A Trustee’s Primer—Corporate Governance and the Hospital Board

AHA Awards Presented

AHA Outlines Organization’s 2007 Goals and Strategies

Number of Uninsured Rises Above 46 Million
It’s the fast way to check:
• Eligibility
• Benefits
• Claims status

Interactive voice response means:
• No waiting; no “on-hold”
• No buttons to push; responds to your voice
• 24-hour access, seven days a week
• Saves you time and money

Call My Blueline, 24/7.

ATTENTION BUSINESS OFFICE STAFF:

You want quick answers to your insurance questions?

Call number on the member’s ID

BlueAdvantage Administrators of Arkansas
Call number on the member’s ID

Health Advantage
1-800-843-1329

Arkansas BlueCross BlueShield
1-800-827-4814
A Trustee’s Primer – Corporate Governance and the Hospital Board

The Critical First Step Out of Crisis: Convincing the Staff

What to Do About the Rising Number of Uninsured?
With new leadership in the US Congress – leadership that we believe will be more attuned to healthcare issues – we find ourselves relieved that public debate on healthcare issues is finally getting back to a place of prominence in our nation.

With the pre-election polls showing healthcare as third in the top five concerns of Americans, we believe that our nation is ready for healthcare reform. Not since the early 1990s – early in the Clinton administration – has healthcare been as much on Americans’ minds as it is today. It is good to get our country back to serious discussion!

Why has healthcare become such a hot topic now? With ever-increasing numbers of uninsured and underinsured citizens, politicians are hearing the message as never before from many economic strata. No longer is the discussion held only around the healthcare needs of lower income Americans. Today, the discussion involves an increasing number of those in the middle class who see their healthcare costs rising, employers discontinuing or lowering healthcare benefits, and a rising number of formerly insured individuals and families who now find themselves without adequate coverage.

In Arkansas, greater numbers of employers each year do not provide health insurance for their workers. It’s not that they don’t want to provide the insurance; it’s that the ballooning costs of providing healthcare coverage make the benefit economically impossible for many.

It’s a sad fact that in many other industrialized nations, all citizens’ basic healthcare is covered, and they achieve better medical outcomes than we do here in the US. Our system is at a tipping point in regard to the costs of providing healthcare. With Medicare and Medicaid reimbursements less than the cost of providing care, and with some citizens simply choosing not to take responsibility for purchasing their own health insurance or paying for their healthcare (they know our nation’s hospitals will not turn them away), many American hospitals are in a financially precarious position that continues to worsen with each passing year.

So, as healthcare brews on both the national and state levels, and with the convening of the Arkansas General Assembly in January, I want to ask you to be ready to roll up your sleeves on the political front this year.

In Arkansas, the Senate and House Public Health Committees have many new members who do not have a deep background in healthcare issues. These members will hear from the Arkansas Hospital Association on behalf of Arkansas hospitals; they will, on occasion, also need to hear from you directly, as those who best know healthcare in our state.

Please be prepared to contact your legislators if we send a request. We promise you that we will not ask you to do so unless it is absolutely essential, as we know that spending time on the political front is not your first priority.

However, since Medicare and Medicaid make up most of your hospital’s revenues, it remains incumbent on hospital administrators, members of the hospital staff at all levels, and hospital governing boards to respond to the political winds that will blow from Little Rock and Washington.

Good communication with elected officials helps us help you protect your hospital. And it makes for wiser decisions in both Washington, DC and Little Rock when those involved in healthcare do not shy away from the debate.

Phil E. Matthews
President and CEO
Arkansas Hospital Association
> Pharmacy Benefits Manager
> Home Delivery Pharmacy
> Specialty Pharmacy
> Health Information Management

Better health outcomes for members.
Better cost outcomes for plans.

For more information, please contact NMHC at 800-251-3883 or online at www.nmhc.com

AHA Services, Inc.
A wholly owned subsidiary of the Arkansas Hospital Association.

AHA Services is committed to providing AHA member hospitals with access to quality products and programs.

For information on any of our programs please contact Tina Creel or Phil Matthews

Phone 501-224-7878       Fax 501-224-0519
http://www.arkhospitals.org/aha_services
Employee Benefits Simplified.

For more than 25 years, the professionals of Hagan Newkirk have partnered with healthcare providers throughout Arkansas to make administering employee benefits simple.

With our online enrollment and HR management systems, ALL your benefit information is just a key stroke away.

Hagan Newkirk Financial Services, LLC.

1501 N. University, Ste. 365 • Little Rock, AR • (501) 664-9381 • hagan-newkirk.com
Ray Kordsmeier of Conway has been appointed an at-large member of the American Hospital Association’s Committee on Governance. His term will expire in December 2009. Kordsmeier currently serves on the board of Conway Regional Medical Center and is a former member of the Arkansas Hospital Association board of directors representing the Arkansas Association of Hospital Trustees.

Russell D. Harrington, Jr., president of Baptist Health in Little Rock, recently accepted a 2006 Employer Support Freedom Award from the U.S. Department of Defense. The award, presented in Washington, D.C. September 21, was presented to 15 outstanding employers of National Guard and Reserve members. Hundreds of those members from across the country nominated their employers for their exceptional support to ease their transition from civilian employees to active military personnel and back.

Connie Melton, CHE, has been named Section Chief, Health Facilities Services, DHHS, Division of Health. She succeeds Renee Mallory who has assumed the role of Branch Chief, Health System Licensing and Regulation. Melton is a former vice president for hospital services at Saline Memorial Hospital in Benton and recently worked in physician practice management. She is immediate past-president of the Arkansas Health Executives Forum.

Jonathan Davis, administrator and CEO of St. Anthony’s Medical Center in Morrilton, has resigned to assume the position of president and CEO at Mt. Carmel Regional Medical Center in Pittsburg, Kansas. He joined St. Vincent Health System, which operates St. Anthony’s, in 1996 and was awarded the C. E. Melville Young Administrator of the Year Award from the Arkansas Health Executives Forum in 2005.

James W. Fairchild, CHE, has been named president and CEO of Delta Memorial Hospital in Dumas. He succeeds Mark Deal. Fairchild was most recently CEO of healthcare facilities in Kansas and Nebraska.

Angela Richmond has been named president and CEO of Community Medical Center of Izard County (CMCIC) in Calico Rock. She succeeds co-administrators Meryl Grasse, MD, and Genna Nave, RN. Richmond is a former director of finance for Ozarks Medical Center in West Plains, Missouri and has over 25 years of business experience. Dr. Grasse will continue at CMCIC overseeing new construction and Nave will remain quality/infection control/discharge planning coordinator at the hospital.

AHA Names Three to Board

Hospital CEOs Richard Goddard, CHE and Gary Looper were elected to the Arkansas Hospital Association Board of Directors during the AHA’s October 5 House of Delegates meeting in Little Rock. Goddard is CEO of Drew Memorial Hospital in Monticello and will represent the Southeast District through October 2008. Goddard succeeds John Neal, CEO/Administrator of Stuttgart Regional Medical Center, who was elected alternate delegate representing Arkansas on the American Hospital Association’s Regional Policy Board 7.

Looper is CEO of Northwest Health System in Springdale and will represent the Northwest District. His term expires October 2010. Peg Kuhnly of Hot Springs, president of the Arkansas Hospital Auxiliary Association, will serve a one-year term on the AHA board.
Scott Peek — Innovative Financing, Two Expansions as Danville’s CEO

A family man who has built a family atmosphere at Chambers Memorial Hospital in Danville, Scott Peek is a person committed to his community. On the day we spoke with him, he and his wife, Lisa, planned to spend their evening at an important high school football game – Danville vs. Bigelow – where his son, Chase, would serve as quarterback. (Danville ultimately went on to the quarter final round in the Arkansas 2A high school football championships.)

Peek came to hospital administration through the paths of finance and business administration. Growing up in Mena, Scott spent his senior year of high school at Plainview. He then went on to Arkansas Tech in Russellville, where he double-majored in Economics/Finance and Business Administration. Upon graduation, he accepted a position in Tatum, Texas, later moving to Marshall, Texas working for the Texas Utility and Generation Company in its accounting department.

“Lisa is from Danville, and when we unexpectedly got a call one night in 1983 saying that Chambers Memorial had an opening for a CFO, I immediately applied for the job,” he says. “I was offered and accepted the position. Four years later I was promoted to Assistant Administrator, and became the CEO in 1990.”

With his financial guidance, the hospital has been profitable for 23 consecutive years. “Chambers Memorial has grown from $1.8 million in revenue (1984) to $21 million in revenue in 2006,” he says. “Also, we have grown from 64 employees to 210 during the same time period.” His impact on the hospital’s profitability is testament to his strong commitment, both to the hospital and to the community.

“I came to the hospital at a time of transition,” Peek says. “Healthcare was moving from a cost-based system to the prospective payment system. We realized that for our small, rural hospital to survive, we had to concentrate on inpatient care. A very large part of that depended upon our relationships with our physicians. Today, we attribute our success to our physicians and our excellent relationship with them. We all realize that to be successful, we must work together and have close relationships across the board.”

That is a part of what has created the feeling of “family” at Chambers Memorial. Relationships among coworkers at every level are key. “To be a successful CEO in a small hospital, you can’t have a big ego,” Peek says. “You can’t be domineering. You must be consistent and formulate positive working relationships with everybody who works in the hospital. I pride myself on being the same person with each and every person, each and every day I come to work.”

Chambers Memorial Hospital is a 41-bed facility that provides care to a service area of about 25,000, Peek says. “We provide most all of the ancillary services including home health, physical therapy, occupational therapy, speech therapy and surgery. We perform cataract surgery and have cardiology, urology and podiatry clinics from outside physicians.”

One of the most exciting decisions on the part of the hospital has been to work closely with city and county officials to access the HUD 242 Mortgage Bond Program both in 1999 (toward a $7.1 million expansion) and 2006 (a $12.5 million expansion).

Chambers Memorial is the only hospital west of the Mississippi River to access this funding. Peek says he cannot understand why other hospitals do not tap into the program. “It is a bit of an arduous process,” he says, “but it’s a great financial resource for hospitals.”

Elements of the HUD application process include attending a pre-application meeting in Washington, DC where “you sell HUD on your hospital,” Peek says. The hospital must provide a detailed picture of its financial status, conduct a feasibility study, then, ultimately, attain approval and sell bonds for hospital construction that are backed by the federal government.

“With our 1999 utilization of the HUD Mortgage Bond Program, Yell
County granted us permission to sell $7.1 million in bonds to fund hospital expansion. The county was not ever placed in a financial bind, since HUD guaranteed the bonds, and there was no obligation on the bonds to the county,” he explains. (The bonds on the 1999 expansion will be paid in full in 12 years, less than half the time granted by the bond issue.) “In 2006 we again went to HUD to apply for acceptance into its Mortgage Bond Program, and were accepted. Again, Yell County gave us permission to sell the bonds. With the new expansion, we will retire some patient rooms that are more than 35 years old, and all rooms will become single-patient rooms.” The Department of Housing and Urban Development’s Section 242 Mortgage Bond Program is designed to help hospitals access affordable financing for capital projects. Since the program began in 1968, Federal Housing Administration Insurance has insured approximately 300 hospital mortgages for a total of $8.6 billion. Clients range from relatively small hospitals to some of the nation’s most prestigious teaching hospitals. FHA insurance enables clients to enhance their creditworthiness because their debt is backed by the full faith and credit of the US Government. In fact, FHA-insured county hospitals were not supposed to make money, Peek says, “But you have to make enough to put back into your facility; you must look to the future.”

With that future in mind, the hospital’s governing board began a program in 1987 to totally refurbish the existing hospital, much of which was still operating with its original facility and equipment dating to 1956. “There was some refurbishing in 1968 and again in 1974,” he says. “But the building still had its original wood frame construction in 1987 when the Board voted to do a complete update.”

In 1989, the hospital’s focus was realigned to building closer relationships with physicians serving the hospital. “It isn’t just the community that makes a choice to utilize a hospital facility,” Peek says. “Physicians also make a choice whether or not they will utilize it.” He says that in 1989, physicians wanted 24/7 coverage of the Emergency Department, but they didn’t personally want the responsibility of covering all shifts. “We knew we needed to generate money to cover those ER shifts,” Peek says. “So we worked with our physicians to build an in-hospital clinic to generate the needed funds.”

The collaboration was a great success. “It was sort of a ‘Field of Dreams’ concept,” he says. “We have moved from an average of nine hospitalized patients to an average of 25 inpatients per day, because the community has chosen to utilize the facility. In addition, our clinic sees an average of 65 patients a day – again because our citizens and physicians choose to utilize the facility.”

Peek says he is careful to keep the hospital moving ahead, “or the public thinks you’re falling behind.” The hospital has recently added a new Toshiba 16-slice CT machine, new ultrasound and laparoscopic equipment, and new cataract surgical equipment.

“Our hospital continues to be prosperous because our physicians work with us, our community/region supports us, and monies generated are put back into the facility,” he says. He also credits some of the hospital’s success to low management turnover, and a great reduction of turnovers in the nursing department.

“Like many hospitals, we had a real problem with recruiting and retaining good nurses,” Peek says. “But four years ago, we were fortunate to hire a director of nursing who is excellent in recruiting and retaining our nursing personnel. We see our relationships with our nurses as vital to the hospital’s continued success. And the significant decrease in nursing turnover has added a tremendous level of comfort to our patients.”

Another element of the hospital’s success – which Peek attributes to the
hospital’s governing board – is creation of the position of Community Relations Liaison. “Our liaison visits with every single patient,” he says, “to make certain their stay is the best it can possibly be. She helps us uncover things that help the facility improve. She finds out how patients believe the hospital can be more helpful to the community. And then, she makes certain the hospital’s message is available to and heard in the community.”

So what are the true factors contributing to the success of Chambers Memorial Hospital? Its feeling of “family?” Its close touch with the community? Its highly positive hospital/physician relationships? Its attention to continuity? Whatever the mix, it is certain that each of these contributes to Chambers Memorial’s selection to Solucient’s Top 100 Hospitals list three years running. It is the only Arkansas hospital to achieve this honor.

Yet challenges persist. Peek sees reimbursement, especially outpatient reimbursement, as a major issue faced by his, and every, small hospital. “Managed care has also become a concern, as has the rapidly expanding world of medical technology as we try to keep a leading edge.”

In his years as a hospital administrator, Peek says DRG reimbursement is one of the major changes he has seen. “Changes to swing-bed and Medicaid UPL have also greatly affected us,” he says. He also cites the shortage of medical professionals, including RNs, med techs, ultrasound techs and others as both a change over the years, and as a present concern.

Through all the changes, he says, he appreciates the role the Arkansas Hospital Association plays in his work as an administrator. “The AHA is a resource for me,” he says. “I utilize their expertise on issues, and I feel they are our advocate. Their being there allows me to do my job, here.”

Scott and his wife, Lisa, married 24 years, have three children. Their eldest, Kayla, attends Arkansas Tech University, and is studying nursing. Her husband, Daniel, is Defensive Coordinator for the Danville High School football team. Son Chase is a high school senior who hopes to go on to play college basketball at Arkansas Tech or at the University of Central Arkansas at Conway. Youngest daughter, Tori, 9, is in the third grade.

