actions taken against those who violate hospital policy
- Review audit results
- Approve annual compliance program work plans
- Approve outside consultant hires
- Ensure the compliance officer has the necessary resources to effectively perform his or her role
- Report compliance activities to the board

As your compliance program expands, you will need to address future functions and concepts as they become part of the overall hospital operating structure and daily routine.

This tip was adapted from The Compliance Officer’s Handbook 2nd Edition, by Christine Bachrach, CHC-F; Bret S. Bissey, MBA, CHE, CMPE; and Robert Wade, Esq. For more information about the book or to order a copy, you may visit the HC Pro Healthcare Marketplace at HCMarketplace.com.

Estes Park Institute’s Top Issues in Healthcare 2011

The Estes Park Institute has released its report on “Top Issues in Healthcare for 2011,” based upon surveys conducted at five of its conferences from late 2009 through mid-2010.

The surveys asked attendees to rate 15 healthcare issues on importance to their hospital and the degree of difficulty in achieving each goal.

Taking part in the surveys were hospital management leaders, governance board members and physician leaders.

Emerging as the two most important issues were improving patient safety and getting adequate reimbursement from Medicare. Listed as the most difficult issue to resolve was getting adequate reimbursement from Medicaid. Also among the top five issues: reimbursement from commercial carriers and improving physician-hospital communications.

According to the report, for the first time there is a good deal of consensus on the most important issue to be addressed. For board members and physicians, improving communications is the top issue, and it’s tied for second place among members of management.

All three groups rate “Engaging Effectively in Changing the Healthcare Delivery System” as one of the top three issues to address in the coming year.

The report also notes differences among the three groups. Management leaders say they want to cut costs, while board members list as highly important achieving better reimbursements from Medicare. Physician leaders say an important issue for them is resolving the on-call problem.

Detailed in the report are rankings of the top 15 issues collectively, as well as by group. The perceived difficulty in achieving resolution for each issue is also addressed. Comparisons of importance vs. difficulty are noted, both collectively and broken down by group.


Since 1974, the Estes Park Institute has provided more than 75,000 physicians, healthcare executives and trustees with the focused, up-to-date information, analysis and insight they need to help guide their healthcare organizations toward their goals. To find out more about Estes Park Institute conferences, resources and faculty, visit http://www.estespark.org or call 1-800-727-8225.
FUTURESCAN 2011: Tool Looks at Healthcare Trends, Implications through 2016

Written by an expert panel with data from a survey of nearly 1,000 healthcare leaders across the country, Futurescan 2011: Healthcare Trends and Implications 2011-2016 highlights eight key trends impacting the nation’s healthcare organizations, including:

- Contingency planning for health reform
- Meaningful use of health information technology
- Using wireless medical devices to facilitate care
- Reimbursement related to quality and efficiency outcomes
- The increasing demand for primary care

The guide is designed to fuel strategic planning as it discusses important trends. It is available at a cost of $45 from the American College of Healthcare Executives.

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On October 18, an Administrative Law Judge (ALJ) for the Department of Labor (DOL) issued a ruling that the Florida Hospital of Orlando is subject to federal affirmative action laws by virtue of its agreement to provide healthcare services to eligible TRICARE beneficiaries. [OFCCP v. Fla. Hosp. of Orlando, DOL OALJ No. 2009-OFC-00002 (October 18, 2010).]

If this decision stands, it means that the hospital will be required to follow federal rules on equal opportunity hiring in addition to the myriad of CMS healthcare regulations.

TRICARE, the U.S. Department of Defense’s worldwide healthcare program for active duty and retired military and their families, had contracted with Humana Military Healthcare Services, Inc. (HMHS) to, among other things, establish networks of healthcare providers to provide healthcare services to eligible TRICARE beneficiaries.

HMHS then contracted with the Florida Hospital for the hospital to become a participating hospital in HMHS’ network under its agreement with TRICARE and to provide healthcare services for TRICARE beneficiaries.

The contract between HMHS and TRICARE stated in its contract with HMHS that healthcare service providers are not considered covered subcontractors under the federal affirmative action laws, so there was no language in the contract between HMHS and the Florida Hospital that required the hospital to comply with affirmative action obligations.

HMHS paid the Florida Hospital $100,000 or more annually for medical services that the hospital provided directly to individuals who were beneficiaries of TRICARE.

In August 2007, the Department of Labor’s Office of Federal Contract Compliance Programs (OFCCP) notified the Florida Hospital that it intended to audit its compliance with federal affirmative action laws. When the hospital argued that it is not a covered subcontractor under the federal affirmative action statutes, the OFCCP filed a claim against the hospital.

The case made it through to the ALJ level in late 2010. The ALJ ultimately determined that the hospital was covered under affirmative action laws because it specifically contracted to provide medical services to TRICARE beneficiaries.

According to the ALJ, while participation in Medicare and Medicaid has long been held not to trigger federal subcontractor status because reimbursements under those programs are legally classified as “federal financial assistance,” TRICARE is different because it is required to provide healthcare, and not just pay for care provided by others.

The Florida Hospital is appealing the ALJ’s decision to the DOL’s Administrative Review Board. The American Hospital Association has filed a motion to join the action as a “friend of the court.”

We at the Arkansas Hospital Association will be following the Florida Hospital case closely as the appeal continues. However, even though the case very likely will be headed to federal court for a protracted legal battle, hospitals may want to closely analyze their relationships with federal government agencies through provider networks and similar arrangements and consult with legal counsel regarding possible affirmative action obligations.

Suggested topics for the Legal Note may be submitted to elisawhite@arkhospitals.org. The Legal Note is provided solely for informational purposes and does not constitute legal advice. Readers are encouraged to consult with their own attorneys about any legal issues, including those discussed in this article.
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EHR Reality Check

The number of hospitals that have adopted EHR systems rose slightly from 8.7% to 11.9% between 2008 and 2009. Many see this growth as an indication that EHRs are finally taking hold in the medical community.

However, as we all know, EHR adoption doesn’t necessarily translate to EHR meaningful use. According to a recent report by Health Affairs, only 2% of the U.S. hospitals reported as having EHRs would meet the meaningful use criteria outlined by ARRA (American Recovery and Reinvestment Act) incentives. The report, titled A Progress Report on Electronic Health Records in U.S. Hospitals, analyzed data from an American Hospital Association survey that polled 3,101 non-federal acute-care hospitals about their health IT capabilities as of March 1, 2009.

