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Personal responsibility. A small term that has big ethical implications. Most of us would say it is a “given” in our society: Each person needs to take responsibility for themselves and their actions.

Group responsibility. Another small term with even bigger ethical implications. Many of us would hope it is a “given,” but we just aren’t sure: Is the group responsible for each of its members?

National responsibility. Now, we’re getting tricky. Another small term, with huge ethical implications. Does a nation have responsibility for every person who lives within its borders?

Herein lies the lively discussion taking place today over healthcare in America. Does every person have responsibility to live the healthiest life possible? Do our “groups” – communities, schools, hospitals, media, physicians, insurance companies and others – have a responsibility to enhance or even provide healthcare? And on a national level, are we of a mind to see it that every person living in America has access to affordable, accurate, efficient healthcare?

As most of you know, the American Hospital Association, working with many of the groups listed above and with each state hospital association, has been on a quest to define what reasonable, fair and accessible healthcare should look like in America. In recent days, the AHA has outlined its vision for healthcare in America and is spreading the word far and wide.

As with the idea-gathering discussions that took place earlier this year, the AHA is coming to hospital associations across America to explain its vision, its plan. Rich Umbdenstock, president of the AHA, scheduled just such a discussion with the Arkansas Hospital Association board September 14.

At that meeting, we learned that the AHA’s national vision is based on each person’s basic healthy life. Called “Health for Life: Better Health, Better Health Care,” the plan pivots on the three main guiding principals above. People need to take personal responsibility for their health, groups traditionally associated with healthcare need to work together to expedite better health and healthcare, and our nation must provide the legal, financial and expectational foundation for a healthy citizenry.

As we have said so many times, 80% of our nation’s healthcare spending is directly related to chronic illness, such as obesity and diabetes. So much of this spending – based upon this unhealthiness – is avoidable. In addressing people’s individual behaviors (smoking, poor eating habits, lack of exercise, drug and alcohol abuse), much chronic illness could be avoided. In addressing our physical and social environments (exposure to toxins, air pollution, poverty, lack of education, etc.) we could, as a nation, vastly improve individual health and lower the rate of chronic illness.

The AHA, in its vision for a Healthy America, says that as a society we must provide access to education and preventive care, we must help all people reach their highest potentials for health, and we must reverse the trend of avoidable illness. This will mean asking individuals to take personal responsibility to achieve healthier lifestyles. Each one of us, healthy or not, must take action to support a healthier America.

When we pull together, when we take personal, group and national responsibility seriously, our nation will become healthier, more productive, more vibrant. We will see to it that everyone has prompt access to needed healthcare, that every person is treated with dignity and respect, and that better health for our nation is viewed as a common goal. We will move together in a more positive direction, rather than in the too-often-fragmented fashion in which healthcare is approached today.

So whose responsibility is a healthy America? It is the responsibility of every individual, every employer, every insurer, every healthcare supplier, every community, every level of government, every doctor, every hospital, every provider of care.

The time for discussion and planning is now. The responsibility rests with each of us. How will you respond?

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Peter D. Banko, FACHE, has been named president and CEO of St. Vincent Health System. He previously served as vice president and COO of CHRISTUS Spohn Health System in Corpus Christi, Texas. Prior to that time, he was affiliated with PhyAmerica Physician Group in North Carolina. Banko is a graduate of the University of Notre Dame and Cornell University, where he earned his MHA.

Governor Mike Beebe has appointed Jennifer Lang, Ph.D., administrator of Methodist Behavioral Hospital in Maumelle, to the new Children’s Behavioral Health Care Commission. The Commission was created by Act 1593 of 2007 to advise the Arkansas Department of Human Services and the Department of Health on improving the system of mental healthcare for children. Lang is a licensed psychologist and has served as a consultant to many health organizations.

Claude E. “Chip” Camp, FACHE, was named CEO of Harris Hospital in Newport effective May 1, succeeding Butch Naylor. Camp is a former CEO of White County Community Hospital in Sparta, Tennessee, and previously held administrative positions with hospitals in New Mexico, Oklahoma, Mississippi, and Alabama. He has an MHA from the University of Alabama at Birmingham.