Peek says that quality of life in the Danville community is a major reason he has enjoyed such a long career there. “My family means everything to me,” he says. “I have not missed a single event in which they were involved. We think that we have our kids with us for 18 years, 20 years, but that is really such a short time. It’s important to me to stay involved.”

He is also highly active in his community, where he serves as a deacon in his church, is a member and past president of the local Lions Club, and a member and past president of the Danville Area Chamber of Commerce.

“I have been lucky,” Peeks says. “My healthcare career has been short and sweet...in one hospital where I worked up through the ranks. I am very happy here.”
LA-Z-BOY CONCEPTS

PATIENT ROOMS • WAITING ROOMS
LA-Z-BOY HEALTHCARE FURNITURE
Because Comfort heals

• LOWEST PRICES IN ARKANSAS • GREATEST SERVICE IN ARKANSAS • FULL DESIGN SERVICE WITH PURCHASE

1000 S. Shackleford Road, Little Rock AR 72211
(501) 224-4655 • Fax (501) 224-6208

TME, Inc.

Utility Bill Review
Utility Rate Analysis
Energy Audits
Energy Conservation
Utility Management
Life Cycle Cost Analysis

HVAC Design
Electrical Design
Engineering Studies

5800 Evergreen Drive, Little Rock, Arkansas 72205.1757
Phone: 501.666.6776
www.tmecorp.com

More Voices
More Impact
More Results

Helping our members prosper through sound energy policy.

Arkansas Electric Energy Consumers, Inc.
Arkansas Gas Consumers, Inc.
West Central Arkansas Gas Consumers, Inc.
(501) 921.6900 • www.aeec-agc.org

Dan Burbine Associates
Architects & Project Managers

Planning, Programming and Design
Needs Analysis  Market Analysis
Strategic Planning  Master Site Planning
Construction Management
Financial Planning and Evaluation
Physical Evaluation of Existing Facility
Functional Evaluation of Existing Facility
Space Programming
Medical Equipment Evaluation and Planning
Construction Cost Estimating
Mechanical, Electrical Plumbing
Evaluation and Planning
Information Technology Network
Assessment and Security Analysis
Hardware Replacement and Integration

Call for a consultation  972-387-0580
Email  rrkitect@aol.com
www.danburbine.com

Winter 2007  •  Arkansas Hospitals  11
Russ Sword Receives 2006 Weintraub Award

Russ D. Sword, CEO of Ashley County Medical Center in Crossett, accepted the 2006 A. Allen Weintraub Memorial Award at the AHA's Annual Awards Dinner held October 5, 2006 at the Peabody Hotel in Little Rock.

The award, named for the late administrator of St. Vincent Infirmary Medical Center in Little Rock, was presented as a part of the AHA's 76th Annual Meeting. The A. Allen Weintraub Memorial Award is the highest honor bestowed upon an individual by the AHA. The award honors hospital administrators who contribute to their hospitals and communities in such a way that they serve as a model for their fellow administrators.

Sword has served as CEO of Ashley County Medical Center since 1998. Prior to joining ACMC, he was CEO of Northwest Health System in Springdale for six years.

He began his healthcare career as an administrative assistant at Man Appalachian Regional Hospital in West Virginia, moving into the executive healthcare ranks at hospitals in Charleston, West Virginia and Hazard, Kentucky.

During his eight-year tenure with ACMC, Sword converted the facility to a Critical Access Hospital to improve payments from Medicare and Medicaid and established a Balanced Scorecard Quality Improvement Program to measure the hospital’s performance in clinical quality, patient and public perception of care, employee and medical staff satisfaction and financial performance. He has presented the program to national audiences.

Sword also doubled the size of the hospital’s medical staff, increasing the number of programs and services offered by the 25-bed hospital. Other improvements include initiating a hospitalist program, developing a provider-based rural health clinic, upgrading radiology and adding obstetrical, occupational medicine, sleep medicine and audiology services.

Sword serves on the AHA board of directors as a member of the Arkansas State Board of Health, is past-president of the Southeast Hospital District and is a member of the AHA’s Blue Cross Blue Shield Advisory Committee, as well as other committees and task forces.

He is a diplomate in the American College of Healthcare Executives. Active in civic and community affairs, Sword is chairman-elect of the Crossett Chamber of Commerce and a member of the Rotary Club.

AHA Awards Presented

High honors were given to the recipients of the AHA’s 2006 Distinguished Service Awards, Statesmanship Award and Young Administrator of the Year Award, all presented at the 2006 Annual Awards Banquet held in conjunction with the AHA’s 76th Annual meeting October 5 in Little Rock. In addition, those receiving 2006 Diamond Awards and the ACHE Regent’s Awards were recognized for their superior performance.

Distinguished Service Awards

The field of nursing was the venue for this year’s Distinguished Service Awards of distinction. Honored for their many years of service and leadership in the field were Shirlene Harris, PhD, RN and Linda Hodges, EdD, RN.

Dr. Shirlene Harris retired in June of 2006 after 30 years as executive director of the Baptist System School of Nursing in Little Rock. During her career, she was dedicated to bridging the gap between education and practice as well as enhancing the educational programs available to those eager to enter the nursing profession.

Some of her many accomplishments include establishing two new schools for occupational therapy assistants and surgical technology, the establishment of the Baptist System School of Nursing Southeast Campus in McGehee and a campus in Northwest Arkansas in Springdale.

Dr. Harris has served on many boards, task forces and committees directly responsible for creating stan-
Nursing at the University of Arkansas for Medical Sciences (UAMS) in October after 16 years at the helm. She is a professor in the College of Public Health’s Department of Health Policy and Management at UAMS and a member of the Hartford Center of Geriatric Nursing Excellence Leadership Team.

Responsible for all aspects of the College of Nursing related to teaching, research and service, Dean Hodges was instrumental in increasing the number of nursing programs offered at UAMS, offering courses by interactive video and at additional sites away from the main campus.

She brought the necessity of increasing the nation’s nursing programs to Washington, DC, testifying before congressional committees on nursing education. She also researched public policy on nursing education and co-authored several state nursing initiatives.

**Statesmanship Award**

State representative Jay Bradford from White Hall is the recipient of the Arkansas Hospital Association’s (AHA) Statesmanship Award for 2006. The AHA Board of Directors selected Bradford to receive the award in recognition of his contributions to and leadership on Arkansas hospital and healthcare issues.

Rep. Bradford currently serves as the state representative for Arkansas District 18, located in Jefferson County, a seat he has held since 1999. He served as the state senator from Arkansas’ Ninth District from 1983 to 1999, when he had to retire due to term limits; during his last two years in the Arkansas Senate, he also served as president pro tempore.

Bradford is the first person in recorded Arkansas history to serve as president pro tempore of the state Senate and speaker pro tempore of the state House of Representatives. He is also the only legislator who has chaired the House and the Senate Public Health, Welfare and Labor Committees.

In addition, he is a key member of the Aging, Children and Youth, and Legislative and Military Affairs committees.

Jay Bradford has been a relentless leader and spokesperson for many areas of health and health-related issues throughout his entire legislative career. As a senator, he was the primary leader in the fight to mandate the use of seat belts. Rep. Bradford has led the fight for mental health parity for years in this state and he directed the formulation of the state’s welfare reform law, which resulted in Arkansas ranking second in the nation for reduction of welfare recipients.

Among his most significant contributions to the health of all Arkansans is the role he played as chief architect of the Tobacco Settlement Funding Bill legislation that ultimately was enacted as Initiated Act 1 of 2000. This Initiated Act made Arkansas the only state in the nation to focus all of its tobacco settlement funds on healthcare.

During the 2005 legislative session, he sponsored Act 134 that prohibits smoking in hospital campuses throughout Arkansas, and in the First Extraordinary Legislative Session of 2006, he was a co-sponsor of the Clean Indoor Air Act, which prohibits smoking in the workplace and in restaurants.

In addition, Rep. Bradford has sponsored numerous pieces of legislation that have impacted and will continue to influence public health in this state, and his legislative career will be remembered for his tireless advocacy of healthcare issues.

**C.E. Melville Young Administrator of the Year Award**

Leah A. Osbahr has been President of Lawrence Health Services for two years. Prior to taking leadership at LHS, she was Director of Medical Services at the University of Arkansas for Medical Sciences for six years, and Respiratory Care Supervisor at Baptist Health Medical Center-Little Rock for seven years.

During her tenure at Lawrence Health and Lawrence Memorial Hospital, she has led the hospital to JCAHO accreditation without recommendation; spearheaded construction on a new emergency department, outpatient and clinical wing; field-tested the first community health center to base in a hospital, and added additional rooms to the hospital wing.

Well-versed in organizational theory, Osbahr practices the latest in leadership trends. She has challenged 300 employees to place the right people in the right places. Her span of control is

---

**Dr. Linda Hodges**

Dr. Linda Hodges retired as Dean and Professor of the College of Nursing and allied health.

Dr. Linda Hodges (right) accepts the Distinguished Service Award from AHA Chairman Bob Atkinson.


Rep. Jay Bradford

**Leah A. Osbahr**

Leah A. Osbahr has been President of Lawrence Health Services for two years. Prior to taking leadership at LHS, she was Director of Medical Services at the University of Arkansas for Medical Sciences for six years, and Respiratory Care Supervisor at Baptist Health Medical Center-Little Rock for seven years.

During her tenure at Lawrence Health and Lawrence Memorial Hospital, she has led the hospital to JCAHO accreditation without recommendation; spearheaded construction on a new emergency department, outpatient and clinical wing; field-tested the first community health center to base in a hospital, and added additional rooms to the hospital wing.

Well-versed in organizational theory, Osbahr practices the latest in leadership trends. She has challenged 300 employees to place the right people in the right places. Her span of control is

---

**John Robbins, ACHE Regent, presents Leah Osbahr with the C. E. Melville Award.**

---

**AHA Annual Meeting**

John Robbins, ACHE Regent, presents Leah Osbahr with the C. E. Melville Award.
over a 189-bed nursing home, 25-bed critical access hospital, three medical clinics and a durable medical equipment retail store.

Under her guidance, the hospital has maintained impressive benchmarks in quality of care when compared to both hospitals of similar size and larger hospitals. Lawrence Health has been awarded the highest awards from the Arkansas Foundation for Medical Care the past two years.

Osbahr obtained her Master in Health Services Administration from the University of Arkansas at Little Rock and her Masters degree in Public Health from Tulane University, after earning her Baccalaureate of Science in Respiratory Care from the University of Central Arkansas.

"I am grateful for this honor but emphasize that the recognition it represents did not come without hard knocks," Osbahr says. “Academic learning stretches your reach, but application of the principles has been the true test of all who invested in the learning process. I thank my husband, Dennis, as well as my teachers, mentors and my children. They provide a safety net for an always-learning administrator."

Named for the late C.E. Melville, administrator of Jefferson Regional Medical Center in Pine Bluff, the Young Administrator of the Year Award is selected and presented by the Arkansas Health Executives Forum.

2006 Diamond Awards

The Arkansas Hospital Association’s 2006 Diamond Awards, co-sponsored by the Arkansas Society for Healthcare Marketing and Public Relations, are designed to recognize excellence in hospital public relations and marketing. They were presented during the Arkansas Hospital Association’s 76th Annual Meeting and Trade Show at the Peabody Hotel in Little Rock.

Diamond, Excellence and Judges’ Merit Awards were possible in three divisions (hospitals with 0-99 beds, hospitals with 100-249 beds and hospitals with 250 or more beds) in 12 categories. The competition drew 139 entries.

Judging for each entry was based on goals and objectives, audience to whom directed, reasons for choosing the format, frequency and quantity, portions that were created internally/externally, results/evaluation and total budget.

Hospitals receiving the top level Diamond Awards are:

Arkansas Children’s Hospital, Little Rock
Arkansas Heart Hospital, Little Rock
Arkansas Hospice, Little Rock
Baptist Health, Little Rock
CARTI, Little Rock
Conway Regional Health System
Jefferson Regional Medical Center, Pine Bluff
Medical Center of South Arkansas, El Dorado
Mena Regional Health System
National Park Medical Center, Hot Springs
North Arkansas Regional Medical Center, Harrison
St. Bernard’s Medical Center, Jonesboro

St. Joseph’s Mercy Health Center, Hot Springs
White County Medical Center, Searcy

ACHE Regent’s Awards

John Robbins of Conway, Arkansas’ ACHE Regent, presented two Regent’s Awards during the American College of Healthcare Executives/Arkansas Health Executives Forum breakfast October 5 in Little Rock.

Recipients were Michael Givens, CHE, Vice President of Patient Services at St. Bernards Medical Center in Jonesboro, who received the early career healthcare executive award; and Ken Haynes, CHE, Interim President and CEO of the St. Vincent Health System, Little Rock, who received the senior level healthcare executive award.

AHAA Awards

Phillip K. Gilmore, FACHE, President and CEO of HSC Medical Center in Malvern, was named Administrator of the Year for hospitals with fewer than 100 beds by the Arkansas Hospital Auxiliary Association (AHAA) during the AHAA’s annual meeting October 6, held in conjunction with the Arkansas Hospital Association’s annual meeting.