In my opinion, the results of this report are skewed for one obvious reason – meaningful use criteria weren’t defined until mid-2009 and the final Stage 1 meaningful use rulings were not released until summer, 2010. Clearly, hospitals that adopted EHRs prior to March 1, 2009 had no idea how the federal government would define meaningful use and weren’t implementing these systems with this criteria in mind.

One would hope that the 2% figure indicated by the report would improve if you surveyed hospitals about their health IT capabilities today. Hospitals are now motivated to hit specific EHR benchmarks outlined by the federal government and are installing new systems or updating existing ones in line with this criteria.

EHRs Result in Longer Wait Times?

Another recent study (based on old data) published in the journal Medical Care Research and Review also calls the effectiveness of EHRs into question. This study, which analyzes results from a 2006 Arizona State University survey of 30,000 patient visits to 364 U.S. hospitals, shows that use of basic EHR systems that aren’t “fully-functional” result in longer wait times in hospital emergency departments (EDs).

According to the results, patients who received care at an ED with a basic EHR system experienced 47% longer wait times than those visiting EDs with minimal or no EHR systems.

However, the researchers also found that patients who sought care at hospital EDs that had a fully functional EHR system experienced a 22% shorter length of stay and 13% shorter treatment times than patients who visited EDs that had minimal or no EHR systems.

Among the facilities included in the study:
- Only 1.7% of EDs surveyed had fully functional EHR systems;
- 10.8% of EDs had basic EHR systems; and
- Nearly 88% of EDs had minimal or no EHR systems.

EHRs Effective if Implemented Correctly

While each of these studies is slightly flawed in my opinion, they do point out one universal truth – EHRs will only be effective at streamlining healthcare workflows if implemented correctly.

You’ll notice that in the previous study that fully-functional EHRs contributed to significant reductions in wait times and treatment times. Simply plugging in the software and hoping for the best is a recipe, however, for disaster. Healthcare facilities need to fully understand their existing workflows and how these workflows can be optimized through digitization before implementing EHR technology. Also, rather than rushing into an EHR implementation in an effort to capitalize on federal stimulus incentives, many facilities may be better served by easing into EHR adoption by first installing smaller automation systems, such as document imaging and capture systems, e-forms solutions, or e-prescribing platforms. These systems can provide the “baby steps” some facilities need to become comfortable with the technology itself and the workflow changes these systems trigger.

Secondly, it is important to become familiar with the federal government’s meaningful use criteria, deadlines, and incentive payout schedule. You’ll want to capitalize on the incentives that make sense for your facility and are in line with your EHR rollout plan. However, don’t base your plan solely on securing meaningful use incentive payments. Much of the federal government’s meaningful use criteria is to progress the U.S. healthcare system toward an automated and interoperable environment at the fastest pace possible. You’ll have to judge whether or not this pace is realistic for your healthcare facility. Remember, rushing an EHR project can lead to an ineffective implementation. And, as illustrated by the aforementioned studies, an ineffective EHR implementation can produce negative results instead of the positive productivity, financial, and patient satisfaction gains that are intended.

Finally, it’s important not to lose sight of your patients on your quest for EHR meaningful use. Digitization is designed to improve their quality of care. Healthcare facilities need to take the steps necessary to ensure this occurs.

Article used with permission. Ken Congdon is editor in chief of Healthcare Technology Online (www.htoinfo.com), an online B2B publication and resource center dedicated to providing healthcare professionals with the information they need to make informed Health IT purchasing and implementation decisions. For more articles like the one above, subscribe to Healthcare Technology Online’s free weekly email newsletter at http://tinyurl.com/y8bdhp. Ken Congdon can be reached at ken.congdon@jamesonpublishing.com.
Seven Ways Community and Rural Hospitals Can Achieve Meaningful Use

Although many hospitals are rapidly making a move toward deploying healthcare information technology in order to qualify for incentive payments through the American Recovery and Reinvestment Act, there is widespread concern that healthcare providers in smaller communities will not be able to keep up with this swift movement toward electronic health records. Community and rural hospitals, lacking financial strength and IT expertise, often cannot afford the big investment in healthcare IT larger health systems are able to make. Here are seven ways community and rural hospitals can achieve meaningful use despite lack of funding and resources.

1. **Understand and stay educated on meaningful use.**
   The federal government released an estimated 800-page document that outlines and details the definition, requirements and goals behind meaningful use. Eric Geis, managing director of CommunityWorks at Cerner, says because the information is so complex, it is critical for community and rural hospitals to work diligently to parse out the information and truly understand the measures, criteria and requirements tied to Stage 1 of meaningful use, as well as understand what criteria might be required in later stages.

   “Looking ahead is critically important, as the requirements around meaningful use will only become more stringent and demanding with the finalization of Stages 2 and 3.” Mr. Geis suggests community and rural hospitals establish a committee whose sole responsibility is to monitor the climate around healthcare IT and meaningful use on Capitol Hill.

   “Step one is getting organized,” says Mr. Geis. “Rural and community hospitals can start to overcome [the challenges of meeting meaningful use] by first figuring out who within the organization is tagged to learn and keep track of everything.”

2. **Consult other resources.** Hospitals should consult federal- and state-level organizations created to offer healthcare providers the services and tools needed to achieve meaningful use. State Offices of Rural Health, regional extension centers, the National Rural Health Association and industry experts can serve supporting roles for rural and community hospitals. Mr. Geis says reaching out to other small healthcare organizations on how they succeeded in deploying EHRs can prove beneficial.

   “The Office of the National Coordinator recently hosted a meeting to discuss where smaller hospitals fit into meaningful use,” says Janet Kiburz, program manager at Cerner. “It’s important to get the ‘small hospital’ perspective because most have the same questions: How are small hospitals managing healthcare IT? What do meaningful use rules mean for small hospitals, especially in the critical access space?”

3. **Gain buy-in and support of EHR deployment.** Successful EHR deployment and qualification for incentive payments directly depend on whether community and rural hospitals successfully obtain buy-in and support. This includes the hospital board, physicians, other medical staff and the surrounding community. If there are no clinicians on board to use the system and no patients willing to take advantage of a personal electronic record, rural and community hospitals will struggle to achieve meaningful use and reap the benefits healthcare information technology can provide.