Russell D. Harrington, Jr., FACHE, president of Baptist Health, has announced that Greg Stubblefield has been named administrator of Baptist Health Medical Center – Arkadelphia. He has served in an interim capacity for the past few months, following the death of longtime administrator Dan Gatbright. Stubblefield has been affiliated with Baptist Health since his administrative residency in 2002.

Tad Hatton has been named chief operating officer for Northwest Medical Center – Willow Creek Women’s Hospital in Johnson. He succeeds Linda Worman. Hatton previously served as associate administrator at Northwest Medical Center in Springdale. He has more than ten years of healthcare operations and finance experience, including serving as division controller for Triad Hospitals, Inc. in Plano, Texas.

Scott Landrum, FACHE, has been named CEO at Rebsamen Medical Center in Jacksonville, after serving in an interim capacity since February. “Scott has progressive ideas for the future growth of Rebsamen and we are excited to work with him,” said Mack McAlister, chairman of the hospital board. A Kentucky native, Landrum brings more than 30 years of healthcare experience and was most recently CEO of Campbell Health System in Weatherford, Kentucky.

John Neal has resigned as CEO/administrator of Stuttgart Regional Medical Center. Bob Phillips, has been named interim administrator while a search is conducted. Neal came to Stuttgart in 1999 from executive positions with Mercy Hospital/Turner Memorial in Ozark and Haskell County Hospital in Stigler, Oklahoma. Neal was Arkansas’ delegate to the American Hospital Association Regional Policy Board 7 and served on the Arkansas Hospital Association board of directors by virtue of that appointment. He also was chairman of the Arkansas Hospital Association Political Action Committee.

Barry Pipkin, division vice president for Universal Health Services, Inc., has announced the appointment of Jennifer Nolan as CEO/managing director of The BridgeWay Hospital in North Little Rock. Nolan has been with Universal Health Services for four years and previously served as CEO at River Oaks Hospital in New Orleans and Lakeside Behavioral in Memphis. While in New Orleans, she experienced both Hurricanes Katrina and Rita, and successfully led patient and staff evacuations each time.

Franklin E. Wise, administrator of Fulton County Hospital in Salem, has retired after 14 years with the organization, culminating a 42-year healthcare career. He served for many years as administrator of North Arkansas Regional Medical Center in Harrison before moving to Salem. Wise, an esteemed member of the Arkansas Hospital Association (AHA), has served as chairman of the organization’s board and member of the executive committee, while also participating on many AHA councils and committees throughout the years. He also served as president of the Arkansas Hospital Administrators Forum as well as the Mid-West Health Congress, which has since ceased operations.

In addition, Wise worked as a member of a number of committees for the Arkansas Department of Health and the Arkansas Foundation for Medical Care. In 1991, he was honored with the A. Allen Weintrab Memorial Award, the highest honor the AHA can bestow upon a hospital chief executive officer.

Judith Wooten, FACHE, COO of Arkansas Hospice in Little Rock, achieved Fellow status with the American College of Healthcare Executives in June.

Herbert K. “Kirk” Reamey, III, FACHE, CEO of Ozark Health Medical Center in Clinton, has been named to the Arkansas Hospital Association (AHA) Board of Directors as the At-large Delegate succeeding Robert R. Bash of Warren, who recently resigned his position. Reamey will fulfill the remainder of Bash’s term, which expires in October 2009. Reamey has been CEO of the Clinton facility for the past two years, following a seven-year term as CEO of Magnolia Hospital. He currently serves on the American Hospital Association’s Regional Policy Board 7 and is a former president of the Arkansas Hospital Administrators Forum.

Terry Amstutz, FACHE, CEO of Magnolia Hospital, and Christy Hockaday, CEO of St. Anthony’s Medical Center in Morrilton, were recently named by the AHA Board of Directors to the Arkansas Rural Medical Practice Student Loan and Scholarship Board. The AHA has two appointments to the board.