Jerry L. Stevenson, CHE, President and CEO of St. Edward Mercy Medical Center in Fort Smith, received the association’s Administrator of the Year Award for hospitals having 100 beds or more.  ●
2006 AHA Annual Meeting and Trade Show Sponsors and Exhibitors

Administrative Consultant
Service, LLC
**AHA Services, Inc.**
AIG VALIC
Air Distributors Company, Inc.
Aigas Puritan Medical
Alberici Healthcare Constructors
Alliance Imaging
Allison’s Fun Incorporated
American Data Network
American Health Facilities Development
American Red Cross Blood Services
Amerinet
ArCom Systems, Inc.
ArHIMA
Arkansas Association of Hospital Trustees
Arkansas Auxiliary of Gideons International
Arkansas Blue Cross and Blue Shield
Arkansas Foundation for Medical Care
Arkansas Health Care Access Foundation, Inc.
Arkansas Health Executives Forum
Arkansas Healthcare Personnel, Inc.
Arkansas Managed Care Organization (AMCO)
Arkansas Regional Organ Recovery Agency
Benefit Management Systems, Inc.
BE&K Building Group
**BKD, LLP**
Brasfield & Gorrie
C2P Group, LLC
CABSON Consulting, LLC
CareLearning
Carstens
Carter & Burgess
Community Health Centers of Arkansas, Inc.
CoreSource, Inc.
Correct Care, Inc.
Delta Physician Placement
Disability Determination for Social Security
DMS Imaging
Dynamix Group
EagleOne Logistics
EDS and Arkansas Medicaid
EmCare
Emdeon Business Services
Emergency Service Partners
EMS Innovations, Inc.
Engelkes, Conner & Davis, Ltd.
Enserv Midwest, LLC
**Exit Marketing**
EZ Way Inc.
First Uniform, Inc.
The Fleming Companies
Franklin Collection Service, Inc.
**FTI Consulting**
G2N, Inc.
Guldmann Inc.
Hagan Newkirk Financial Services, LLC
Hammes Company
Hayes, Inc.
Health Planning Solutions
Healthcare Administration
Healthcare Technologies, Inc./Xpack
Healthcare Funding Solutions
Hilco Healthcare Receivables
Hill-Rom Company, Inc.
HMN Architects, Inc.
Hospital Care Consultants
Hubble-Mitchell Interiors
Hughes, Welch & Milligan, Ltd.
Inman Construction Corp.
Inpatient Management, Inc.
Innerface Architectural Signage, Inc.
Intellamed
Jackson & Coker
KCI
Kutak Rock, LLP
Kwalu, Inc.
The Lawrence Group
The Legend Group
LG Electronics USA Inc.
**LHC Group**
LumineRx
Mainline Information Systems
Marshall Erdman & Associates
Mays & Associates, Inc.
MDG Medical
**MedAssets**
MEDCLR
Medical News of Arkansas
MEDITECH (Medical Information Technology, Inc.)
MediTract, Inc.
Meridian Art Group
Merritt, Hawkins & Associates
Mid-South Marking Systems
Mobile Instrument Service
Modern Biomedical & Imaging, Inc.
Modular Services Company
**Morgan Keegan & Company, Inc.**
Morrison Healthcare Food Service
MultiPlan, Inc.
Nabholz Construction
National HVAC Service
National Wallcovering
Pentax Medical Company
Performance Surfaces
PCI (Publishing Concepts)
Pinnacle Health Group
PPOplus
Press Ganey Associates, Inc.
QHR (Quorum Health Resources)
QualChoice
Ramsey, Krug, Farrell & Lensing
Service Plus Telecommunications Inc.
Service Professionals Inc.
Sign Systems, Inc.
Signet Health Corporation
SimplexGrinnell
Snell Prosthetic and Orthotic Laboratory
Sodexo Health Care Services
Specialized Radiology Partners
Spectron Corporation
The SSI Group, Inc.
**Stephens Inc.**
Synergy Medical
Tandus
Team Health
Tech Systems
TERM Billing, Inc.
**TIAA-CREF**
TME, Inc.
**TPL Company**
Trane Arkansas
TransMotion Medical, Inc.
**Triple-S Alarm Co., Inc.**
TRO Jung/Brannen
US Medical LLC
Vocera Communications/IBM
Voice Products, Inc.
Walker & Associates, Inc.
Wilcox Group Architects
Wittenberg Delony & Davidson Architects

**Corporate Sponsors**
listed in red

---

**Virtual Trade Show Announced**

The Arkansas Hospital Association (AHA) has developed a new “Virtual Trade Show” showcasing the vendors and sponsors that participated in the 76th Arkansas Hospital Association Annual Meeting and Trade Show which was held October 4-6 in Little Rock. By clicking on [http://arkhospitals.org/calendarvirtual.htm](http://arkhospitals.org/calendarvirtual.htm), visitors may view each company’s booth and representatives, link to their Web site (if available), and explore their product descriptions and contact information.

The trade show also includes a special notation for AHA’s corporate sponsors — companies or organizations that not only participated in the trade show, but also contributed dollars toward the annual meeting educational program. The AHA sincerely appreciates the contributions of our many exhibitors and sponsors. Through their participation, our membership enjoys a high-quality educational program that they might not otherwise enjoy.
Moderator Steve Rivkin opens the 76th Arkansas Hospital Association Annual Meeting, which featured an innovative background reflecting the faces of hospitals today.

AHA board members and CEOs John Neal (left) of Stuttgart, and Bob Bash of Warren, joined other hospital CEOs for the AHA’s annual House of Delegates Meeting.

Liz Carder (left), Administrative Assistant, and Tina Creel, Vice President, AHA Services, Inc., opened the annual meeting with musical selections.

A fan of keynoter Mark Shields, Second District US Congressman Vic Snyder (center) attended the session. With him are (from left) Chairman-elect Ray Montgomery, Searcy; Chairman Bob Atkinson, Pine Bluff; AHA President and CEO Phil Matthews, Little Rock; and Past-Chairman Tim Hill, Harrison.

Recognizing the importance of trustee involvement in advocacy issues, Kirk Reamey (right), CEO of Ozark Health Medical Center in Clinton, invited two of his governing board members to the Advocacy Luncheon. Joining him are (from left) Earl Goatcher and Dr. Robert Bass, both of Clinton.
AHA ANNUAL MEETING

Political strategist Mark Allen (right) of Virginia, joined AHA Executive Vice President Bo Ryall and President Phil Matthews prior to his presentation of views of the upcoming November state and national elections.

Hospital CEOs Jan Burford (from left) of Little Rock and Tim Hill of Harrison, along with COO Chris Whybrew of Harrison, listen intently to a presentation on successful recruiting efforts.

Hospital CEOs Jan Burford (from left) of Little Rock and Tim Hill of Harrison, along with COO Chris Whybrew of Harrison, listen intently to a presentation on successful recruiting efforts.

What is it like to be convicted of healthcare fraud? Annual meeting participants learned valuable insight and lessons from Dr. William Couser, a world-renowned nephrologist, who spoke about his personal experience as a target of a federal Medicare fraud and Office of Inspector General investigation.

National syndicated columnist and keynote speaker Mark Shields enthralled the audience with his funny, irreverent and insightful comments about politics and how the hospital field must operate to be effective in Washington.

Closing the annual meeting with “Reflections from the Road,” filmmaker Eric Saperston described his personal journey to find the answers to life’s biggest questions – Why am I here? How can I find happiness? What is success?

With more than 120 healthcare vendors and educational groups on hand at this year’s annual Trade Show, visitors like CEO Jason Spring (right) of Hot Springs had a chance to network, learn and share new ideas.
AHA Outlines Organization’s 2007 Goals and Strategies

The Arkansas Hospital Association each year sets forth its goals and strategies for the coming year. As always this year, we focus on the four major areas of Advocacy, Education, Data Gathering/Monitoring, and Communication. The goals and strategies for 2007 include:

**ADVOCATE – Actively Advocate for Arkansas’ Hospitals**

1) Obtain an increase in Medicaid payment rates for hospital outpatient services.
2) Work with Arkansas Department of Health officials and others to secure funding to implement the previously approved plan for a statewide trauma care network.
3) Gain support of the entire Arkansas congressional delegation for legislative and regulatory items included on hospitals’ advocacy agenda that will be developed for the 110th Congress.
4) Advocate and protect Arkansas hospital interests throughout the 86th regular session of the Arkansas General Assembly.
5) Actively oppose any and all attempts by the Centers for Medicare & Medicaid Services to reduce or prohibit the use of Intergovernmental Transfers from local government entities as Medicaid matching dollars.
6) During the 2007 session of the Arkansas Legislature, actively support the addition of state general revenues to fund increased Medicaid hospital payments; oppose all efforts to reduce Medicaid hospital payments; retain the Arkansas sales tax exemption that currently applies to the state’s non-profit hospitals.
7) Oppose legislation that would establish directly or indirectly any staffing ratios for the state’s hospitals.
8) Meet with lawmakers through the year to enhance relationships and increase awareness of issues of critical importance to hospitals.
9) Meet with members of the state’s congressional delegation and/or their chief health aides at least two times during the year to discuss issues important to Arkansas hospitals.
10) Increase contributions to the AHAPAC over the 2006 total.

**EDUCATE – Provide Education Opportunities**

11) Increase AHA-sponsored educational opportunities for member hospitals on issues such as information technology and exchange, electronic health records, coding, expanded quality improvement measures, flu pandemic preparation, Medicare PPS changes and others.
12) Publish a report showing the amount of community benefits that Arkansas hospitals provide for their communities.

**ANTICIPATE DATA NEEDS – Seek, Explain and Provide Data; Address Data Reporting Issues**

13) Improve the number and type of data sources available for AHA member hospitals.

**COMMUNICATE – Inform, Communicate, Network**

14) Develop and post a hospital transparency consumer information Web site to make public individual hospital price and quality information.
15) Implement a new in-house information management software system to allow the AHA to better manage member relations, educational events, Web site development and financial management.
16) Work closely with Pinnacle Business Solutions, Inc., the state’s Medicare Fiscal Intermediary, to ensure that no payment delays occur due to the requirement to transition to the use of Medicare National Provider Identifier numbers on Medicare claims.
17) Work with member hospitals to address pandemic flu preparedness issues, including the distribution of vaccine doses, ensuring that front-line healthcare workers are at the top of the priority list for vaccinations, and liability issues for hospitals where immunizations are provided.
18) Work with business, government, consumer and other healthcare organizations in Arkansas to develop a better awareness about the impact on healthcare costs created by the growing numbers of uninsured Arkansans.
19) Develop a closer relationship with the state’s business community and reposition hospitals as large employers that pay excellent wages and strongly influence economic development.
20) Increase the dialogue around emergency department coverage for unassigned call.
21) Improve participation of member hospitals in local hospital district meetings.
22) Redesign the AHA Web site to make it a more effective tool for members and others seeking to learn more about the Association and its activities.
In August 2006, following a lengthy discussion, the Arkansas Hospital Association board of directors voted to voluntarily establish a “transparency” Web site to display price and quality information for Arkansas hospitals. It wasn’t an easy decision, but it probably was the only choice. The board decided to be proactive and intervene on an issue that is steadily gaining in popularity among members of Congress and state legislatures.

The move gives the state’s hospitals a head start on the inevitable. Despite evidence that hospital price information provides very little useful information for consumers, Congress shows no inclination to abandon its plans to make available as much information as possible about hospital charges. It is their opinion that more publicly available hospital information translates into better-informed consumers when it comes to making decisions about healthcare. Some members of the Arkansas Legislature are also leaning in that same direction.

Arkansas is actually a late arrival to this information sharefest. This month, it became the 40th state to make hospital prices public. Thirty-two of them require the reporting by law; eight others, including Arkansas, do it voluntarily, which gives hospitals a bit more say in what to report and how to display it. Many states have been publishing the prices for several years.

The Arkansas site, called Hospital Consumer Assist, went live on December 21. For now, it only reflects the average price, along with a price range, that each Arkansas hospital charges Medicare and covers conditions for about 75% of all Medicare inpatients. The data is limited, since it is based on Medicare claims for patients who were admitted during the Federal 2005 Fiscal Year with conditions covered by the 25 most frequent diagnosis-related groups, or DRGs. The site could be expanded to show all-payer data in the future.

Once connected with the Web site, consumers may download pages that include a profile of the hospital and its price report, as well as a table showing the hospital’s ratings on all of CMS’ Hospital Compare quality measures. The Arkansas transparency site also addresses several caveats included in an American Hospital Association policy statement on price reporting. For example, it contains public education materials to explain why prices for similar care can vary not only from hospital to hospital, but also from patient to patient within the same hospital, as well as information to inform consumers about the vast difference between charges and the actual payments hospitals receive for services.

One thing that is not a part of the Hospital Consumer Assist Web site is the amount that patients might expect to pay out-of-pocket for a hospitalization. Because hospitals deal with so many health plans, each of which has a variety of coverage options, it would be impractical to have a report reflecting how much any given patient might owe for a specific type of hospitalization under a specific health plan. That information is best left to insurers to distribute.

The American Hospital Association policy statement recommended as much, saying that insurers should be a part of the equation by making available information about enrollees’ expected out-of-pocket costs in advance of medical visits. Some members of Congress concur. One of the more recent transparency bills introduced in the House takes the added step of requiring insurers to provide that information to consumers for certain services, whenever it’s requested, which makes that side of the equation a little more transparent.
**Mid-Management Series Will Again Be Offered in 2007; 2006 Series Yields 30 Graduates**

The Arkansas Hospital Association congratulates 30 Arkansas hospital representatives upon their achievement of earning the 2006 Mid-Management Certificate. The AHA-sponsored series featured eight individual programs offered in April through November targeted specifically for individuals new to hospital supervisory or mid-level management positions.

The programs helped “groom” employees who may eventually be moving into middle-management positions or advancing along their career path. The courses featured topics such as leaping from staff to management, building a culture of commitment, financial skills for healthcare managers, presentation skills, dealing with conflict and government relations 101.

Those individuals achieving the certificate by attending at least five of the programs are:

Karen Bailey, RN, Ouachita County Medical Center, Camden
Stephen Becker, OR Room Supply Manager, Sparks Health System, Fort Smith
Lisa Carlton, RN, Johnson Regional Medical Center, Clarksville
Charlotte Carter, RN, White County Medical Center, Searcy
Kendra Collier, Health Information Management, Arkansas Surgical Hospital, Little Rock
Laura Counts, Administrative Supervisor, White County Medical Center, Searcy
Susan Daugherty, Post-Anesthesia Care Unit Manager, Sparks Health System, Fort Smith
April Fulton, Clinical Nurse Manager, White County Medical Center, Searcy
Diana Glidewell, Dietary Manager, Arkansas Surgical Hospital, Little Rock
Mary Gray, RN, Pre-Op Manager, Sparks Health System, Fort Smith
Kathy Hall, RN, OR Supervisor, Bradley County Medical Center, Warren
Cynanne Hamill, RN, White County Medical Center, Searcy
Richard Heath, RN, UAMS Medical Center, Little Rock
Marina Henry, RN, Ouachita County Medical Center, Camden
Jackie Kassler, RN, Assistant Director of Nursing, St. Vincent Rehabilitation Hospital, Sherwood
Charolet Laster, X-Ray Department, Bradley County Medical Center, Warren
James Marks, Stores and Distribution Manager, Sparks Health System, Fort Smith
Jeana Meador, Sterile Processing Manager, Sparks Health System, Fort Smith
Greg Moser, Environmental Services Night Manager, Johnson Regional Medical Center, Clarksville
Sam Nelson, Ambulatory Services Case Manager, Sparks Health System, Fort Smith
Michelle Parish, Director, ER/ICU, Southwest Regional Medical Center, Little Rock
Crystal Pasman, Pediatric Team Leader, Saline Memorial Hospital, Benton
Jimmie Rice, Surgical Services Support Manager, Sparks Health System, Fort Smith
Teresa Saunders, RN, White County Medical Center, Searcy
Melodee Sanders, RN, Ouachita County Medical Center, Camden
Corey Tedford, Director of Radiology, Southwest Regional Medical Center, Camden
Chris Tropp, OR Manager, Arkansas Surgical Hospital, Little Rock
Richard Watkins, Print Shop Supervisor, Baptist Health Medical Center, Little Rock
Elaine White, Manager, Central Supply, Baptist Health Medical Center, Little Rock
Dee Ann Wilcox, OR Manager, Sparks Health System, Fort Smith

Each individual will receive a certificate of completion, a leather portfolio and a letter sent to their CEO announcing their achievement.

Plans are underway for the 2007 Mid-Management Certificate Series which will begin in April 2007. For more information, please contact Beth Ingram at 501-224-7878 or bingram@arkhospitals.org.

---

**AHRQ Issues Hospital Employee Safety Tips**

Surveying staff to assess and improve the culture of safety, limiting shifts of more than 24 hours for medical residents, and eliminating intern shifts of more than 30 consecutive hours in intensive care units are only three of ten safety tips that the Agency for Healthcare Research and Quality issued November 16.

In addition, the agency recommends hospitals adopt interventions to prevent ventilator-associated pneumonia, count surgical instruments and sponges before and after procedures and X-ray patients after surgery, and use senior nurses and appropriate round-the-clock staffing levels in ICUs to prevent airway tube complications.