   “Many community and rural hospitals may not have done much strategic planning around health IT initiatives,” Mr. Geis says. “Getting the community involved is going to be very important.”

4. **Research alternative financial arrangements.** Because rural and community hospitals generally don’t experience as much of a cash flow as some other larger hospitals and health systems, it will be incumbent upon them to research alternative and creative financial arrangements with their supplier of choice. Mr. Geis says some suppliers understand not all healthcare organizations are capable of putting down as much capital on the front end, so they will sometimes work with smaller hospitals to design a payment plan that is more feasible.

   “There are definitely companies that are trying harder to be creative with their financing and payment terms,” Mr. Geis says. “For example, many suppliers have varying approaches to hosting, application management and upgrades, whether those services are included or will have to be paid for separately.”

5. **Deploy a system that fits your organization’s needs.** Because the healthcare IT industry has exploded in the past couple of years, rural and community hospitals should take advantage and choose a vendor whose system fits the hospital’s needs. Contracts and relationships with healthcare IT vendors should also be treated like marriages: for the long-term and

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continued on page 32
through thick and thin. Clinician adoption is a big part of the meaningful use measurement criteria, so choosing a system that gets good adoption scores is also very important.

“If [a community or rural hospital] is going to make a purchase of an EHR system, the organization needs to make sure they are going with a supplier they are confident will meet Stages 1-3 of meaningful use and the goals the organization wants to achieve, such as patient safety and improved quality of care,” Mr. Geis says. “This really ties back to the timelines of meaningful use and the reimbursement methodology. [Community and rural hospitals] should not go with the cheapest product.”

6. Consider how to become interoperable. Meaningful use has a theme around exchange of information, whether at the patient, provider or even state level. Examples are vaccinations, lab results and continuity of care documents. These capabilities and strategies need to be taken into consideration when looking at suppliers and implementation strategies. Outside resources can also give guidance around state initiatives. The next stages of meaningful use will most likely include more requirements around interoperability and exchange of information.

“Sharing patient information with other agencies is huge, so [rural and community hospitals] will have to establish some different processes in order to achieve that interoperability,” Mr. Geis says.

7. Address your organization’s key ongoing concerns. Hospitals across the country are faced with a multitude of challenges, but some challenges are more specific to the rural and community healthcare arena where staffing and capital are limited. Mr. Geis says small hospitals should remain mindful of considerations related to support, training and interfacing. All these issues require a good strategy with the supplier.

“There are some issues [rural and community hospitals] will have to spend some time trying to address,” he says. “One to note is the change in technology. Many physicians in smaller hospitals may not have a computer at home or older nurses aren’t as familiar with computers. To address this, [rural and community hospitals] will have to implement a comprehensive training plan to ensure good adoption of the system.”

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The Office of the National Coordinator for Health Information Technology (ONC) on January 4 issued its final rule establishing a permanent certification program for electronic health record technology and other health information technology.

ONC’s current temporary certification program will be replaced by the provisions in this regulation. ONC will accept applications beginning this spring from organizations that want to conduct certifications under the permanent program.

Testing and certification under the permanent certification is expected to begin January 1, 2012.

For more information about the permanent certification program and the final rule, please visit http://healthit.hhs.gov/certification.

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EHR Contracting Guidelines to Achieve “Meaningful Use”

The American Hospital Association (AHA) in mid-January issued guidelines to help hospitals address common issues that arise when they license electronic health record (EHR) software and related products and services from a vendor to achieve “meaningful use” of EHRs.

Intended for hospitals that will run the licensed software applications on their own servers, the members-only resource provides a checklist of topics and questions that hospitals should consider when establishing a vendor relationship.

It is not intended to substitute for responsible legal advice.

Topics include licensing, custom development, certification, delivery and implementation, hardware and equipment, training, testing, maintenance, regulatory compliance, pricing and payment.

The guide has been e-mailed to AHA members. For more information, see http://www.aha.org/aha/content/2011/pdf/2011EHRguide.pdf?group=hospital&coamfd=t.

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Final Rule on Permanent EHR Certification

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Registration Begins for Medicare EHR Incentives

CMS and the Office of the National Coordinator for Health Information Technology (ONC) announced January 3 the beginning of registration for the Medicare and selected states’ Medicaid electronic health record (EHR) incentive programs.

CMS and ONC are encouraging broad participation and outlined online and in-person resources that are in place to assist eligible professionals and eligible hospitals who wish to participate.

As of January 3, registrations were ready to be accepted from eligible healthcare professionals that wish to participate in the Medicare EHR incentive program.

Registration in the Medicaid EHR Incentive Program also began in Alaska, Iowa, Kentucky, Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee, and Texas.

Registration was to open in California, Missouri, and North Dakota in February. Other states likely will launch their Medicaid EHR Incentive Programs during the spring and summer of 2011.

Future key dates to remember related to EHR implementation are:

- April 2011 – Attestation for the Medicare EHR incentive program begins.
- May 2011 – Issuing of Medicare EHR incentive payments expected to begin.
- July 3, 2011 – Last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR incentive program for federal FY 2011.
- September 30, 2011 – Federal FY 2011 payment year ends at midnight for eligible hospitals and critical access hospitals (CAHs).
- October 3, 2011 – Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 to demonstrate meaningful use for the Medicare EHR incentive program.
- November 30, 2011 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for federal fiscal year 2011.
- December 31, 2011 – Calendar 2011 payment year ends for eligible professionals.
CARE TRANSITIONS: Focus on Quality and Accountability

As today’s healthcare continuum grows more complex, information management and communication are essential components to ensure the best outcomes for patients. Because patients see multiple physicians and healthcare providers, there is a growing risk of poor care coordination. This can increase the potential for medication errors, adverse events and more frequent visits to the hospital through readmissions and emergency room visits. Addressing duplication of services and waste by improving care transition will lead to more efficient and higher quality care.