Harold Mitchell has been named administrator of Bradley County Medical Center in Warren. He succeeds Robert R. Bash who recently resigned. Mitchell is the former chief financial officer of the facility.

Eugene Zuber has been named administrator of Advanced Care Hospital of White County in Searcy. The 27-bed long-term acute care hospital, scheduled to open this summer, will be located at White County Medical Center. Zuber was administrator of the former Newport Hospital, which closed in 2005 and was purchased by Harris Hospital in Newport. Zuber is a former chairman of the Arkansas Hospital Association’s board of directors and was named the A. Allen Weintrab Memorial Award recipient in 1996.
Leading Change in Tenuous Times: Collaboration is the Key

Raymond W. Montgomery

When Ray Montgomery, President and CEO of White County Medical Center in Searcy, looks back over his career in hospital administration, he remembers the partnerships and collaborations with others most fondly. Montgomery said he has been blessed in his leadership roles, able to work as an agent of change when a vision has been created by people who understand the facility’s history and future needs.

“I see myself as a part of a larger team,” he said. “My work as a hospital administrator is done in tandem with our medical staff, our board of directors, our leadership team and our community.”

He will be installed in his newest leadership role – Chairman of the Board of the Arkansas Hospital Association – on October 11. Montgomery said he hopes to continue facilitating change during this remarkable time for healthcare. “We’re at a time when we see healthcare transforming. Our focus will continue to be on quality of care. We know we must meet the needs and expectations of our consumers.”

He also sees the AHA continuing its focus on reimbursement issues, state and national insurance issues and finding a way to somehow address the excessive costs of healthcare in our nation. “We want to lead change in healthcare, rather than being forced into transformation. It is our responsibility to let our communities know how much hospitals do for the economy and for medical care. It is also incumbent upon us to help our hospitals survive in these tenuous financial and heavily regulated times.”

Montgomery believes the biggest changes in healthcare he’s seen are the introduction of DRGs and managed care reimbursements. He is very interested in the new pay-for-performance programs.

He sees the current focus on healthcare costs as slightly misplaced. “Over the years, healthcare has certainly become more complex, and the costs of healthcare have certainly risen. Our mission is quality healthcare for all,” he said. “Yet we must pay attention to the financial side.” He said he believes healthcare has been exploited. “There are too many hands in the cookie jar. We have a responsibility to care for people in a fiscally cost-efficient manner, yet the current system of inadequate reimbursements has put extreme pressure on our hospitals. We need to transform the system to assure adequate resources and the ability to do our mission – caring for people.”

And as for healthcare’s future? “All of us in healthcare, particularly those of us who are working as a part of the AHA board, must continue in our roles as leaders of change. After all, we are the technical experts; it is up to us to set the course. And we must do so through collaboration.”

During his career, Montgomery has served as a respiratory therapist, a financial planner, a strategic plan-
ning expert and as hospital administrator. He worked for hospitals in Kansas, Oklahoma and Texas before coming to Arkansas. When Montgomery first came to White County Medical Center in 1988, he was assistant administrator. He was named President and CEO of the facility in 1992, and is in his 16th year in this role.

When Montgomery joined WCMC, the facility was at a crossroads. Hard financial times had caused a complete re-visioning of the hospital’s role, both in the community and as an employer.

“The board and medical staff saw a need for change, and envisioned a dynamic future for WCMC,” he said. “As it is so often in life, the visions of others allow us to come in as facilitators of change. And that has been my role at WCMC.”

During his administrative tenure, he has helped design and orchestrate two major hospital renovations. The first – a $16 million expansion that doubled the size of the existing hospital – was completed in 1998. WCMC then doubled in size again in 2004 with the completion of a $38 million expansion. This project was done without incurring any debt.

WCMC acquired Central Arkansas Hospital in the fall of 2005. The merger allowed White County to more efficiently utilize the limited number of healthcare personnel available in the community and provide a broader range of services. The new additions are a 40-bed assisted living facility, an 18 bed adult psychiatric unit and a new long-term acute care hospital, all opening this fall. Montgomery sees these moves as particularly valuable to the community, as jobs were saved and created.