For a complete list, see [http://www.ahrq.gov/qual/10tips.htm](http://www.ahrq.gov/qual/10tips.htm).
Arkansas’ Newborn Screen Exam Numbers Increasing Under New Rules

The number of required newborn screening exams in Arkansas will increase substantially under new rules being proposed by the Arkansas State Board of Health.

In October, the board approved a set of proposed rules and regulations that will eventually cover 21 “core” newborn disorders and 25 “secondary” disorders. That will bring Arkansas to the level of screening done in most other states.

Since the 1990’s the state has required that all newborn infants be screened for eight conditions. In 2003 and 2005, bills were passed which authorized the Board of Health to expand the testing to include genetic disorders “if reliable and efficient testing techniques are available.”

Currently, the state Department of Health and Human Services (DHHS) charges hospitals $14.83 per newborn screened. This rate has not changed since 1995. The new rate for the expanded set of exams will be $89.25.

The Arkansas Medicaid program, which pays for about 60% of all newborns delivered in the state, will reimburse hospitals for their costs in the same manner that reimbursement for existing screens is handled.

According to Division of Health officials, Arkansas Blue Cross has indicated that it supports the additional newborn screening, but details on the company’s coverage plans aren’t yet known. The DHHS expects the additional newborn screening in Arkansas to be effective in approximately one year.

Arkansas Hospital Association Joins 100,000 Lives Campaign

The Arkansas Hospital Association (AHA) Board of Directors voted November 10 for the AHA to become a participant with the 100,000 Lives Campaign, which is sponsored by the Institute for Health Improvement (IHI). The campaign is a nationwide voluntary initiative launched by the IHI to significantly reduce morbidity and mortality in American healthcare, with a current focus on hospitals.

The program was first established in 2005 with the intent of getting at least 2,000 US hospitals to agree to implement proven best practices that could save as many as 100,000 lives between the start date and June 2006. The final report showed more than 3,000 hospitals participated and more than 122,000 lives were saved.

IHI is now preparing to initiate Phase 2 of the program. As a participating organization, the AHA will work with the Arkansas Foundation for Medical Care, the primary organization in Arkansas for providing implementation and communication support for Campaign hospitals in the state. Participating hospitals are asked to voluntarily take the following steps to reduce harm and deaths:

- Deploy Rapid Response Teams at the first sign of patient decline
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction to prevent deaths from heart attack
- Prevent Adverse Drug Events by implementing medication reconciliation
- Prevent Central Line Infections by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle"
- Prevent Surgical Site Infections by reliably delivering the correct perioperative antibiotics at the proper time
- Prevent Ventilator-Associated Pneumonia by implementing a series of interdependent, scientifically grounded steps including the "Ventilator Bundle"

The program does not replace the Hospital Quality Alliance measures, but does parallel them to some extent. There is also some limited reporting involved, including "Hospital Profile" information, which gathers data such as number of licensed beds, teaching status, average daily census, etc., and monthly acute care inpatient mortality data.

Eighteen Arkansas hospitals are already participating in the initiative.

Winter 2007  Arkansas Hospitals  21
Arkansas Hospital Association Announces 2007 Advocacy Agenda

In November, the Arkansas Hospital Association board of directors approved an initial list of advocacy priorities for the upcoming 86th Session of the Arkansas General Assembly. The list was based on recommendations of the AHA’s Council on Government Relations.

These are the main areas of focus on which the AHA will concentrate in its work with legislators and our congressional delegation. They are also the areas on which each person with an interest in Arkansas healthcare may want to weigh in with local elected legislators and officials:

- Ensure that inpatient and outpatient Medicaid rate increases are covered in the Department of Health and Human Services’ budget.
- Establish a Statewide Trauma Care System, including establishing both a funding stream and a system for paying for uninsured patients, a trauma database and the services of on-call physicians.
- Authorize through legislation the Arkansas Hospital Association’s use of the Hospital Discharge Data System. This information will be used in pricing transparency measures.
- Change the Workers’ Comp law to allow Workers’ Comp to pay for on-the-job injury to a worker testing positive on a drug test. (This would shift financial responsibility from the healthcare provider to Workers’ Comp.)
- Amend the Deemed Status Law to replace “JCAHO” with “any accreditation agency.”
- Work toward passage of the Medicaid False Claims Act.
- Change the Employment Security Department test on part-time employees, as this test is different from the IRS test and captures hospital contract employees.

For more information on discussing this agenda with your elected officials, please contact Bo Ryall, Executive Vice President, Arkansas Hospital Association, 501-224-7878.

VoterVOICE Reminder!

With the Arkansas General Assembly scheduled to convene January 8 and the 110th US Congress convening January 7, the Arkansas Hospital Association (AHA) reminds hospital CEOs, staff members, trustees, auxiliaries, and other hospital personnel to sign up for the AHA’s advocacy tool, VoterVOICE. VoterVOICE is the industry-leading grassroots lobbying tool for associations to influence both state legislators and congressional leaders. Grassroots lobbying is one of the best ways to influence the legislative process, especially with Arkansas’ law on term limits.

1. If you have not signed up with VoterVOICE, please take a couple of minutes and sign up. Go to the AHA homepage at www.arkhospitals.org and click on “Legislative/Regulatory,” then click on “VoterVOICE/Grassroots,” and then register.
2. After you have registered, ask other staff members, department heads, and trustees to sign up. Large numbers are a key provision of grassroots contacts.

When we ask you to contact a legislator, we want as many emails or faxes going to the elected official as possible. Numbers influence legislators. They like to know what the people “back in my district” feel about an issue. With VoterVOICE, we can let them know very quickly and very loudly.

VoterVOICE will be used in two ways. The first is for the AHA to send an email to you requesting that you contact a legislator or congressman regarding a particular bill. We can provide you with the information to communicate so all you have to do is point and click in order to send an email to the appropriate person.

The second way to use VoterVOICE is for you to communicate individually with legislators or with Arkansas’ congressional delegation. You can create a hospital-specific message through VoterVOICE where you have the option of having the message faxed or emailed to the recipient.

If you have any questions regarding the sign-up process please contact AHA’s Bo Ryall or Sandra Davis at 501-224-7878.
A Trustee’s Primer —
Corporate Governance and the Hospital Board

RESPONSIBILITY. This one word sums up the requirements involved with serving on the board of directors or board of trustees of a hospital. As a director, you are responsible for knowing current law and, in many circumstances, for ensuring that the entire hospital, including the board itself, is complying with the law. The responsibility for oversight of the CEO and management falls on the board. This amount of responsibility may seem overwhelming to a director, regardless of his or her experience level. Fortunately, these general responsibilities can be broken down into separate legal duties. The purpose of this article is to review the individual legal duties of a hospital director, to offer tools to directors to fulfill his or her legal duties, and to offer suggestions for minimizing your personal risk for serving on the board. The information in this article will generally be applicable to both nonprofit and for-profit corporations, except where deviations explaining the differences are essential.

WHAT ARE THE DUTIES?

The duties that a director owes to the several groups discussed above are the duty of care, the duty of loyalty, and the duty of obedience. A director must know and comply with these duties to avoid potential liability. Simple awareness of the duties is not enough. Compliance means being conscious of the duties and acting to ensure that the duties are being followed. The Sarbanes Oxley Act of 2002 (SOA), while not generally applicable to smaller for-profit and nonprofit entities, is a good model for the board and directors to follow for knowledgeable maintenance of their duties. Other sources of guidance, including the Internal Revenue Service, provide good models for directors to follow.

DUTY OF CARE

In Arkansas, a director must discharge his or her duties “(1) in good faith; (2) with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and (3) in a manner the director reasonably believes to be in the best interests of the corporation.” This general responsibility is the common law duty of care. A hospital director can uphold the duty of care by reading documents that are provided by management, asking questions, and continually learning the intricacies of the health care industry. Although the duty of care does not require a director to become an expert on every subject brought before the board, each director must be careful to demonstrate good faith efforts to become and remain a knowledgeable and effective director.

Audit Committees

One series of questions a prudent director should ask is, “Do we have a separate audit committee? Do we need a separate audit committee?” The “best practices” standards which have developed as a result of the passage of the SOA require certain larger corporations to create a separate audit committee of independent directors to oversee the financial affairs of the corporation, including the selection of outside audit firms. Because most hospital directors are volunteers and are not paid for their service to the board, many hospital directors do not have the time or expertise to devote to complex audit committee work. Smaller hospital boards may suffer from the sheer lack of directors available to serve. And some members of the hospital board may not be truly independent because the community in which they are located is small. Finally, the skill set required for overseeing audits of hospital financial records might not be widely available in any community, large or small.

Hospital directors must determine the necessity and feasibility of creating an audit committee. Some hospital boards, out of ease or perceived necessity, may assign or defer to one director the responsibility of heading up the audit committee in exercising its review of the financial information of the hospital. Those with little experience reviewing financial information must aim toward achieving some level of financial literacy.

For those hospitals that employ outside auditors or audit firms, the board must be able to effectively communicate with the auditors and be able to implement changes or actions in the hospital if the auditors find something amiss. Although it may be appropriate and practical to assign the director or directors with the most financial experience to work with the auditors, each director bears ultimate responsibility for finan-
cial oversight. Each director should know whether the hospital employs an audit firm, how much the services cost, how often audits are performed, and the issues uncovered by the audit. Consideration should also be given to having the board or audit committee meet at least once a year without the presence of the CEO or management personnel.

**Policies and Procedures**

A director should be active in developing policies and procedures for board governance. From dealing with auditors to the mechanics of holding board meetings, hospital boards should have a set of policies and procedures to define their method of governance. Some hospital boards use outside legal counsel to develop policies and procedures. Other hospital boards use outside legal counsel to update board policies and procedures. Many hospital boards feel comfortable developing and updating their own policies and procedures. Whatever method the hospital board employs, a director should know the actual policies and procedures, the last time that the policies and procedures were updated, and should (of course) follow the policies and procedures. A director should be willing to question the effectiveness, the implementation, and the oversight of policies and procedures. Furthermore, each director should be willing to act to implement changes if action is required.

**Continuing Education**

The best method for ensuring that a director maintains his or her duty of care is through participating in continuing education opportunities. Directors should receive education upon their initial appointment. This should consist of an introductory session and a series of ongoing sessions to inform the director of hospital issues. Continuing education must include an overview of legal issues that may or will affect hospital boards. Next, the board should hold education sessions either annually or as needed as changes in the law occur. Outside opportunities such as meetings and conferences can augment board-developed sessions. And although the responsibility of being educated rests on the individual, the board as a whole should develop policies and requirements (such as 20 hours of education per year) that encourage everyone to be knowledgeable of their duties as directors. A board should make efforts to make educational opportunities accessible at the directors’ convenience.

**Litigation Against the Board or Hospital**

A director should be aware of the litigation history of the board and/or of the hospital. A director must know the issues that were alleged in any lawsuit filed against or on behalf of the board. However, a director does not have to be aware of every single malpractice action filed in the past and present. The hospital should already have systems in place through the medical staff and administration that address patient quality issues and responses to patient lawsuits. A director should let these systems operate. But, a director may want to learn about past medical malpractice actions when a judge has rendered a written opinion. A pattern of malpractice lawsuits may indicate a breakdown in a hospital oversight system. Finally, if there is any lawsuit that alleges unfair billing practices or the lack of charity care provided by the hospital, a director must be alerted. In these circumstances, the board may be required to implement new policies or launch investigations into current policies and procedures.

**DUTY OF LOYALTY**

The duty of loyalty requires that a director put aside his or her individual interests and act for the best interests of the corporation. Although this duty sounds similar to the duty of care, there are distinct differences. Heeding the duty of loyalty requires directors to be cautious about and avoid conflicts of interest and to protect confidential information available to directors.

Procedures for addressing conflicts of interests are usually addressed in state statutes, and are often augmented by policies of the board. In Arkansas, a director with a conflict of interest in a transaction will not be liable if the transaction was fair to the corporation or the board knew about the conflict of interest and approved the transaction.

However, simply complying with state law may not be enough.

**Conflicts of Interest Policy**

Directors of tax-exempt hospitals recognized under Internal Revenue Code 501(c)(3) are responsible for maintaining the hospitals’ tax-exempt status. The IRS virtually requires all tax-exempt hospitals to adopt a conflicts of interest policy. Those organizations that have not adopted a conflicts of interest policy must justify to the IRS in their annual tax returns the reasons that the board does not have a conflicts of interest policy, and must ensure that conflicts of interest transactions are being adequately addressed. For nonprofit hospitals that have not adopted a conflicts of interest policy, a prudent director should suggest the adoption of such a policy. The IRS has developed a sample conflicts of interest policy, so most of the work is complete.

A director must do more than merely developing or approving a conflicts of interest policy. A director must comply with the policy. Compliance is essential for tax-exempt hospitals, because conflicts of interest can lead to intermediate sanctions and/or jeopardize the tax exemption status of the hospital. A director of a tax-exempt hospital should be hyper-vigilant. A director has a duty to inform the rest of the board when he or she is involved in a transaction with a conflict of interest. Annual updates should be required of all directors. To ease with implementation of the conflicts of interest policy, and to remind directors of their duty of loyalty, boards can implement an annual questionnaire that every director is required to complete and sign. Boards should also review the conflicts of interest policy periodically to ensure that each director is upholding his or her duty of loyalty.

**Confidentiality**

The duty of loyalty also means that a director will not reveal confidential information related to the board and/or the hospital to any outside sources. This seems like a relatively easy task to perform. Even new directors understand the concept of “keeping a secret.” However, it is not enough for a board to be good at keeping secrets. A hospital board should adopt a short statement for all directors to sign that affirms their responsibility to maintain confidentiality. Some hospital boards even have a
separate policy addressing confidentiality. Whether the board adopts a short statement or an entire policy, a director should adhere to his or her responsibility to keep board and hospital matters confidential and should willingly sign an affirmation on an annual basis stating this adherence.

**DUTY OF OBEDIENCE**

The duty of obedience requires that a director adhere to the mission of the hospital in all actions and do so in compliance with applicable laws. The mission can usually be found in the purpose section of the articles of incorporation or the corporate charter. All directors should review the articles of incorporation/corporate charter as part of their service to the board. When considering board matters, a director must keep this duty in mind to ensure that the hospital’s mission is being fulfilled through the transaction in issue. The adoption of compliance programs at the board level and hospital-wide can help ensure that a hospital’s mission is being fulfilled.

**False Claims and Whistleblower Protection Laws**

The board is responsible for the oversight of a compliance program for Medicare and other state and federal health programs. The penalties for submitting fraudulent claims to the federal government are severe. Hospitals can be sued using the Federal False Claims Act or can be liable under the civil and criminal penalties of the Social Security Act. The Federal Government may (and sometimes must) exclude the hospital from participating in Medicare and other Federal healthcare programs. In addition, states may have false claims laws that assess additional penalties. Provisions in the Deficit Reduction Act of 2005 (DRA) encourage states to pass new false claims and/or whistleblower protection laws. The DRA also requires organizations receiving more than $5 million dollars in Medicaid funds to implement new policies and procedures educating their employees and contractors about state and federal false claims and whistleblower protection laws. These policies have to be implemented by January 1, 2007. All board members must be aware of these federal and, if applicable, state laws.