The Journal of the American Medical Association details a study which sought “to characterize the prevalence of deficits in communication and information transfer at hospital discharge and to identify interventions to improve this process.”1 The study analyzed hospital and physician communications over an approximately 30-year period. The results revealed infrequent direct communication between hospital physicians and primary care physicians (PCPs), ranging between three percent and 20 percent occurrence. Also, discharge summary availability was low at post-discharge visit (12-34 percent) and also at four weeks post-discharge (51-77 percent). This was shown to affect quality of care in approximately 25 percent of follow-up visits and to contribute to patients’ dissatisfaction with the PCP. Even when discharge summaries were available, important information such as diagnostic test results, treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling and follow-up plans was often missing.1

The need for improved care coordination has been widely recognized. In July 2007, a Transitions of Care Consensus Conference (TOCCC) was convened by the Executive Committees of the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM) and the Society of Hospital Medicine (SHM). Fifty-one participants from 30 organizations attended this conference, including a staff representative for the AMA-convened Physician Consortium for Performance Improvement®. Participating organizations included the American Academy of Family Physicians, America’s Health Insurance Plans, Case Management Society of America, the Centers for Medicare & Medicaid Services, National Committee for Quality Assurance and the National Quality Forum. Representatives from pharmacist groups and patient groups such as the Institute for Family-Centered Care were also in attendance.2

In 2009, the Physician Consortium for Performance Improvement published Care Transitions: Performance Measure Set for public comment. This measure set has since been endorsed through the National Quality Forum. The measures focus on safe and effective transitions of care between settings. Processes addressed include:

- Timely delivery of care
- Effective coordination
- Timely transfer of information
- Increasing engagement
- Increasing understanding adherence to treatment plan

The recommendation is to address the measures as an entire bundle which includes:

I. Reconciled medication list is received by discharged patients
II. Transition record with specified elements received by discharged patient:
   a. Reason for inpatient admission
   b. Major procedures and tests performed during inpatient stay and summary of results
   c. Principal diagnosis at discharge
   d. Advance care plan or reason for not providing
   e. Current medication list
   f. Studies pending at discharge
   g. Contact information valid 24 hours a day, seven days a week, including a physician for emergencies related to inpatient stay
   h. Plan for follow-up care
   i. Physician or other healthcare professional designated for follow-up care

III. Transition record with specified elements received by discharged patient3

Healthcare providers who address these measures recognized the role that accurate medication management plans in patient outcomes, the impact of detailed discharge information in patient self-management and follow-up care, and how timely communication of this information can improve continuity of care and reduce readmissions.

Care Transitions and the Medicaid Inpatient Quality Incentive Program

The Medicaid Inpatient Quality Incentive (IQI) program, implemented in 2006 for state fiscal year (SFY)...
2007, awards participating hospitals for achieving improved quality by meeting criteria and reaching improvement thresholds. In 2008, for SFY 2009, the concept of care transitions was introduced to hospitals providing care to Arkansas Medicaid patients. Initially, hospitals were required to implement a discharge process which included a care transitions/care coordination process. Hospitals’ records were reviewed to determine if they had a process which includes a document with required elements for communication. Only 21 of 63 (33.3 percent) passed the validation of this process.

For SFY 2010, the draft three measure set bundle was included in the program for data submission. Forty-eight hospitals chose to participate in the program. The results were as follows:

I. Reconciled medication list is received by discharged patients – 71.6%

II. Transition record with specified elements received by discharged patient – 25.2%

III. Timely transmission of transition record – 39.8%

Measure II is an “all or nothing” measure. In other words, the transition record must contain all of the elements required to pass the measure. Hospitals achieving the most success with this are those that have implemented a standard form or template for capturing the information. Evaluating processes, understanding the rationale behind the measures and physician support are at the heart of improving these measures.

Going Forward

A focus on care transitions is continuing to grow. The Arkansas Medicaid IQI program for SFY 2011 will evaluate three care transitions measures for performance improvement. Hospitals will be required to achieve above the 75th percentile calculated from the statewide baseline for each measure or a 35 percent reduction in failure rate based on the hospital’s own baseline performance. Performance rates are also validated. A hospital can achieve one or the other threshold to pass the performance criteria. On a national level, The Joint Commission includes this in both its national Patient Safety Goals and its survey process for accreditation. Care transitions are at the center of the medical home model which establishes a hub or “home” for coordination of a patient’s care. The Centers for Medicare & Medicaid Services (CMS) continues to hold care transitions across settings of care as a priority. The multiple professional organizations and stakeholders who have committed to better communications and care coordination only further underscores the importance of this work for improving patient outcomes.

Hospitals showing the most success with this measurement have implemented a standardized process using a format that ensures capture of the key elements and communication of the information to the next provider of care. This strategy is most successful when the care team accepts accountability of patient handoffs. As healthcare embraces the electronic exchange of information, this process should become more efficient. Until then, organizations are challenged with providing information to the next provider of care which may not have electronic access to a hospital’s medical information.

J. Gary Wheeler, MD, MPS, is medical director for quality improvement at the Arkansas Foundation for Medical Care and professor of pediatrics at the University of Arkansas for Medical Sciences. Pamela Brown, RN, BSN, CPHQ, is assistant vice president for healthcare quality improvement at the Arkansas Foundation for Medical Care.

REFERENCES


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Summit Report Outlines Important Safety Issues with Infusion Devices

In the past five years alone, the U.S. Food and Drug Administration (FDA) has received 56,000 adverse incident reports involving infusion devices. Making infusions safer was the focus of the recent Association for the Advancement of Medical Instrumentation (AAMI)/FDA Infusion Device Summit, attended by more than 300 multidisciplinary stakeholders. Their Summit Report outlines 13 themes and priorities for healthcare leaders to consider regarding use of infusion devices, which will ultimately improve patient safety.

Arkansas NDMS Discussions Will Have Positive Nationwide Ramifications

Our nation grieved with those suffering the effects and uncertainties of life during and after Hurricanes Katrina and Rita in 2005. Then, in 2008, the same fears returned with the landfall of Hurricanes Gustav and Ike. Thankfully, for many, those difficulties are finally beginning to ease.

Among those particularly affected by the latest duo of hurricanes – a little known group which stepped up immediately to help many families and individuals displaced by those storms – were those hospitals, mostly in Arkansas, that accepted patients as medical refugees in the wake of these four hurricanes, offering safety in a time of storm and uncertainty.