Today, White County Medical Center has two hospital campuses and a combined total of 438 licensed beds. The hospital’s services include acute care, physical rehabilitation, geriatric psychiatry, a heart institute and an inpatient hospice unit. The hospital also offers state-of-the-art surgical services as well as obstetrical care. More than 150 physicians comprise the medical staff. White County Medical Center is the second largest employer in Searcy, with more than 1300 associates living, working and raising families in Searcy and the surrounding communities. The hospital serves a six-county area including Cleburne, Independence, White, Jackson, Woodruff and Prairie counties.

Montgomery sees the hospital’s leadership skills. He’s been on WCMC’s board since the hospital opened, and he’s been on many other boards from education to business.”
He added, “I have had great role models like my father, Ray Montgomery, who emphasized the importance of diversity and treating everyone equally special. Another role model has been Dr. Jimmy Carr, White County Medical Center Assistant to the President. Dr. Carr has an incredible work ethic and at 93 is working towards retirement at his third career.”

Montgomery also gives credit to his colleagues. “My administrative team works so well together. Stuart Hill and LaDonna Johnston have been on this team the longest. Stuart brings a mastery of healthcare finance while LaDonna brings a no-nonsense passion for high quality care. Being successful in the current and future healthcare arenas requires this level of wisdom and experience.”

Living a balanced life is important to Montgomery. He and his wife, Rebecca, have a blended family with three grown children and one grandchild. “God balances me while Rebecca encourages me,” he said. “Then, everything else falls into place.” He lives by the familiar creed of putting God first, family second and career third – and he sees his career in healthcare as a ministry, not as a job.

His community work includes membership in the Searcy Chamber of Commerce, Lions Club, White County United Way Leadership Council and the Searcy Leadership Institute. He serves as an elder at Fellowship Bible Church, and he and his wife serve as mentors for college students, opening their home to several students each semester so they can live and enjoy a family atmosphere with the Montgomerys.

Long active in the AHA, he has served as the North Central Hospital District delegate to the AHA board of directors, as president of the Arkansas Hospital Administrators Forum and as Chairman of the American Hospital Association Governing Council for Small or Rural Hospitals. He is a fellow of the American College of Healthcare Executives and a member of the VHA Oklahoma/Arkansas board of directors.

“It is an honor and a privilege to be selected to serve as AHA Chairman of the Board,” he said. “The AHA allows hospitals to compare best practices and allows each of us to network with some of the greatest minds in healthcare. And the AHA’s unifying efforts are all-important. The AHA serves as one of Arkansas hospitals’ greatest resources.”
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Care with Compassion:
Does Your Hospital Offer Palliative Care?

Hospitals are generally equipped and staffed to provide acute care, but often fall woefully short when it comes to managing chronic illnesses. And, as the patient population ages, some hospitals are finding that they are not prepared to handle the social, physical, emotional, and quality-of-life issues presented by a growing influx of chronically ill patients with complex diseases.

“As an acute care hospital, we see a lot of very complex patients,” Petasnick says. “We felt that a palliative care program would allow us to provide a full continuum of care and meet the needs of patients who are chronically ill in a more caring way. Palliative care provides a compassionate and cost-effective means of providing care in the most appropriate venue, with the most appropriate support, and in a way that is more conducive to a patient’s quality of life.”

Michael Wiener, a trustee with Mount Sinai Medical Center (in New York City), which started a palliative care program about ten years ago, agrees. “Every major clinical medical center today is pushing the envelope in terms of technology and scientific advances,” he says. “The other side of medicine is the patients and what we are doing to keep them comfortable. Palliative medicine cuts a wide swath across hospital care. It helps fulfill the humane part of healthcare and should be brought to the same level of importance as clinical technology.”