**Internal Assessments Under the Sarbanes Oxley Act**

Section 404 of the SOA requires internal assessments of a company’s financial operations. These internal assessments may be done by outside auditors, but the auditors cannot be the same auditors that are already auditing financial records. This has challenged lots of companies that are required to implement section 404. At best, the internal assessments are expensive to implement. At worst, the internal assessments are criticized for offering little or no value to the companies that are forced to implement them.

Why should hospital directors concern themselves with an SOA provision that most critics agree is hard to implement? The answer is that several non-governmental bodies, including bonding companies (Fitch and Moody’s) look to the SOA, and section 404, as a positive factor of board governance of nonprofit hospitals. As more entities jump on the Section 404 bandwagon, hospital directors should be aware of this movement. The responsibility to implement parts or principles of SOA Section 404 will fall on the hospital boards. Hospitals may now want to consider adopting some form of practice related to SOA Section 404.

**HOW CAN YOU MINIMIZE YOUR RISK AS A DIRECTOR?**

To ease director concerns about the risk of failing to satisfy these myriad legal obligations, several protections are available. Some are contained in state and federal statutes. Others are included as a component of corporate governance best practices. And, some are devices available to individuals or whole boards. The next part of this article will discuss the various protections available to you that minimize your risks as a director.

**Indemnification**

Directors can be indemnified by the hospital for their individual actions. This protection is found in federal statutes and state statutes. Hospital boards can take further steps to indemnify their directors when the bylaws are adopted. Some hospital boards negotiate contractual agreements with directors.

**Federal Indemnification**

The Federal Volunteer Protection Act protects volunteers of nonprofit public benefit corporations or 501(c)(3) tax-exempt organizations. Volunteers are individuals, including directors, who are not paid and do not receive anything of value over $500. To be protected, a volunteer must act within the scope of his or her role as a director. The harm that is caused by the volunteer cannot be from “willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer” or from the operation of a vehicle that requires a license or mandatory insurance by the state. Because the nonprofit organization can still sue the director, state law affords greater protection to a director.

**State Indemnification**

Several states have indemnification statutes for directors of corporations. In Arkansas, directors of nonprofit corporations may be indemnified if he or she acts in good faith and with the reasonable belief that he or she, acting within the scope of his or her role as a director, acts in the best interests of the corporation. Directors of nonprofit corporations may also be indemnified when the director is not acting within the scope of his or her role as a director, and acts in a manner that is not against the best interests of the corporation. In a criminal action, a director must reasonably believe that his or her actions are not unlawful. Furthermore, the corporation may reimburse the legal expenses of a director. For-profit directors share similar protections.

**Indemnification in Corporate Formation Documents**

State statutes also allow an indemnification provision to be included in the articles of incorporation or bylaws of the corporation. In Arkansas, for-profit corporations can limit the liability of directors in the articles of incorporation or bylaws so long as directors remain liable for breaches of the duty of loyalty, the duty of care and other acts. Nonprofit corporations have slightly
broader powers to limit the liability of directors, and can also state these limits in the articles of incorporation and bylaws. If these provisions are present in the corporation’s formation documents, a director should read these provisions and understand how they work.

**Contractual Indemnification**

The hospital may also negotiate an indemnification agreement with each director. Some hospital boards provide all directors with such an agreement when they initially join the board. An indemnification agreement may supplement state and federal indemnification by serving as a private contract that cannot be taken away in the future unless the director consents. These agreements give a director and the board a written record of their mutual understanding that can be referred to when a director wants or needs to be indemnified.

**Reliance Statutes**

State reliance statutes may also protect hospital directors. In Arkansas, for instance, a director can rely on information obtained from officers or employees of the corporation if the member reasonably believes in the reliability and competence of the officers or employees. A director can rely on information from attorneys, accountants, or other professionals so long as the member reasonably believes the information is within the realm of the professionals’ competence. A director can rely on committee reports so long as the member reasonably believes the “committee merits confidence.” The reliance is not reasonable if the director has different knowledge about the information being presented. So, a director should not rely on information if he or she knows that the information being presented is not reliable, faulty, or has other knowledge about the validity of the information. For-profit corporations have similar reliance provisions.

**Insurance Policies**

Insurance policies are another area of protection for directors. The board itself should purchase directors and officers’ liability insurance for directors. If a director does not feel that this insurance is enough, he or she can always elect to take on a personal insurance umbrella that covers losses from business decisions.

A director’s best protection, however, is a clear understanding of his or her duties and responsibilities. This knowledge also makes the director a more productive member of the board and an effective advocate for the hospital.

**About the Authors**

Elisa M. White is a Partner in Kutak Rock LLP’s Little Rock, Arkansas office. She practices healthcare law and corporate law, and concentrates her practice in the transactional and compliance aspects of the healthcare practice. Ms. White also serves as general counsel to the Arkansas Hospital Association.

Mary R. Daniel is an Associate at Kutak Rock LLP in the Kansas City office, and practices healthcare law, corporate law and tribal finance.

---

**Hospital Rules, Regulations Specify Who Can Conduct Medical Screening Exams**

The Rules and Regulations for Hospitals and Related Institutions in Arkansas (2005) allow “qualified medical personnel” (QMP) to conduct the “medical screening examinations” (MSE) that are required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) for patients presenting to hospital emergency departments.

Earlier this year, the Arkansas State Board of Nursing (ASBN) concurred that a registered nurse (RN), who can be designated as a QMP, may perform the MSE, as long as that examination is consistent with the RN’s scope of practice. The ASBN position also included certain cautionary steps that a hospital should take to ensure that appropriate personnel perform MSEs based upon the overall complexity of the patient’s healthcare problem (see the Arkansas Hospital Association’s The Notebook, January 31, 2006).

While there is no question that the hospital-designated QMPs may perform the screening exams, the Rules and Regulations go on to establish specific procedural requirements and decision-making protocols related to the MSEs with which hospitals must comply.

The rules state under Section 36 (F) (1), “Each patient presenting to the emergency department shall have a medical screening examination by a qualified medical personnel. The examination shall be completely documented. If a physician is not present, the qualified medical personnel shall contact the physician requested by the patient or the physician on call to discuss the assessment findings and determine the patient’s condition.”

While RNs and other medical professionals clearly qualify to perform MSEs in hospital emergency departments and may do so without direct physician supervision, a physician must be consulted before the final determination of a patient’s medical condition is made.
Citizens’ Health Care Working Group Has Plan for Improving US System

In a set of final recommendations released September 25, the Citizens’ Health Care Working Group lays out a plan for improving the US healthcare system. The recommendations were adopted after the group held a series of community forums throughout the nation during the past year to solicit input.

The 15-member work group includes representatives from healthcare, business, consumer organizations and government. It is led by Patricia A. Maryland, president of central Indiana’s St. Vincent Hospitals and Health Services, Inc.

The recommendations are to be presented to President Bush and to Congress. They are similar to interim recommendations released by the group earlier in 2006 and call for the creation of public policy that will allow all Americans to have affordable healthcare by 2012.

The group also endorses a move that would require all Americans to participate in a coverage program, and believes that there ought to be a set of defined core benefits and services for all Americans.

The five congressional committees that oversee healthcare policy will be required to hold hearings on the recommendations. The Citizens’ Health Care Working Group was created under the Medicare Modernization Act of 2003.

To read more about the group and its recommendations, see http://www.citizenshealthcare.gov/recommendations/recsover.php.
American Hospital Association Supports New JCAHO Governance Standard

In an October 23 comment letter, the American Hospital Association (AHA) expressed support for the latest draft revisions to the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) standard for medical staff bylaws and other governance documents. The AHA said the revised standard (MS.1.20) gives hospitals greater flexibility to articulate, organize and adopt provisions for medical staff governance, management and accountability.

Further, the AHA urged the JCAHO to clarify the language used in a proposed new Element of Performance (EP 27), which requires that the bylaws give medical staff as a whole the right to offer bylaws or amendments directly to the governing body.

New Study Helps Hospitals Better Understand, Meet Needs of Populations They Serve

A new study provides guidelines to help hospitals collect data on patients’ race, ethnicity and language so they can better understand and meet the needs of the populations they serve.

The study in the August issue of Health Services Research, coauthored by Romana Hasnain-Wynia of the AHA’s Health Research and Educational Trust affiliate, encourages healthcare organizations to collect race, ethnicity and language information directly from patients and their family members, as opposed to relying on staff observation.

It offers a uniform framework for data collection to address patient concerns about how race and ethnicity information will be used and ensure the accurate collection of data.

The article may be viewed on the Health Research and Educational Trust Web site at: http://www.hret.org/hret_app/index.jsp. The article’s title is “Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions.”

Arkansas Hospital Auxiliary Association Contributes More than Meets the Eye

The assistance that auxiliary members and teen volunteers give each year to hospitals throughout the state is remarkably valuable.

While it’s true that the time and talent the 7,300 dedicated volunteers of the Arkansas Hospital Auxiliary Association (AHAA) contribute to their hospitals often convert into funds to support new facilities and services and to purchase new equipment and furnishings for the hospitals, perhaps their more important contribution is the peace of mind they provide for thousands of Arkansas hospital patients every day.

During the past year, hospital auxiliaries and volunteers worked 1,160,142 hours in Arkansas hospitals, and raised a total of $2,884,231 for use by the hospitals and for auxiliary-sponsored scholarship programs.

Their assistance in helping with evacuees from Hurricanes Katrina and Rita was especially memorable.

However, the volunteers’ contributions are not limited to work in the hospitals. During legislative sessions, the AHAA serves as a resource for the Arkansas Hospital Association, making contacts with individual legislators on issues important to hospitals.

As we enter a new year, the Arkansas Hospital Association and its member hospitals salute all the state’s hospital auxiliaries and volunteers for their devotion, contributions and continuous support.
When detected early, cervical cancer is one of the most treatable cancers with a five year survival rate of 92 percent.

The Centers for Disease Control and Prevention estimates half of the women diagnosed with cervical cancer have never been screened and an additional 10 percent have not been screened in the past five years. BreastCare, a program of the Arkansas Department of Health and Human Services, provides coverage for breast and cervical cancer screening for eligible women. Refer your patients to 1-877-670-2273 for eligibility determination.

Although some women are receiving the new HPV vaccine, the Advisory Council for Immunization Practices only recommends it for females between ages 9 and 26. The vaccine does not replace the routine Pap test. It’s still important to include a Pap test as part of a woman’s physical examination.

**Pap Facts**

- Cervical cancer screening should begin approximately three years after a woman becomes sexually active, but no later than 21 years old.
- Women over 21 years of age should have a Pap test at least once every three years after three consecutive negative tests.
- Women 70 years of age who have had at least three consecutive normal Pap tests and no abnormal results in the last 10 years may decide to stop screening.

Source: American Cancer Society
The Critical First Step Out of Crisis: Convincing the Staff

“This hospital is losing $2 million a year,” laments Chairman Throckmorton. “And there’s not a person in this room who doesn’t realize that a good part of the problem is that we’re not getting our story out. Clearly, we’ve got to spread the word and we’ve simply got to start advertising.”

Welcome to the most futile exercise in the life cycle of a hospital – the attempt to resuscitate a distressed hospital’s reputation through increased advertising.

“Futile” because advertising your way out of a declining image not only never works, it generally exacerbates a hospital’s problems.

In counseling hospital management on rebuilding reputations, we regularly advise that image revitalization begin with the very constituency that trustees and senior managers regularly overlook: Employees.

Indeed, it’s virtually impossible to change how the people outside view the hospital, if the people inside don’t believe the story.

Too often, trustees and CEOs needlessly throw precious communications resources at newspaper, radio and TV advertising, while disregarding the one area that can deliver a real return on investment – employee communication.

The result of such a wrongheaded communications strategy: A sparkling portfolio of upbeat and uplifting ads that convince few and alienate many – particularly those inside the hospital.

It’s no mystery why the staff is generally the last constituency to whom a hospital turns for turnaround support.

National statistics suggest that only one half of all U.S. employees believe that management tells them the truth.

Almost one third don’t believe in their employer’s stated vision and values. And three of five employees believe management communicates more honestly with customers and other stakeholders than with them.

The situation is even worse in a hospital – particularly one in distress – where many employees feel underpaid, overworked and unloved. Employees have little say in the conduct of their jobs and little control over their fate.

Moreover, union organizers routinely exhort employees to look dubiously at anything management proposes.

No wonder the most consistent communications course among hospitals in dealing with employees is to avoid them.

How then can a CEO and a board influence employees to support and endorse management’s effort to turn around hospital performance and reputation?

The answer lies first in adopting a tough, substantive program of operational improvement – enhancing core delivery of services, shoring up key processes such as billing, cutting unnecessary expenses.

Second, the turnaround program must be embraced by those expected, through their sacrifice and hard work, to carry it out. In other words, rank and file employees must “buy in” to the program.

This is a difficult task. It can only be achieved with the implementation of a four-pronged, focused employee communications program. Such a program is based on four underlying criteria that we identify through the acronym, “S.H.O.C.”

- Strategic
- Honest
- Open
- Consistent

First, all communications must be “Strategic.”

What strategic communication boils down to is this: Most employees want you to answer only two basic questions for them:

1. Where is this hospital going?
2. What is my role in helping us get there?

That’s it. Once you level with the staff as to the hospital’s direction and goals and their role in the process, even the biggest bellyachers will grudgingly acknowledge your attempt to “keep them in the loop.”

The case of the 180-bed Algonquin Memorial Hospital is typical. We counseled Algonquin’s board and CEO to let the staff know early on what management’s loss projections looked like for the year, and how the turnaround firm
they’d hired would likely call for some staff cuts.

A few board members at Algonquin (not its real name) questioned the wisdom of this approach. After all, they argued, after two successive losing years, employee morale stood at rock bottom. Some employees feared Algonquin would have to close. And most viewed management with suspicion. So how could providing employees with budget projections accomplish anything?

The answer, of course, was that once the CEO announced that Algonquin’s goal was to cut its annual loss in half, those who feared the hospital would go bankrupt or close were reassured. Moreover, in further announcing that although across-the-board layoffs would be avoided, some terminations were inevitable – the CEO began, finally, to earn employees’ trust.

Second, all communications must be “Honest.”

The sad fact is that many healthcare managers may pay lip service to candor and honesty, but few practice either when it comes to confronting the staff. More often than not, they dispense, obfuscate and pull their punches.

They seem to fear, as Jack Nicholson raged in the movie “A Few Good Men,” that the staff “can’t handle the truth.”

Such trepidation is foolish. For one thing, the staff already discounts anything management tells them. For another, you can’t hope to build credibility through prevaricating or sugar coating.

In Algonquin’s case, when the CEO acknowledged at employee forums that, “Yes, we are considering outsourcing the food services operation,” and “No, we don’t foresee any gain-sharing possibility this year or next,” he began to build back internal trust.

Third, all communications must be “Open.”

This is another way of saying that there must be feedback. The best communications are two-way communications.

In the case of a hospital, employee views must be solicited, listened to and, most important, acted upon.

One Algonquin trustee balked at the notion of suggestion boxes in the hospital cafeteria. “Nobody ever uses them at our bank,” he said. “They’re a waste.”