This first major activation of U.S. civilian hospitals to provide “definitive medical care” in the aftermath of a disaster exposed a series of unknown weaknesses in the Memorandum of Agreement (MOA) signed voluntarily by the hospitals and other partners taking part in the National Disaster Medical System (NDMS) response effort. Discussions surrounding reimbursement and logistical issues related to the activation have continued for more than five years. Hope, understanding and agreement are finally on the near horizon.

Issues with the MOA first surfaced after Arkansas hospitals received patients airlifted from the New Orleans area in the wake of Hurricane Katrina. Problems generally involved system failures in getting patients returned to their home state and the transferring hospitals, as well as a disconnect between NDMS reimbursement policies and the Medicare policies that govern payment for Medicare patients caught up in such evacuations.

Also at issue was the lack of adequate coordination between NDMS and the Federal Emergency Management Agency (FEMA) to ensure that hospitals can be reimbursed for non-medical out-of-pocket expenses incurred when patients are required to remain in host-state facilities for lengthy periods.

The Arkansas Hospital Association (AHA) immediately began working with NDMS, FEMA and the U.S. Department of Health and Human Services (HHS) after patients received in the wake of Hurricane Katrina had been treated and returned to Louisiana.

Although discussions were ongoing, no new policies had been instated before the hurricane season of 2008, when Arkansas hospitals again received patients at the time that Hurricanes Gustav and Ike struck the Gulf region.

For many of these patients, the violent storm season meant lengthy stays in Arkansas hospitals. For the hospitals, the difficulties surrounding reimbursements and relocation of patients multiplied; the Arkansas Department of Health (ADH), an NDMS partner, stepped in and performed many of the logistical duties helping track patients, assisting in their return home and providing housing to those forced to stay in Arkansas longer than expected.

Again, discussions with federal agencies continued. Of great assistance in trying to move the process forward was Dr. Paul Halverson, Arkansas’ State Health Officer and director of the ADH.

Hospitals in the Little Rock metro area urged that at least some of the discussed changes should be made official prior to the 2010 hurricane season. When this did not happen, these hospitals felt they had no choice but to withdraw from NDMS participation, which they did on June 1, 2010.

Arkansas Senator Mark Pryor asked representatives from the AHA to testify before the Senate Homeland Security ad hoc Subcommittee on State, Local and Private Sector Preparedness. July 22 of 2010, AHA’s Executive Vice President Paul Cunningham represented the state’s NDMS hospitals before the committee, giving testimony as to the MOA’s weaknesses and their ramifications for NDMS volunteer hospitals.

Since that time, there has been considerable progress and improved communication on the issues, due in large part to AHA’s discussions with HHS Assistant Secretary of Preparedness and Response (ASPR) Dr. Nicole Lurie and Dr. Kevin Yeskey, deputy assistant secretary, Office of Preparedness and Emergency Operations.

At a meeting held in Little Rock January 25, HHSP/ASPR and other federal agency representatives met with representatives of the affected Little Rock area hospitals to discuss new standards and policies that would support the hospitals during and after any NDMS incident. Patient return
issues, improved reimbursement processes and solutions for the communication disconnects during times of emergency were outlined.

HHS/ASPR speakers presented information on how their process development on patient movement had evolved, through experience with NDMS incidents and the Arkansas hospitals’ experiences. Local, state and federal team components were delineated, as were time frame estimations based on various emergency scenarios.

The most important aspect of this presentation centered on the deployment of new Service Access Teams (SATs) designed to follow the patient from originating hospital discharge through relocation and eventual facilitation of patient return. The SATs work out of NDMS Federal Coordination Centers (FCC). Included in these teams’ scope of work are transportation, medical case management, non-patient support and data collection. Upon ADH request, the SAT teams will be located at the ADH Emergency Operations Center. Those teams will work directly with the NDMS Federal Coordination Centers, one of which should be located in Little Rock.

Facilitation of NDMS reimbursements was perhaps the most streamlined of all the new policies. Hospitals receiving NDMS patients will no longer submit claims through CMS, but will work through the FCC directly; the FCC will keep track of all patients, financial intermediaries and payment processes. Web-based payment processes will be utilized.

A new, 10-phase National Patient Movement Framework was developed as a result of the 2008 hurricane season, which saw hurricanes make landfall in the Gulf area and maintain extreme force through the South, Midwest and into the Northeast.

Working on this extremely well-coordinated framework were all NDMS players, including the Department of Defense, National Guard, Veterans Administration, AHA, ADH, Department of Homeland Security, Department of Transportation, all U.S. Regional Emergency Coordinators and representatives from the states of Florida, Oklahoma, Texas, Louisiana and Arkansas.

A new Patient Return Contract was discussed, as was the new MOA with changes made to reflect the difficulties states, especially Arkansas (as Arkansas hospitals received the bulk of the evacuated patients in the case of all three hurricanes), had encountered.

Key changes to the MOA include the addition of the SATs and definition of their function and role, a defined reimbursement table, a statement covering physician billing for the care of NDMS patients, and a provision that the MOA will be updated and redesigned as necessary every five years.

Arkansas hospitals received assurances that hospitals would NOT be in the business of:

- relocating patients and families upon patient discharge;
- providing financial assistance to family members;
- completing a myriad of different forms for various agencies;
- working with FEMA to get patient identification for reimbursement; or
- fighting for months and years for reimbursement, among other problems Arkansas hospitals incurred during Hurricanes Gustav and Ike.

As the liaison when Arkansas hospitals are involved in NDMS operations, I can report that the AHA is very pleased with the thought and coordination that has gone into the new policies. We felt that the meeting was very positive, and that positive changes are being made to improve a broken system. We also believe that Arkansas hospitals will sign the revised MOA when it is ready and that Little Rock metro hospitals will once again participate in NDMS.

As a further tip of the hat to Arkansas’ hard work outlining the difficulties and making suggestions for system improvements, Greg Crain, Vice President, Baptist Health and the Metropolitan Hospital District representative on NDMS issues, was invited to attend a January 28 meeting in Washington, D.C. with the Senior Leaders Council on Patient Movement. The council, convened by HHS, consists of senior-level personnel from the Veterans Administration, Department of Defense and Department of Homeland Security. The group provides a mechanism to coordinate activities across the NDMS partnership regarding the evacuation of victims, tracking patients through the system, and their return to their home states.