According to the Center to Advance Palliative Care (CAPC), located at the Mount Sinai School of Medicine in New York City, 70 percent of hospitals in the United States with 250 or more beds have a palliative care program, and 55 percent of hospitals with more than 100 beds report having a program. The
One of the biggest impediments to hospitals’ acceptance of palliative care is their lack of understanding about what it entails, Meier says. Palliative care first involves relieving pain and suffering to ensure the best quality of life possible for patients and their families. “There has been widespread documentation and recognition of the high level of pain and suffering experienced by patients with chronic, complex illness,” Meier says. “Palliative care seeks to relieve that suffering by offering a great deal of genuinely patient-centered care involving listening and responding to physical, emotional, and practical needs identified by the patient and family.”

While palliative care and hospice overlap in their patient-centered philosophy of care, they are different in that palliative care is provided at any time during a person’s illness – often from the time of diagnosis – and is frequently delivered along with curative and life-prolonging treatments. Hospice care is designed for terminally ill patients who are no longer seeking curative therapies and who have a life expectancy of six months or less.

Palliative care is usually offered to patients by a team of physicians, nurses, and social workers. This team might also include chaplains, massage therapists, pharmacists, nutritionists, or any other appropriate care provider. Spiritual support, counseling, and complementary medicine are also important components of many programs that can bring additional relief to patients and families. The care team can help ease case management burdens on primary care physicians and other staff and provide assistance with care coordination between the hospital and home and among care providers, as well as time-intensive patient-family communication.

Several years after a hospital has begun offering palliative care to patients, the need for a dedicated unit may be necessary, as some patients will likely require care from nurses and doctors specially trained for palliative care, notes Meier. Dedicated palliative care units include space for families, to give them privacy for meetings, meals, and rest.

Quality of Care

When Mount Sinai introduced its palliative care program in 1997, it anticipated receiving about 50 referrals in its first year, but was quickly deluged with 250. Now the hospital follows well over 1,000 new patients each year and is in the process of developing a dedicated inpatient palliative care unit.

“Our palliative care program has made an enormous difference in the quality of care for those patients whose lives have been compromised by the chronic suffering associated with long-term illness,” says Kenneth Davis, M.D., president and CEO at Mount Sinai Medical Center. “These are complex patients, and it takes skilled clinicians who have a clear understanding of how to decrease suffering and maximize a person’s quality of life to provide optimal care.”

“Clinicians trained in palliative medicine have critical skill sets, including sophisticated pain and symptom management, well-honed communication skills, and expert knowledge about the continuum of care outside the hospital,” says David Weissman, M.D., director of the palliative care medicine program at Froedtert (which he helped initiate and develop) and professor of medicine in neoplastic diseases at the Medical College of Wisconsin. “While some of these skills overlap with geriatrics, oncology, and critical care, their additional knowledge focuses on the needs of patients with serious, complex illness.”

The palliative care team at Froedtert acts as a consultative service that consists of physicians trained in providing palliative care, nurses, psychologists, pharmacists, nutritionists, and chaplains. The hospital has established a dedicated “virtual” unit on the internal medicine floor, to which palliative care patients with special needs can be admitted and followed closely. The program currently serves approximately 1,000 patients each year. “It was difficult getting it started at first,” Weissman says. “But once other physicians and clinicians started seeing the value and benefits of the care we provided, it began to catch on fairly quickly.”

And those benefits are many. According to Weissman, palliative care consultation teams are better at: identifying and treating physical and psychological pain and symptoms than clini-

continued on p. 14
Financial Benefits

Palliative care should also be viewed in the context of the spiraling price of care for high-cost, high-technology tests and treatments of little or no benefit, which often cause unnecessary stress and suffering without significantly influencing the course of a patient’s illness. Weissman estimates that Froedtert Hospital saves between $200 and $500 per day per patient as a consequence of avoiding unnecessary tests and procedures.

“Palliative care does not restrict healthcare services but allocates them where they are most needed,” Weissman explains. “We have a huge aging population, healthcare costs are out of control, and the over utilization of healthcare resources is widely recognized, especially in patients near the end of life. As medicine has become highly fragmented and over-specialized, we are seeing an ever-increasing use of high technology and the higher costs that accompany it. The palliative care team helps patients and families establish important values and achievable goals for the medical care they are receiving by initiating open communication about the pros and cons of different treatment choices. The trade-offs are put out on the table. Once this has been done, we can discuss which tests and procedures might really be helpful, and which are not. The end result is that you will see a dramatic drop in healthcare utilization and cost.”