But when the suggestions started to trickle in – and the CEO started responding to them in the bi-weekly Algonquin Update and then acting on them – the trickle turned into a torrent.

Over time, Algonquin’s staff came to expect action on the supply needs they raised and the facilities improvements they suggested. And for the most part, action there was. By yearend, the number of suggestion boxes in the hospital had tripled, along with the quantity – and quality – of suggestions.

Fourth, all communications must be “Consistent.”

Once you’ve begun to communicate, for Pete’s sake, keep it up. Maintain a regular, on time and predictable program of internal newsletters, employee forums, leadership meetings and reward celebrations.

On again/off again communications undercut management’s commitment to keeping the staff informed. So do programs that start with bold promises, only to peter out.

Early on, Algonquin’s CEO promised to update the staff on the progress of the hospital’s turnaround program through enclosures in bi-weekly pay envelopes.

Thereafter, like clockwork, every other Friday, Algonquin’s staff was apprised of the very latest personnel decisions, changes in organizational structure, physicians recruited, and financial results.

On December 31, in the year’s 26th Algonquin Update, the CEO reported: “Preliminary results suggest that we have accomplished our goal for the year of cutting our annual loss in half. I am personally grateful to all of you for working so hard in support of our turnaround. Thanks to you, our reputation is on the way back.”

About the Author

Steve Rivkin founded Rivkin & Associates Inc., a communications consulting firm that specializes in serving healthcare institutions, in 1989. He is the co-author of five books on marketing and communications strategies, and has been an Estes Park Institute faculty member for 14 years. He can be reached at www.HospitalCrisis.net.

Guidelines Define Nurse Supervisors

The National Labor Relations Board has set forth guidelines for determining whether an individual is a supervisor under the National Labor Relations Act.

In a decision made public October 3, the Board held that the permanent charge nurses employed by the Employer, Oakwood Heritage Hospital, an acute care hospital, exercised supervisory authority in assigning employees within the meaning of Section 2(11) of the Act. Specifically, the board concluded that the charge nurses regularly assigned nursing personnel to care for specific patients during their shifts.

The decision follows a 2001 Supreme Court ruling (NLRB v. Kentucky River Community Care) that nurses who use independent judgment in directing employees are supervisors. As a result, the Board found that only the Employer’s permanent charge nurses were supervisors, rather than employees, under the Act.

The decision is posted on the Board’s Web site at http://www.nlrb.gov.
New ICD-9-CM Codes

Each year the Centers for Medicare & Medicaid Services and National Center for Health Statistics releases updated guidelines for coding and reporting clinical diagnoses and procedures using the ICD-9-CM coding system. The AHA, American Health Information Management Association, CMS and NCHS have approved the recently released guidelines, which took effect November 15.

Adherence to the coding guidelines is required under the Health Insurance Portability and Accountability Act, which adopted the ICD-9-CM procedure codes for inpatient procedures reported by hospitals and the ICD-9-CM diagnosis codes for all healthcare settings.

Healthcare Weighing Heavily on Americans’ Minds

Healthcare remains firmly positioned among Americans’ top five concerns, according to an ABC News/Washington Post survey conducted in October. Survey results showed the most important issues driving voter choice in the recent congressional elections were (1) the war in Iraq, (2) the economy, (3) healthcare, (4) immigration, and (5) terrorism.

Some reasons why the public’s interest in healthcare is so great might be found in a separate poll completed October 18 by the same group. It showed that 78% of Americans are dissatisfied with the cost of the nation’s healthcare system, including 54% who are “very” dissatisfied. Fifty-nine percent are worried about future affordability of healthcare and, for the first time since 1993, a majority, 54%, says that they are dissatisfied with the overall quality of healthcare in the United States. That’s up 10 points since 2000.

The survey also found that Americans by a 2-1 margin say that they would prefer a universal health insurance program based on the Medicare model over the current employer-based system. Sixty-two percent of those surveyed support the universal healthcare concept, versus 32% who do not; however, if a new healthcare delivery-financing model would mean a limited choice of physicians or lengthy waits for some non-emergency care, less than 40% would choose a universal health coverage plan.

In addition, 70% of those surveyed said that it should be legal to buy prescription drugs from foreign countries, despite the FDA’s safety qualms.

Employers’ Health Premiums Still Rising; Up 87% in Past Six Years

A new report from the Henry J. Kaiser Family Foundation shows that premiums for employer-sponsored health coverage rose an average 7.7% in 2006, less than the 9.2% increase recorded in 2005 and the recent peak of 13.9% in 2003.

The group’s 2006 Employer Health Benefits Survey, released in conjunction with the Health Research and Educational Trust (HRET), said that the 2006 increase was the slowest rate of premium growth since 2000.

However, not all the news was good. Premiums still increased more than twice as fast as workers’ wages (3.8%) and overall inflation (3.5%). Employers’ premiums have increased 87% over the past six years. Family health coverage now costs an average $11,480 annually, with workers paying an average of $2,973 toward those premiums, about $1,354 more than in 2000.

Foundation president and CEO Drew E. Altman, PhD said, “While premiums didn’t rise as fast as they have in recent years, working people don’t feel like they are getting any relief at all because their premiums have been rising so much faster than their paychecks.”

HRET president Mary A. Pittman, DrPH, added, “The burden of a fragmented system of coverage falls heaviest on the small employer and their workers.” Pittman noted that 40% of employers do not even offer health insurance, and those that do require workers on average to contribute significantly more to their premiums for family coverage.

While there is substantial debate about consumer-driven healthcare, the survey finds modest enrollment in consumer-driven plans, with 2.7 million workers in high-deductible plans with a savings option, including those that qualify for Health Savings Accounts (HSAs). About 4% of covered workers are enrolled in such plans, a rate statistically no different from last year.

Relatively few firms that offer other types of health insurance say that they are “very likely” to adopt high-deductible plans that qualify for an HSA (4%) or that are associated with a Health Reimbursement Arrangement (6%) in the next year.

To read the full report, go to http://www.kff.org/insurance/7527/.
Almost half of U.S. hospitals experience crowded conditions in the emergency department (ED), with almost two-thirds of metropolitan EDs experiencing crowding at times, according to a new report from the Centers for Disease Control and Prevention.

About one-third of US hospitals reported having to divert an ambulance to another ED due to overcrowding or staffing shortages at their ED.

Crowding in metropolitan EDs was associated with a higher percentage of nursing vacancies, higher patient volume, and longer patient waiting and treatment durations. Half of EDs in metropolitan areas had more than 5% of their nursing positions vacant.

The US had an average of 4,500 EDs in 2003 and 2004, more than half of which saw fewer than 20,000 patients annually. However, one in 10 EDs had an annual visit volume of more than 50,000 patients. The data are based on the 2003-04 National Hospital Ambulatory Medical Care Survey.


One of the most overlooked benefits that hospitals provide to their communities is their positive influence on the economy.

In many cities and towns, the local hospital is the largest employer. The American Hospital Association’s 2007 edition of its Hospital Guide lists 22 Arkansas hospitals having more than 500 employees, and according to Arkansas Business, five hospitals and health systems are among the state’s 28 largest employers and nine are included in the 75 largest private companies in the state.

BusinessWeek magazine took note of healthcare’s impact on employment in its September 25 issue. In its cover story titled, “Health Care Has Added 1.7 Million Jobs Since 2001. The Rest of the Private Sector? None,” the business journal reports that while the number of private-sector jobs outside healthcare is no higher than it was five years ago, hospitals and other employers in the healthcare field are propping up the economy.

The article cites Children’s Hospital of Philadelphia as nearly doubling its workforce over six years as it added the equivalent of 4,000 new full-time jobs. At the same time, all the non-healthcare businesses in the Philadelphia area combined added virtually no jobs over the same stretch.

The House Judiciary Committee has approved a bill (H.R. 4997) that would extend for two years the State 30/J-1 Visa Waiver program, which allows state health agencies to annually hire up to 30 foreign physicians to practice in rural and inner-city communities that often have difficulty recruiting physicians.

The American Hospital Association supports the extension. The program allows foreign physicians who have completed medical residency programs in the US to remain in the country on their J-1 visa, provided they agree to practice medicine for three years in an underserved area.
COSTS UNINSURED

What to Do About the Rising Number of Uninsured?

If the nation’s healthcare system is not reformed and the surge of uninsured Americans stemmed soon, more than 50 million people in the U.S. will have no healthcare insurance by 2010. That means another four million Americans more than today will be feeling the serious health and financial effects of being uninsured. Roughly 17% of the population will put their healthcare needs on hold and once they decide it’s time to do something, they’ll be worse off physically or mentally, or both.

As a result, they’ll require more care and their bills will be higher. They’ll strive to pay the doctors, hospitals and other healthcare providers what they can, which is generously estimated at 30-cents on the dollar. Their medical bills, the chief contributor to US bankruptcies, will impoverish many families and significantly worsen the financial plight of others.

While not everybody who claims bankruptcy as a result of medical bills is uninsured, it’s a safe bet that having no insurance is a major risk factor. With that kind of personal tragedy staring 50 million-plus Americans squarely in the face, why is it that healthcare reform isn’t higher on the nation’s political agenda? It almost seems that today’s government leaders are ignoring the issue and hoping for someone else to take the lead.

If so, who can blame them? Social Security may be the third rail of American politics, but history is littered with the failed attempts of presidents, senators and congressmen who tried to tamper with the line that energizes the US healthcare system and couldn’t hold on. The best way to power down the grid enough to install needed changes would be an unexpected turn of events that would cause a politically forceful group that historically and vigorously has opposed healthcare reform to begin pushing for it.

That might be a group like – oh, big business, for instance. A substantial amount of research shows that leaving a large share of the population without health insurance affects not only those who are uninsured, but also the health and economic wellbeing of the nation, and that makes it a big business worry.

For proof, look no further than a recent comment by H. Lee Scott, CEO of Bentonville-based Wal-Mart (which also happens to be a synonym for “Big Business”). Scott, during a PBS broadcast this summer said about the country’s healthcare crisis, “I think first of all, business and labor are going to have to participate and probably play more of a leadership role than government.”

Scott went on to say that the two groups are “...going to have to bring the political side of this thing along.” That’s right. Business and unions working together to reform healthcare!

Unions have actively pushed for more healthcare coverage for workers over the past 100 years, while business has been more concerned with the major costs of providing the coverage. However, America’s business community is beginning to realize that a massive uninsured population creates a hidden burden on employers’ health insurance premiums. In short, it affects the bottom line.

One study by Families USA concludes that by 2010, employer-provided family health coverage in 11 states will cost more than $2,000 extra to pay for health services provided to uninsured patients. Four of those states are located in the West South Central region of the U.S., including Arkansas, where the added uninsured premium subsidy is estimated at $2,750.

We’re often reminded that politics makes strange bedfellows. That never has been more tailor-made for any situation than this. Although, Shakespeare’s original thought might be more fitting in this case. In “The Tempest,” Shakespeare wrote, “Misery acquaints a man with strange bedfellows.” The same work includes another familiar Shakespearean phrase that could aptly apply here. The character, upon seeing great opportunity for change in her life, utters simply, “O, brave new world!”

Number of Uninsured Rises Above 46 Million

The number of Americans without health insurance rose by 1.3 million in 2005 to 46.6 million, according to a new report from the U.S. Census Bureau. The report showed that 17.2% of Arkansans were uninsured at last count. Total uninsured Americans with employment-based health coverage fell to 59.5% from 59.8%, while the number of uninsured children rose to 8.3 million from 7.9 million, among other changes.

According to the study, the percentage of residents who are uninsured in 31 states, including Arkansas, was sig-
The percentage of Americans without health insurance hit 15.9%, or roughly 46.6 million people, in 2005. That is up from 15.6% of the population in 2004, or about 45.3 million people, according to the US Census Bureau.

### Health Insurance Coverage, 2001 to 2005*

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured</th>
<th>Medicaid/ SCHIP</th>
<th>Employer-sponsored insurance</th>
<th>Individually-purchased insurance</th>
<th>Medicare</th>
<th>Military Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (Millions)</td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
<td>Percent</td>
</tr>
<tr>
<td>2005</td>
<td>46.6</td>
<td>15.9%</td>
<td>13.0%</td>
<td>59.5%</td>
<td>9.1%</td>
<td>13.7%</td>
</tr>
<tr>
<td>2004</td>
<td>45.3</td>
<td>15.6%</td>
<td>13.0%</td>
<td>59.8%</td>
<td>9.3%</td>
<td>13.6%</td>
</tr>
<tr>
<td>2003</td>
<td>45.0</td>
<td>15.6%</td>
<td>12.4%</td>
<td>60.4%</td>
<td>9.2%</td>
<td>13.7%</td>
</tr>
<tr>
<td>2002</td>
<td>43.6</td>
<td>15.2%</td>
<td>11.6%</td>
<td>61.3%</td>
<td>9.3%</td>
<td>13.4%</td>
</tr>
<tr>
<td>2001</td>
<td>41.2</td>
<td>14.6%</td>
<td>11.2%</td>
<td>62.6%</td>
<td>9.2%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

*Based on current population surveys. Percentages do not sum to 100% because some people have more than one type of coverage.

### Contracts for Studies Mandated in IPPS Final Rule Are Signed

In its 2007 Medicare inpatient prospective payment system (IPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) indicated that it would complete two studies to serve as a foundation for the 2008 IPPS rule. The agency has now signed contracts with groups that will conduct the studies.

Under the first contract, RTI International will study methods of improving estimates of the cost of Medicare inpatient hospital discharges used in constructing the DRG relative weights, a key determinant of the amount Medicare pays for an inpatient hospital stay.

The second contractor, RAND Corporation, will evaluate alternative severity-adjusted DRG classifications systems. The systems to be evaluated are all variants of the Yale severity of illness system developed under contract with CMS in 1989. RAND Corporation will analyze at least two years of MedPAR for the 2008 proposed rule, due out in May 2007. Another two years of data may be analyzed for at least some of the systems by the time a final report is completed.
CMS Releases 2007 Outpatient PPS Final Rule

The Centers for Medicare & Medicaid Services (CMS) has released the 2007 hospital outpatient prospective payment system final rule.

In the rule, the agency scrapped its original proposal to link inpatient quality reporting to the outpatient payment update. The American Hospital Association (AHA) pushed for the change in its formal comments on the rule. Instead, CMS will work with the American Hospital Association, the Hospital Quality Alliance and the Ambulatory Care Quality Alliance (AQA) to develop appropriate quality measures, which hospitals will begin reporting in 2009.

In addition, CMS will pay for five levels of outpatient services – instead of the current three levels – for evaluation and management services performed in emergency departments and clinics. The AHA had warned about making such changes without first developing national coding guidelines for evaluation and management services.

The rule also incorporates a payment reduction for 280 ambulatory surgical center (ASC) services previously paid more than the outpatient hospital setting and expands inpatient hospital quality reporting requirements for fiscal year (FY) 2008 and other important changes.

The rule contains a 3.4% market basket update for hospitals, and is posted at the CMS Web site, http://www.cms.hhs.gov.