It is a rare honor for someone from outside the Senior Leaders Council to be invited to attend one of these meetings. According to Crain, “It was a very positive meeting with Dr. Yeskey and the Senior Leaders Council. We went over every item in the contract that had been changed, such as addressing the significant issues we had in 2008, having a repatriation contract signed and in place with multiple transportation avenues attached, having the SAT teams in place and the plans written for them to function to be deployed pre-event, and their role in helping to discharge patients from hospitals, and having the JPATs communication systems so the hospitals can know what is in route to their region.

“In Dr. Yeskey’s own words, this was a very bad situation for the hospitals that they are trying to turn into a positive one moving forward. They addressed every major issue that we asked them to. Once it has gone through the Executive Secretary rotation for each of the Federal Partners to sign, and if it is presented to the Arkansas hospitals in its current form, I will be very glad to recommend that we rejoin NDMS,” continued Crain.

Oftentimes, lessons learned from negative experiences can turn into positive new processes. Arkansas hospitals’ difficulties with NDMS patient movement, reimbursement and coordination among federal entities and our bringing to light our experiences has resulted in NDMS system improvements that will affect hospitals throughout the entire nation from this time forward. ●
FCC Takes First Step to Help Revolutionize America’s 9-1-1 Services for Consumers, First Responders

Rapid Sharing of Videos, Photos and Data to Improve Emergency Response

The Federal Communications Commission (FCC) on December 21 took an important step to revolutionize America’s 9-1-1 services for consumers and first responders. On that date, a Notice of Inquiry (NOI) seeking public comment on how Next Generation 911 (NG911) can enable the public to obtain emergency assistance by means of advanced communications technologies beyond traditional voice-centric devices was adopted.

The FCC has undertaken this proceeding in response to a recommendation in the National Broadband Plan seeking to harness the life-saving potential of text messaging, email, video and photos from mobile and landline broadband services.

Despite the fact that there are more than 270 million wireless consumers nationwide and that approximately 70 percent of all 9-1-1 calls are made from mobile hand-held devices, today’s 9-1-1 systems support voice-centric communications only and are not designed to transfer and receive text messaging, videos or photos.

In some emergency situations – especially in circumstances where a call could further jeopardize someone’s life and safety – texting may be the only way to reach out for help. In addition, many Americans, particularly those with disabilities, rely on text messaging as their primary means of communication.

The sharing of timely and relevant videos and photos would provide first responders with on-the-ground information to help assess and address emergencies in real-time. For example, these technologies could help report crimes as they are happening, thus giving law enforcement officials an increased advantage when responding.

The NOI asked a comprehensive set of questions that address a number of issues related to the deployment of Next Generation 9-1-1 services, including, but not limited to:

- The technical feasibility and limitations of text messaging, video streaming and photos;
- Consumer privacy issues, particularly related to the sharing of personal electronic medical data;
- Development of technical and policy standards;
- Consumer education and awareness; and
- Inter-governmental coordination and coordination within the public safety community.

For additional information about the NOI, please contact Patrick Donovan, Policy and Licensing Division, FCC’s Public Safety and Homeland Security Bureau, at 202-418-2413 or via email: Patrick.Donovan@fcc.gov.

21ST CENTURY 9-1-1

In December, the FCC took steps to revolutionize America’s 9-1-1 system by harnessing the life-saving potential of text, photo, and video in emergencies.

Background:

- The National Broadband Plan laid out a vision for next-generation 9-1-1 that harnesses cutting-edge technologies to help save lives. 9-1-1, which was established as the national emergency number in 1968, has been a wildly successful lifeline to those in distress. Americans place more than 237 million 9-1-1 calls every year – 650,000 per day.
- Seventy percent of 9-1-1 calls come from mobile phones. But increasingly, consumers are using their mobile phones less to make calls, and more for texting and sending pictures and videos. These new technologies have the potential to revolutionize emergency response by providing public safety officials with critical real-time, on-the-ground information.
Today’s 9-1-1 system is not equipped to take advantage of new technologies. 9-1-1 call centers lack the technical capability to receive texts, photos, videos, and other data. Many 9-1-1 call centers don’t have access to broadband, which makes it difficult to receive incoming data, particularly in large volume. Finally, call center operators have not been trained to effectively communicate using these new technologies.

The technological limitations of 9-1-1 can have tragic, real-world consequences. During the 2007 Virginia Tech campus shooting, students and witnesses desperately tried to send texts to 9-1-1 that local dispatchers never received. If these messages had gone through, first responders may have arrived on the scene faster with firsthand intelligence about the life-threatening situation that was unfolding.

Bringing 9-1-1 into the 21st century is one of the FCC’s key public safety priorities. In December, the FCC launched a proceeding, as recommended in the National Broadband Plan, to determine how to transition the current system to broadband-enabled, next-generation 9-1-1. This action builds on the FCC’s recent order to improve 9-1-1 by beefing up location-accuracy requirements so that first responders can quickly find people who reach out for help on their mobile phones.

Benefits of Next-Generation 9-1-1

• **Text for Help:** Many Americans, particularly those with disabilities, rely on texting as their primary means of communication. In some emergency situations – especially in circumstances where a call could further jeopardize someone’s life and safety – texting is the only way to reach out for help. Next-generation 9-1-1 will allow call centers to receive texts and put them to use.

• **Real-Time Rapid Response:** Mobile video and photos provide first responders with on-the-ground information that helps them assess and address the emergency in real-time. These technologies also help report crime as it is happening. Next-generation 9-1-1 would expand the multi-media capabilities of 9-1-1 call centers.

• **Automatic Alerting:** Next-generation 9-1-1 would enable emergency calls to be placed by devices, rather than human beings. Examples of such devices include environmental sensors capable of detecting chemicals, highway cameras, security cameras, alarms, personal medical devices, telematics, and consumer electronics in automobiles.

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AHA/AAHT to Offer Best on Board Trustee Training

Thanks to a generous grant from Arkansas Blue Cross and Blue Shield (ABCBS), the Arkansas Hospital Association (AHA) and the Arkansas Association of Hospital Trustees (AAHT) are joining forces with the national Best on Board organization to offer a unique program designed specifically for the education, testing and governance certification of healthcare trustees and executive leaders.

Best on Board specializes in helping hospital trustees and other healthcare leaders gain the confidence and competence needed to make better, more informed decisions and to govern more effectively on behalf of the patients and communities they serve.

In November 2009, Arkansas hospital governance leaders participated in a pilot test of Best on Board’s “Essentials of Healthcare Governance.” Following that meeting, more than 40 Arkansas trustees and hospital executives successfully passed the Essentials course, while offering comments and recommendations about the program.

Revisions were made based on the Arkansas responses to finalize the course now being offered.

The course will be offered twice this year to Arkansas governance leaders. On April 27, during the AAHT Spring Forum, workshop participants will have the opportunity to go through three hours of the “Essentials of Hospital Governance” and learn how to take the remaining three hours online. In addition, those who have completed the first course will participate in the second series, “The Board’s Quality Imperative,” and take the remainder of the course online.

The ABCBS grant will allow the program to be offered at a greatly reduced fee for Arkansas participants, making it more financially manageable for AHA members.

For more information on participating in the Best on Board programs, please contact Beth Ingram at the AHA, 501-224-7878 or email her at bingram@arkhospitals.org.

From ACHe-news: Three Questions to Ask Before Merging or Selling Your Hospital

The American College of Healthcare Executives (ACHE) in its online newsletter ACHe-news recently excerpted an article aimed at helping governance leaders considering a hospital merge or sale.

From an article by Lindsey Dunn in Becker’s Hospital Review: “In order to make any deal involving a possible transaction or affiliation as seamless as possible, hospital boards must consider what resources are necessary for long-term success, whether a merger or acquisition target will provide those resources for success and which factors will attract or detract from a potential sale or merger.

“Many mergers or acquisitions are broached to provide a hospital with greater access to capital or technology and greater negotiating power with payors and vendors. Examining hospital balance sheets, market situation and physician relationships can provide executives with the information necessary to determine which resources are needed for future success.

“Executives also must work with partners or acquisition candidates to determine if the resources the hospital needs can be enhanced or supplied through the transaction, which calls for an analysis of more than purchase prices. Hospitals should ensure that problems facing their organization will not hinder deals and are resolvable through the transaction.”

To read the entire article, please visit http://www.beckershospitalreview.com and search the January 10 articles.
In 2008 Arkansas Hospitals
provided over $518 million dollars in services to self pay Arkansas patients. Most of it was uncompensated.

In 2008 self pay Arkansans:
- Accounted for 30,000 hospital admissions annually.
- Cost $17,184 for the average hospital stay.
- Averaged 4.88 days length of stay.

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Proposed IPF-PPS Rule Issued

A proposed rule on the inpatient psychiatric facility prospective payment system (IPF-PPS) would increase payments to those facilities by 2.54%.

The rule includes a 3% market basket update, a 0.25% cut to the market basket as mandated in the Patient Protection and Affordable Care Act, and other proposed policy changes.

Specifically, the rule proposes to change the IPF-PPS “rate year” from July-June to October-September, the federal fiscal year.

In addition, the rule would allow a temporary adjustment to an IPF’s resident cap to reflect residents the facility received from a closed IPF or IPF residency training program.

It also would create an IPF-only market basket. Currently, IPFs are updated using the rehabilitation, psychiatric and long-term care market basket.

CMS accepted comments on the proposed rule through March 20.

CMS Delays Clinical Diagnostic Lab Test Requisition Signing Requirement

The Centers for Medicare & Medicaid Services (CMS) decided late last year not to enforce before April 2011 a requirement that a physician or qualified non-physician practitioner sign requisitions for clinical diagnostic laboratory tests paid under the calendar year 2011 clinical laboratory fee schedule.

A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.

CMS has instead focused on provider education of the new rule in the first quarter of 2011 and will begin enforcement of the requirement in April.

The American Hospital Association and other groups were successful in delaying this requirement.

In the November 29, 2010 Medicare Physician Fee
Schedule final rule, the CMS finalized its proposed policy to require a physician’s or qualified non-physician practitioner’s (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective January 1, 2011.

A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. Although many physicians, NPPs, and clinical diagnostic laboratories may have been aware of, and were able to comply with, this policy, CMS was concerned that some physicians, NPPs, and clinical diagnostic laboratories were not aware of, or did not understand, this policy.

As such, CMS made the decision to focus in the first calendar quarter of 2011 on developing educational and outreach materials to educate those affected by this policy.

The most current information is available at [http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp#TopOfPage](http://www.cms.gov/ClinicalLabFeeSched/01_overview.asp#TopOfPage).

**NPCC has implemented a non-degree program designed for those with a Medical or IT background. This program will provide a pool of qualified workers to aid in the transition to Electronic Health Records (EHR).**

NPCC is offering Health IT Workforce Training for the following roles:

- **Trainer** – Aids in the design and delivery of EHR training programs
- **Practice Workflow Redesign** – Assists in reorganizing workflow and operations
- **Clinician/Practitioner Consultant** – Similar to the “Practice workflow” utilizing the background and experience of a licensed clinical professional
- **Implementation Manager** – Provides on-site management of mobile adoption support teams for the period of time before and during implementation of health IT systems

This program is designed to be completed in six months or less for full time students. Cost for this training program is $300, with payment plan available. Upon successful completion of a workforce role students may receive full/partial tuition reimbursement and be eligible to sit for the national EHR competency exam.

**Applications available at [www.npcc.edu/healthit](http://www.npcc.edu/healthit)**

Registering students now through September 2011 – Call for start dates

For more information visit our website or contact Amy Watson at (501) 760-4190.
Value-Based Purchasing Advisory

The American Hospital Association has issued a Regulatory Advisory containing a detailed analysis of the Centers for Medicare & Medicaid Services’ (CMS) January 13 Proposed Rule on Value-Based Purchasing (VBP).

The Advisory is available at http://www.arkhospitals.org/archive/MiscPDFFiles/FINAL%20vbp%20regulatory%20advisory.pdf in the “Hot Topics” section of the Arkansas Hospital Association’s Web site.

Hospital staff, including quality directors and CFOs, may want to review this Regulatory Advisory closely to begin analyzing the potential impact on your organization.


CMS’ recent proposal for implementing a VBP (aka: pay-for performance) program beginning in FY 2013 links Medicare inpatient payment to quality performance for acute care hospitals paid under the inpatient prospective payment systems (IPPS).