**Highlights of the final rule:**
- The rule includes a 3.4 percent market basket update; however, when combined with other factors, outpatient payments will increase by only 3.0 percent.
- CMS will tie the outpatient payment update to the reporting of outpatient quality measures beginning in 2009. The agency will work to develop measures of quality in the outpatient hospital setting for use in the new link to outpatient payment and quality. Hospitals that fail to report the quality measures would receive the outpatient PPS update minus 2.0 percentage points beginning in 2009.
- The rule reduces “hold-harmless” payments for small rural hospitals from 95 percent to 90 percent, as required by the Deficit Reduction Act of 2005 (DRA).
- CMS maintains the payment for most separately payable drugs at average sales price (ASP) plus 6 percent, rather than implement its proposal to decrease drug payment to ASP plus 5 percent.
- The outlier fixed-dollar threshold increases from the current $1,250 to $1,825 in 2007 and CMS is changing the methodology for calculating the hospital-wide cost-to-charge ratio. The agency proposes to maintain its current target for outlier payments at 1.0 percent of total outpatient spending.
- CMS made significant changes to the evaluation and management codes and payment levels for hospital clinic and emergency department (ED) visits. The rule will increase from three to five the number of ambulatory payment classifications (APCs) for clinic visits and ED visits. The rule also creates new codes for use by freestanding EDs. CMS set payment for these services equal to the payment for clinic visits.

**Other important changes:**
- The final rule includes CMS’ expansion of quality measures for inpatient hospital reporting related to the FY 2008 inpatient PPS annual update. The expanded measures were endorsed by the Hospital Quality Alliance (HQA) in July. The proposed measures include:
  - HCAHPS® Patients’ Perspective of Care Measures;
  - Three additional Surgical Care Improvement Project measures; and
  - 30-day mortality measures for patients with acute myocardial infarction, heart failure and pneumonia.
- In 2007, CMS will cap payment for 280 ASC services at the hospital outpatient payment rate, as required in the DRA, and add 19 services to the list of covered ASC services.
- CMS revises the critical access hospital (CAH) conditions of participation to allow CAHs to use a registered nurse to perform the emergency medical screening examination mandated by the Emergency Medical Treatment and Labor Act.

Home Health Rule for 2007 Released by CMS

The Centers for Medicare & Medicaid Services’ final rule affecting the home health prospective payment system for calendar year (CY) 2007 includes a market basket update of 3.3%, up from the proposed update of 3.1%.

The increase results in an additional $410 million in wage-adjusted home care payments in CY 2007. For a second year, rural providers will receive a 5% add-on payment.

Starting in CY 2007, the Deficit Reduction Act of 2005 requires home health providers to report certain quality data to receive a full market basket update. Providers failing to submit these measures will receive a 2-percentage-point cut in their market basket update. Most home health providers already submit such data.

The final rule also implements a much smaller cut in home oxygen rates than initially proposed – approximately 1% versus nearly 23%.

The rule is available at http://www.cms.hhs.gov.
On September 29, 2006, the Centers for Medicare & Medicaid Services’ (CMS) Medicare outpatient prospective payment system (PPS) final rule includes quality measures that hospitals must submit to qualify for a full market basket update for the fiscal year (FY) 2008 inpatient PPS.

These additional measures for full payment in 2008 were adopted previously by the Hospital Quality Alliance as appropriate for public reporting on hospital inpatient care quality. The new measures include: patients’ experience of care (measured with the HCAHPS survey); 30-day mortality rates for heart attack and heart failure; and care for surgical patients.

Hospitals that fail to report these quality measures face a penalty of 2 percentage points from their inpatient update for 2008.

As originally proposed, the rule sought to link submission of inpatient measures in 2007 and 2008 to receipt of the full outpatient PPS update as well. However, the AHA and others opposed this proposal, and it was eliminated from the final rule, which was released November 1. To prepare, hospitals should:

• Check to ensure that their quality data on the currently required heart attack, heart failure and pneumonia measures continue to be reported accurately to the quality improvement organization (QIO) data warehouse via Q-Net Exchange.
• Determine if the organization is fully prepared and already submitting HCAHPS data to the data warehouse, or if more work needs to be done. If more work is needed, consider contacting a certified HCAHPS surveyor (a list is available at http://www.hcahpsonline.org/).
• Review the mortality data methodology that was sent to each hospital via Q-Net Exchange in early November and the hospital-specific data that was transmitted in early December.
• Ensure their ability to expand abstraction of the surgical care measures to include the new ones derived from the Surgical Care Improvement Project (SCIP).

Further Questions: Contact Nancy Foster, AHA vice president of quality and patient safety policy, at nfoster@aha.org or call 1-800-424-4301.

HCAHPS, Quality Measure Reporting for Full FY 2008 Medicare Market Basket Update

On September 29, 2006, the Centers for Medicare & Medicaid Services (CMS) announced final hospital inpatient prospective payment system (IPPS) rates for fiscal year (FY) 2007. Although CMS completed its FY 2007 IPPS final rule on August 1, the rates announced at that time were tentative. CMS could only make tentative IPPS rates available with the final rule because it was unable to calculate final occupational mix adjusted wage indices as a result of only recently completing the collection of new occupational mix survey data ordered by the 2nd Circuit Court of Appeals in Bellevue Hospital Center v. Leavitt on April 3.

Consistent with the Court’s order, the final rates announced for FY 2007 fully adjust the wage indices for occupational mix. The revised wage indices affect other aspects of IPPS payments such as the DRG relative weights, the outlier threshold and geographic reclassification that, in turn, affect the calculation of the final IPPS rates.

Compared to the tentative rates announced on August 1, the final rates announced on September 29 do the following:

• DRG Relative Weights – The use of occupational mix adjusted wage indices has little or no effect on the DRG relative weights that CMS announced on August 1. No DRG relative weight changed by more than 0.8 percent from the tentative ones earlier announced.

• Outlier Threshold – The use of the revised wage data has a negligible effect on the outlier threshold. The FY 2007 threshold increased $10 from the tentative one of $24,475 CMS announced on August 1 to $24,485.

• Final IPPS Rates – The final IPPS standardized amounts will be approximately $4 less (0.1 percent) than those announced on August 1.

• The changes in the IPPS rates from using occupational mix data are budget neutral. Therefore, there is no change to earlier estimates of the increase in operating and capital payments. CMS is continuing to estimate that payments to hospitals will increase by $3.4 billion or an average of 3.5 percent.
Hospital pharmacy administrators are challenged to continually improve quality of care while implementing cost containment measures. The pharmacy department in many institutions may offer tremendous opportunities for improving patient care through innovative approaches to ensure patient safety, shorten hospital stays, reduce medication errors, and minimize adverse effects.

Pharmacists in several Arkansas hospitals have implemented new programs that have shown clear benefits to their institutions. Here, we highlight experiences shared by three of these institutions.

**St. Joseph’s Mercy Healthcare System, Hot Springs, Arkansas**

Enhancement of clinical and safety initiatives started at St. Joseph’s in 2002. The first initiative was to deploy three pharmacists to the floors to cover 180 beds within the institution. Three floor pharmacists and two pharmacists in the main pharmacy log clinical interventions on a daily basis. Over 60 categories of clinical interventions are included, and each category is associated with a dollar value as a result of cost avoidance. The data is collected and analyzed through a Web-based database, “Health ProLink.” The encounters are grouped into areas such as clinical interventions, consultations with medical staff, formal staff development activities, and patient education. Clinical interventions involving patient safety as the primary outcome accounted for the greatest number of interventions. Patient safety initiatives include clarification of dosage, recognition of allergy contraindications, drug information, and medication reconciliation.

Although most of these activities are performed by pharmacists throughout the state on a daily basis, this institution systematically initiated a system with the intent of increasing pharmacist interventions and determining cost avoidance associated with these activities. With this model, clinical interventions increased from approximately 40/day to more than 170/day. The average monthly savings is reported as $40,000 to $50,000, as a result of more than 5000 interventions/month. Cost avoidance is likely conservative, given the emphasis on improving patient safety and preventing catastrophic errors.

During the month of April 2006, 5248 intervention reports were collected. The interventions consumed 1266 hours and had a cost avoidance of $43,461. The majority of reports were categorized as clinical interventions (81%), followed by consultations with medical staff (14%), patient education (4%), and formal staff development activities (1%).

The enhancement of clinical and safety initiatives in the St. Joseph’s Mercy Healthcare System through this model has been very successful. The data provides a baseline for improvement, encourages teamwork between the healthcare professionals, and pro-
provides information to administration that can be used for planning and continuous quality improvement.

**White River Medical Center, Batesville, Arkansas**

White River Medical Center has also hired clinical floor pharmacists in an effort to improve patient outcomes. One of the areas they have strived to improve is the prevention of venous thromboembolism (pulmonary embolism and deep venous thrombosis). Pharmacists working with an interdisciplinary healthcare team of physicians, nurses, and others assisted with the development of a Deep Venous Thrombosis (DVT) Safety Zone program.

In this program, patients are assessed on admission using a standardized form. If indications for prophylaxis exist, a DVT protocol physician order form is placed on the chart and the physician decides the type of prophylaxis indicated. The program heightens awareness of the risk for thromboembolism.

Early data indicate that the program is successful. Prior to initiation of this program, a chart review for the 2002 calendar year indicated that 140 patients were evaluated based on the diagnosis code for pulmonary embolism and deep venous thrombosis. Eighteen patients had a DVT in the hospital an average of 6.3 days after admission. Fifteen patients were readmitted with a DVT after recent hospitalization (< 30 days). Eight patients had a DVT in the hospital and seven patients were readmitted with a pulmonary embolism after recent hospitalization.

The program was implemented in June 2004. During the first six months, staff education and protocol changes occurred. A 2005 retrospective chart review was conducted to assess the impact of the program. The overall incidence of DVTs decreased from 33 in 2002 to 26 in 2005 and the number of pulmonary embolisms decreased from 15 to 5 during this same period. The incidence per 1000 admissions decreased from 5.72 to 3.76, with an estimated impact of preventing 17 thromboembolic events.

**Baptist Health Medical Center – North Little Rock**

The Pharmacy Department at Baptist Health Medical Center – North Little Rock began its initial efforts toward enhanced clinical activities in 1995. Three clinical pharmacists were placed in direct patient care areas. Their duties included kinetic antibiotic dosing, anticoagulation therapy and patient chart reviews.

Today, these, and many other clinical activities account for approximately 1,700 clinical interventions monthly resulting in an estimated savings to the institution of $130,000. Appropriate formulary management through therapeutic substitutions and cost-effective pharmacotherapy initiatives increases this monthly savings to more than $300,000.

These clinical endeavors have led to professional acceptance of pharmacists as direct patient care providers from the nursing and medical staffs. As a testimony to this respect, clinical pharmacists were given autonomy to screen and initiate pneumococcal and influenza vaccinations for the inpatient population. This privilege was approved via the institution’s Pharmacy and Therapeutics Committee.

This opportunity has resulted in a significant increase in reaching the goal rate for this CMS core measure. The compliance rate with pneumococcal screening and vaccination has increased from 21% during the first quarter of 2005 to 84% in the first quarter of 2006. Due to the obvious success of clinical pharmacy activities on this important measure, clinical pharmacists have been charged with working to improve CMS core measure compliance in the areas of myocardial infarction and heart failure. As of this writing, the impact of these most recent initiatives has not been quantified.

**Making a Difference**

Clinical pharmacy services are contributing to better patient care, improvements in core outcomes, and institutional cost savings. Through documentation of interventions, innovative practices and system-wide approaches, pharmacists can be considered leading contributors to cost effective improved patient care.

**About the Author**

Stephanie Gardner is Professor and Dean of the University of Arkansas for Medical Sciences (UAMS) College of Pharmacy.
JCAHO Unannounced Surveys Begin

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has begun conducting unannounced surveys for hospitals and critical access hospitals (CAHs) seeking accreditation for the first time.

For critical access hospitals, unannounced initial surveys began in mid-August, while unannounced initial surveys for other hospitals were scheduled to begin January 1, 2007.

The JCAHO believes that the transition to unannounced initial surveys will further strengthen the emphasis on the need to always be prepared to deliver safe, high-quality care. The unannounced surveys also ensure that critical access hospitals meet the Centers for Medicare & Medicaid Services (CMS) requirements under the federal deeming authority agreements between CMS and the Joint Commission.

CMS has urged the Joint Commission to conduct initial surveys of hospitals on an announced basis. The Joint Commission began conducting unannounced triennial surveys in January 2006, underscoring the expectation that organizations are providing safe, high quality care at all times. This shift has been positively received by healthcare organizations and stakeholders alike and has prompted other private sector accrediting bodies and CMS to also adopt unannounced surveys as routine practice.

SCIP Participants Asking for Patients to Get More Involved

Participants in the national Surgical Care Improvement Project (SCIP) are inviting patients to become partners in their surgical care and have provided a tip sheet of questions that patients should ask their physicians, nurses and other caregivers.

The tip sheet is designed to make patients aware of things they should ask before surgery to improve their chances of avoiding infection, blood clots and heart attack following a surgical procedure.

At a recent Washington, DC briefing, Department of Health and Human Services Secretary Michael Leavitt applauded the efforts of the partnership to reduce surgical complications and more fully involve patients in their care. During the briefing, a care team including a surgeon, anesthesiologist, nurse executive and quality expert from Franklin Square Hospital Center in Baltimore highlighted their hospital’s success in improving care through SCIP, a national quality partnership of organizations interested in improving surgical care by significantly reducing surgical complications.

More than 1,700 hospitals nationwide, including nine Arkansas hospitals, participate in the project.

See the list of helpful questions at http://www.ofmq.com/user_uploads/FINALconsumer_tips2.

Heightened Hospital Quality Reduces Costs, Report Says

A study released in late summer by Premier Inc. concludes that wider adoption of the quality measures used in its Medicare pay-for-performance project could reduce hospital costs nationwide and save lives.

The study examined whether higher quality care could result in lower costs and improved patient outcomes, based on the quality measures used in the demonstration and outcome and cost data from its hospital database. Quality was measured using the process measure data from the Hospital Quality Incentive Demonstration (HQID) project and outcome and cost data from the Premier Perspective™ database.

Findings showed that patients who received all or most of the project’s recommended interventions for patients in five clinical areas, including certain measures shared by the Hospital Quality Alliance, had better outcomes, shorter lengths of stay and lower costs, with the exception of heart failure patients.

For example, the average cost per discharge for pneumonia patients who received at least 75% of the care steps recommended in the demonstration was $8,412, compared with $10,298 for patients who received fewer than half of the recommended interventions.

Sentinel Event Statistics are Updated: Top Ten Categories Outlined

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has tracked sentinel events since January 1995. As of December 31, 2005, the JCAHO had received 3,661 reports of sentinel events. A total of 3,784 patients were affected by these events, with 2,761, or 73%, of those resulting in patient death. Detailed information about these sentinel events is available on the JCAHO Web site at http://www.jointcommission.org/SentinelEvents/Statistics.

The 10 most frequently reported sentinel events are: patient suicide (483), wrong-site surgery (470), operative/post-operative complication (454), medication error (364), delay in treatment (276), patient fall (198), patient death or injury in restraints (143), assault, rape or homicide (124), perinatal death/loss of function (111) and transfusion error (94).