As required by the Affordable Care Act, the VBP program will be budget-neutral with all funds distributed in the same year they are collected. To make that possible, the pool of dollars to be redistributed among hospitals based on their quality-performance is to be funded through an across-the-board reduction to the IPPS standardized amount for the respective year.

The reduction is scheduled to be 1.0% in FY 2013, increasing by 0.25% each year until the reduction reaches 2.0% for FY 2017 and subsequent years. Under the proposal, hospitals will earn points toward a VBP score, and will receive the higher of an achievement or improvement score for each quality measure that is used for the program.

A total VBP score for each hospital is calculated and will determine a hospital’s gain or loss.

Initially, CMS hopes to use 17 clinical “process of care” measures and eight patient satisfaction measures for the VBP scoring. The measures reflect a subset of those currently reported under the Hospital Inpatient Quality Reporting (IQR) program.

Twenty-three “outcome” measures would be added in FY 2014. In addition, there would be a process to expedite the timeline for adding measures in the future.

Critical access hospitals and certain other hospitals are to be excluded from the program.

As required by the Affordable Care Act, the VBP program will be budget-neutral with all funds distributed in the same year they are collected. To make that possible, the pool of dollars to be redistributed among hospitals based on their quality-performance is to be funded through an across-the-board reduction to the IPPS standardized amount for the respective year.

CAHs to Receive Free Comparative Reports

Beginning in April 2011, CMS will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide.

The report – known as PEPPER, or the “Program for Evaluating Payment Patterns Electronic Report” – provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring activities.

PEPPER is the only free report comparing a CAH’s Medicare billing practices with other CAHs in the state, MAC or FI (Medicare Administrative Contractor or Fiscal Intermediary) jurisdiction, and nation.

For more information visit www.PEPPERresources.org. CAH staff are also encouraged to join the e-mail list on this Web site to receive important notifications about upcoming PEPPER distribution and training opportunities.
Medicare Timely Claims Filing Requirements

Under the Patient Protection and Affordable Care Act (PPACA), fee-for-service physicians, providers, and suppliers submitting claims to Medicare for payment MUST file their claims for services furnished on or after January 1, 2010 with their Medicare contractor no later than one calendar year (12 months) from the date of service, or Medicare will deny those claims.

For claims requiring reporting a line item date of service, the line item date will be used to determine the date of service. For other claims, the claim statement’s “from” date is used to determine the date of service.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the following MLN Matters articles related to this subject:


A video training module describing this new requirement is due soon. Additional information is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf.

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Article Details HHA/Hospice Certification Policy

The Medicare Learning Network has released an article detailing the new Medicare requirement for home health and hospice care certification that became effective January 1.

Enforcement has been delayed until April 1.

As a condition for payment, hospital and other physicians certifying a patient’s eligibility for the home health and/or hospice benefit must document that they or an allowed non-physician practitioner has had a face-to-face encounter with the patient.

The new law affirms the role of the physician as the person who orders home healthcare based on personal examination of the patient.

It requires that a physician who certifies a patient as eligible for Medicare home health services must actually see the patient. The law also allows the requirement to be satisfied if a non-physician practitioner (NPP) sees the patient, when the NPP is working for or in collaboration with the physician.

As part of the certification form itself, or as an addendum to it, the physician must document that the physician or NPP saw the patient and document how the patient’s clinical condition supports a homebound status and need for skilled services. The face-to-face encounter must occur within the 90 days prior to the start of home healthcare, or within the 30 days after the start of care.

While the long-standing requirement for physicians to order and certify the need for home health remains unchanged, this new requirement assures that the physician’s order is based on current knowledge of the patient’s condition. In situations when a physician orders home healthcare for the patient based on a new condition that was not evident during a recent visit, the certifying physician or NPP must see the patient within 30 days after admission.

The new requirement includes several features to accommodate physician practice. In addition to allowing NPPs to conduct the face-to-face encounter, Medicare will allow a physician who attended to the patient but does not follow patient in the community, such as a hospitalist, to certify the need for home healthcare based on their face-to-face contact with the patient in the hospital and establish and sign the plan of care.

Medicare will also allow such physicians to certify the need for home healthcare based on their face-to-face contact with the patient, initiate the orders for home health services, and “hand off” the patient to his or her community-based physician to review and sign off on the plan of care.

Finally, in rural areas, the law allows the face-to-face encounter to occur via telehealth, in an approved originating site.


The new law affirms the role of the physician as the person who orders home healthcare based on personal examination of the patient.
MedPAC Recommends PPS Updates

The Medicare Payment Advisory Commission (MedPAC) in January recommended that Congress provide an update of 1.0% for fiscal year (FY) 2012 inpatient hospital payments, and rejected the productivity cut currently in law. The update represents a 2.5% update with a 1.5 percentage point reduction to reflect a documentation and coding offset, for a final update of 1.0%.

The commission also said that Congress should direct the Secretary of Health and Human Services (HHS) to fully recover all overpayments due to documentation and coding, rather than just overpayments made in FYs 2008 and 2009.

In addition, MedPAC recommended a 1.0% update for the next round of outpatient hospital and physician payments and a 0.5% update for ambulatory surgery centers. Inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities or home health providers would get no payment update in FY 2012 if MedPAC’s recommendations are implemented.

For home health, the commission said Congress also should direct the HHS Secretary to begin a two-year rebasing of rates to reflect the average cost of providing care in 2013; revise the home health case-mix system to rely more on patient characteristics; implement a per-episode co-pay for home health episodes not preceded by hospitalization or post-acute service; and allow CMS to suspend payment or enrollment of new providers if it finds significant problems. The commission recom-

Arkansas Medicaid Offers Web-Based RAs

Arkansas Medicaid has sent out a letter and Remittance Advice (RA) message giving providers a high level notice of a new way to view their weekly remittance advice.

The Arkansas Medicaid program now offers RAs in PDF format, which can be viewed and downloaded from a secure Web site. This new feature will allow providers quicker access to remittance information than can be provided with paper RAs.

The new RA, referred to as a WebRA, looks exactly like the paper RA, while offering the advantage of electronic search functionality.

Workshops focused on the WebRAs are planned.
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