NQF Releases Revised List of Serious Reportable Events

The National Quality Forum has endorsed a revised list of serious reportable events, defined as measurable events of concern to the public and healthcare providers that are significantly influenced by a healthcare organization’s policies and procedures.

The list includes one new event (artificial insemination with the wrong donor sperm or egg) and revised specifications for six events on its 2002 list.

NQF also endorsed a revised list of safe practices to include three new practices and 23 changes to practices approved in 2003.

NQF endorses voluntary national consensus standards for measuring and publicly reporting on healthcare performance.


Latest HQA Data Now Available on Web

The newest hospital quality data available on the Hospital Quality Alliance (HQA) Web site shows performance information on heart attack, heart failure, pneumonia, and surgical infection prevention from participating hospitals through the end of 2005. The data is provided by hospitals participating in the HQA project by reporting on 20 quality measures.

Work groups are currently in the process of expanding the number of reported measures to include patient care quality, efficiency and price across episodes of care in various communities throughout the country.

HQA representatives meet periodically with the Health & Human Services Secretary to update him on progress of the expansion.

The Centers of Medicare & Medicaid Services (CMS) says HQA’s work is central to CMS’ ability to share Medicare data so that it can be combined with other payer information to help identify opportunities for improvement.

Launched in April 2005, the HQA Web site, known as Hospital Compare, enables patients and families to compare the performance of U.S. acute care hospitals on 20 quality measures for care provided since 2004.

The Web site is located at http://www.hospitalcompare.hhs.gov.
NIH Scientists Create Staph Vaccine; Now Being Tested in Mice

National Institutes of Health (NIH) scientists have created a vaccine that protects mice from the bacterium that causes staph infections in humans.

The most common cause of healthcare acquired infection, the Staphylococcus aureus bacterium has developed resistance to traditional antibiotics. University of Chicago researchers created the vaccine by combining four proteins of the bacterium that generated strong immune response in mice.


CDC Issues New Guidelines for Preventing Spread of Staph in Hospitals

The Centers for Disease Control and Prevention (CDC) on October 19 released new guidelines developed by its Healthcare Infection Control Practices Advisory Committee for preventing the spread of multi-drug-resistant infections in hospitals and other healthcare settings.

Among other actions, the guidance encourages healthcare facilities to design prevention programs customized to specific settings and local needs and to ensure the programs are adequately funded and staffed.

According to the CDC, at least 63% of all staph infections seen in hospitals are caused by Methicillin-resistant Staphylococcus Aureus (MRSA), a specific strain of bacterium which has developed antibiotic resistance to all penicillins, including methicillin. That compares with just 2% of the infections that did not respond to the antibiotics in 1972.

The CDC says that MRSA germs, which are the leading cause of skin infections seen in hospital emergency rooms, sicken two million people yearly and cost about $20 billion to treat.

The guidelines suggest that hospitals know at all times whether infections are increasing or dropping; that patients at hospitals with persistent problems be more aggressively tested; and that wards where infections occur repeatedly be emptied and intensively cleaned before new patients are allowed in.

The guidelines offer recommendations for hospital management, education and antibiotic use. They also recommend that hospitals that can’t cut their infection rates should implement special measures in dealing with any patient with MRSA or other germs, such as requiring doctors and nurses to put on gloves and gowns before entering infected patients’ rooms. In addition, hospitals should halt admissions to units and wards when they can’t stop infections.


OIG Announces Investigation of CMS Patient Safety, Quality Oversight at Specialty Hospitals

The Department of Health and Human Services’ Office of Inspector General will look at the Centers for Medicare & Medicaid Services’ oversight of patient safety and quality of care at specialty hospitals for the first time ever in fiscal 2007, as well as examine payments for diagnostic X-rays in emergency rooms and admissions to long-term acute-care hospitals.

The new areas of inquiry join ongoing interests in rehabilitation and critical-access hospitals, outpatient department outliers, and unbundling of hospital services, according to the agency’s work plan.

The 93-page plan outlines the inspector general’s investigational priorities for fiscal 2007, which began October 1. Often new areas of interest reflect trends in whistle-blower lawsuits, growth in healthcare spending, audits by the agency or congressional investigation mandates. According to the plan, admissions from acute-care hospitals to long-term acute-care hospitals have grown rapidly.

Read the plan at http://www.oig.hhs.gov/publications/workplan.html.
FEMA Releases Required NIMS Implementation Activities

The Federal Emergency Management Agency (FEMA) has released the National Incident Management System’s (NIMS) implementation activities for hospital and healthcare systems.

The 17 activities are based on similar requirements that were earlier put into place for state and local agencies.

Hospitals receiving HRSA preparedness funding will be required to gradually come into compliance with all the NIMS implementation elements, over time. Other hospitals also are encouraged to implement them.

The FEMA announcement and a summary and detailed description of the activities can be found online at http://www.fema.gov/emergency/nims/index.shtm.

Use of New Hospital Incident Command System (HICS) Strongly Encouraged by American Hospital Association

The California Emergency Medical Services Authority (EMSA) has released an updated version of the Hospital Incident Command System (HICS), an incident management system designed to help hospitals improve their emergency planning and response capabilities.

HICS consists of a guidebook and planning and training tools developed by a national panel of experts with support from the American Hospital Association (AHA) and its American Society for Healthcare Engineering.

HICS will help hospitals implement elements of the Federal Emergency Management Agency’s Hospital-Based National Incident Management System (NIMS). The AHA is encouraging hospitals to carefully review and consider implementing HICS, as it will strengthen hospital disaster preparedness activities, improve coordination with other community response agencies and help hospitals implement NIMS.

The HICS release and materials are available at http://www.emsa.ca.gov/hics/hics.asp.

Pandemic Preparedness Taking Place

Through a grant from the U.S. Department of Health and Human Services, states are preparing for the possibility of an influenza pandemic. To enhance state hospital preparations, the Arkansas Hospital Association, in cooperation with the four Arkansas Metropolitan Region Tier 1 hospitals and the Division of Health, coordinated a two-day workshop to discuss preparations should rapid escalation of the flu arise in the state.

The goal of the workshop was for the Arkansas Hospital Pandemic Task Force, composed of approximately 30 hospital representatives from each region of the state, to prepare a template for Arkansas hospitals to integrate with their current response plan to ensure that it encompasses all activities necessary for the orderly and effective continuity of operations for a hospital and its staff during a pandemic. When complete, the template will be distributed to all Arkansas hospitals and also will be included in the Division of Health’s state flu pandemic plan, which is a requirement of the grant funding.
Medicare Part B Premium Rises in 2007

The basic Medicare Part B premium will rise in 2007 to $93.50 a month, an increase of $5.00, according to a White House announcement.

However, more affluent beneficiaries will pay a new surcharge, from $12.50 to $68.60 a month, depending on their incomes. The surcharge applies to 1.5 million people with annual incomes exceeding $80,000 for individuals or $160,000 for married couples filing joint tax returns.

The standard premium for 2007 is lower than Medicare first predicted. In May and again in July, the Centers for Medicare & Medicaid Services (CMS) estimated that the monthly premium, at $88.50 in 2006, would climb to about $98.00 in 2007. Citing reasons for the lower premium, Dr. Mark McClellan, former CMS administrator, said Medicare spending for doctors' services, while still growing at a brisk pace, increased less than expected in the last year.

That slowdown could have been aided by the fact that physicians received the same Medicare rates in 2006 as they were paid in 2005. It was still more than CMS planned to pay. Medicare physician rates were supposed to be cut 4.4% in 2006, but the Deficit Reduction Act of 2005 cleared the way for a reversal and extended Medicare’s 2005 payment rates through for another year.

Without a similar intervention, those rates are scheduled for a 5.1% reduction in 2007. The premium is set each year to cover about 25% of projected spending under Part B. If the planned 2007 cuts don’t take effect and Medicare rates are frozen through 2007, the monthly premium will go up another $1.50 per month.

Norwalk Named Acting CMS Chief

Leslie Norwalk, deputy administrator for the Centers for Medicare & Medicaid Services (CMS), has been named acting administrator for the agency. The vacancy was created when former CMS Administrator Mark McClellan stepped down in October.

Before joining CMS five years ago, Norwalk was at Epstein Becker & Green, PC where she advised clients on health policy matters. McClellan announced his decision to leave the CMS post September 5.

IOM Urges Replacement of Fee-for-Service with Pay-for-Performance

In a report issued on September 21, 2006, the Institute of Medicine (IOM) urged the Department of Health and Human Services to gradually replace the current fee-for-service Medicare program with a new pay-for-performance system for reimbursing participating healthcare providers.

The IOM concludes that the current Medicare system provides “few disincentives for overuse, under-use or misuse of care, and does not reward efficiency.”

Because there is little evidence-based data supporting pay for performance, the IOM recommends that programs be phased in to allow policy-makers to build on successes and avert unintended consequences.

In the next three to five years, the authors urge Congress to reduce base Medicare payments for all healthcare providers and use the money to fund rewards for strong performance. In addition, they recommend that payment incentives be designed to allow all providers to assume shared accountability for transitions between settings of care and coordinated care in treating chronic disease patients.

They also stress the need to adopt electronic health records, public reporting and beneficiary incentives and to educate boards of directors to improve healthcare quality and efficiency.

Web Site Gives Tips on Facilitating Medicare Provider Enrollment

Recent concerns about the length of time it takes for some Arkansas hospitals to obtain a Medicare provider number for new physicians resulted in a September 28 meeting between representatives of the Arkansas Hospital Association and Pinnacle Business Solutions, Inc. (PBSI), the Medicare Fiscal Intermediary (FI) and Carrier for most Arkansas Part A and Part B providers.

While PBSI believes there is room for improvement in its processing of applications, the FI also says that provider applications often lack the complete information that the Centers for Medicare & Medicaid Services (CMS) requires for approval.

CMS’ Dallas Regional Office weighed in on the matter in an October 13 update that states that the top reason for Medicare provider enrollment processing delays is the failure by individuals and organizations to submit a complete enrollment package. The update included a link to a few MedLearn Matters articles stressing the importance of submitting a complete enrollment application and all supporting documentation, including the submission of the National Provider Identifier and the CMS-588, Authorization Agreement for Electronic Funds Transfer, at the time of filing.

In addition, the Medicare Provider Enrollment Web site, http://www.cms.hhs.gov/MedicareProviderSupEnroll/, contains information for providers and suppliers to facilitate their enrollment into the Medicare program (see the download titled, “Tips to Facilitate the Medicare Enrollment Process.”)

CMS Summarizes Medicare Restraint, Seclusion Policy; Active Labor Policy Also Detailed

In a September 29 letter to state survey agencies, the Centers for Medicare & Medicaid Services (CMS) summarized the agency’s policy regarding the process by which hospitals report patient deaths associated with the use of restraint and seclusion for behavior management.

A recent report by the Department of Health and Human Services’ Office of Inspector General highlighted shortcomings in communicating and complying with the policy.

CMS also issued a letter to the agencies describing two changes to Emergency Medical Treatment and Active Labor Act regulations that were effective October 1. One change expands the types of healthcare professionals who may certify false labor. The other revises the current requirement of the Act, which states that a hospital with specialized capabilities must accept appropriate transfers regardless of whether or not the recipient hospital has a dedicated emergency department.

The letters can be found on the CMS Web site, http://www.cms.hhs.gov/SurveyCertificationGenInfo/PSMSR/list.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending.

New Employee Policy Information Required in Deficit Reduction Act

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (the “DRA”). Within the Act, Section 6032 imposes mandatory compliance obligations on entities that receive annual Medicaid payments of $5,000,000 or more.

These entities, as a condition of receiving payment under Medicaid, must establish written policies for all of their managers, employees, contractors and agents that contain:

• Detailed information regarding the federal Civil False Claims Act;
• Detailed information regarding the federal administrative remedies for false claims and statements;
• A description of any state laws with civil or criminal penalties for false claims or statements;
• Whistleblower protections under these laws; and
• Detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste and abuse.

Any entity that has an employee handbook must include in it a specific discussion of these topics. These policies were to be prepared and distributed prior to January 1, 2007.

To assist the state’s hospitals in fulfilling the requirement, Arkansas Hospital Association legal counsel Elisa White prepared a sample policy for use as a template in preparing their own DRA compliance policies. The policy was previously distributed to all AHA-member hospital compliance officers. Any hospital needing additional copies of the sample policy should contact Beth Ingram at bingram@arkhospitals.org or (501) 224-7878.
Starting in 2007, the Medicare program will pay physicians more for the time they spend talking with Medicare beneficiaries about their healthcare and will pay for a broader range of preventive services.

The changes, which are folded into an overall 5% reduction in physician fees, will become effective January 1, 2007. They are included in the Medicare Physician Fee Schedule (MPFS) final rule released November 1 by the Centers for Medicare & Medicaid Services (CMS).

CMS projects that it will pay approximately $61.5 billion to more than 900,000 physicians and other healthcare professionals in 2007 as a result of the new payment rates and policies adopted in the rule.

This new spending figure reflects current law requirements to reduce payments by 5% to account for the combined growth in volume and intensity of physician services. The reduction is based on a law that includes a statutory formula used to establish physician rates. It compares the actual rate of growth in spending to a target rate, which is based on such factors as the growth in number of Medicare fee-for-service beneficiaries and statutory or regulatory changes in benefits.

If the actual rate of spending growth exceeds the target rate, the update is decreased; if it is less, the update is increased. Every year beginning with 2002, in response to rising spending, the statutory update formula would have operated to impose payment cuts. The negative update went into effect in 2002, but for 2003 to 2006, Congress intervened and temporarily suspended the requirements of the formula in favor of specific, statutory updates.

CMS is working with physician organizations, the AQA Alliance, the National Quality Forum, and others to develop quality measures, in order to identify and support higher quality care. In November 2006 CMS posted on its Web site a pool of potential quality measures for physicians to report as part of the Physician Voluntary Reporting Program.

More information about this program, including the potential measures can be found at: http://www.cms.hhs.gov/PVRP.

One of the major components affecting a hospital’s Medicare payment rate is the area wage index (AWI), which is supposed to account for differences in wages among various geographic locations throughout the country. However, the process for developing the AWI makes it common to find significant swings in wage index values among the different geographic areas, even when they may be adjacent to each other.

To compensate for those differences among neighboring areas, Congress included a provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 that enables certain hospitals to obtain geographic reclassifications from one area to another for purposes of using a more appropriate wage index and receiving more accurate rates.

Nationwide, 120 hospitals have the reclassifications, including several Arkansas hospitals.

The provision is set to expire in March 2007 unless Congress acts to change the situation, something that Sen. Chuck Grassley (R-IA), Chairman of the Senate Finance Committee, hopes to accomplish. Grassley announced in late October that he will attempt to prevent the expiration by seeking a six-month extension of the provision.

In his announcement Grassley said, “When that [wage index value] difference isn’t recognized, it’s harder for a hospital to recruit and keep on staff nurses and other essential personnel without putting the hospital’s financing health in jeopardy.” Grassley said he is seeking a long-term solution to problems with the area wage index in addition to advocating a six-month extension.
AFMC AD
NEW AD
TO COME
Over 4.5 million square-feet of healthcare construction completed in Arkansas

www.nabholz.com

Arkansas Hospital Association
419 Natural Resources Drive
Little Rock, AR 72205