“The secret is communication,” Meier says. “Often, no one sits down and actually talks to patients and families about the options before them. Once this education happens and they understand the reality of their illness, the process of care changes, with many patients choosing care in the setting of their home. Multiple studies show a very large cost avoidance associated with palliative care for hospitalized patients.”

Starting Your Own Program

According to CAPC, developing a palliative care program requires a relatively low start-up investment and can have an immediate impact on overall resource use and intensive care unit (ICU) utilization. Direct program costs are more than offset by the financial benefit to the hospital system. CAPC states that hospitals with palliative care programs reap the following benefits that help reduce healthcare costs:

- Patients receive appropriate levels of care. This often reduces length of stay, especially in the ICU.
- Proactive care plans expedite treatment. Hospitals plan daily resource use by following the agreed-upon care protocol, often reducing costs for redundant, unnecessary, or ineffective tests and pharmaceuticals.
- A hospital maintains or improves its quality of care while increasing bed capacity and throughput and reducing costs through shorter lengths of stay and lower ancillary and pharmacy costs.

Starting a palliative care program often requires a great deal of reflection before hospital leaders can support it, Weissman notes. This includes: realizing that quality care of complex patients is part of the hospital’s mission; wanting to be seen as a local leader in compassionate, patient-centered hospital care; recognizing that palliative care can reduce costs and improve capacity; having a board member who has/had a personal experience with a friend or relative with a chronic illness; and enlisting a local champion who advocates for improved care for the chronically ill.

The emergence of a physician champion to advocate, help develop, and lead the program can be a key component of a palliative care program’s success, Weissman says. Successful programs also employ a physician trained in palliative medicine. Palliative medicine postgraduate fellowship training programs have grown substantially over the last few years. There are more than 50 fellowship programs currently available throughout the country, as well as short-term preceptorship programs.

Froedttert Hospital, with the Medical College of Wisconsin, has been a primary player in designing and implementing education strategies for health professionals in pain management and palliative care. Weissman, who is recognized internationally for his work in this field, has received funding from the Robert Wood Johnson Foundation to improve medical residency training through the National Residency End of Life Education Project. Since 1998, 394 residency programs have participated in a one-year curriculum reform project to develop new educational programs in palliative medicine throughout the country.

The National Quality Forum, which has established a set of 38 best practices...
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(www.qualityforum.org) for improving palliative care programs, suggests that healthcare organizations that provide palliative care offer the following services:

- Comprehensive, 24-hour availability of palliative care through an interdisciplinary team of trained and certified palliative care professionals.
- Timely communication of patients’ goals and care plans in transfers between healthcare settings.
- Assessments of patients’ pain, anxiety, and other symptoms that respect their cultural and individual preferences.
- Social and spiritual care plans for patients.
- Continuing professional education and support for caregivers on topics such as symptom management and communication.

To help hospitals develop their own programs, CAPC has designated six hospitals as Palliative Care Leadership CentersSM (PCLC). Froedtert and the Medical College of Wisconsin have served in this role for the past three years. The other facilities include: Fairview Health Services, Minneapolis, Minnesota; Mount Carmel Health System, Columbus, Ohio; Palliative Care Center of the Bluegrass, Lexington, Kentucky; University of California, San Francisco; and VCU Massey Cancer Center, Richmond, Virginia.

Hospital teams can apply for a two-day training session and an ongoing mentorship with these hospitals. The two-day training session walks teams through the development and implementation of their own strategic plan, an organizational model that fits their hospital or health system’s needs, staffing plans, instruction on how to collect and interpret financial data, and the implementation of marketing strategies to promote and grow their program. After the on-site training, the PCLC staff continues to provide one-on-one mentoring for a full year to assess progress, troubleshoot, and provide resources.

“This leadership training can be a real boost for hospitals contemplating starting or strengthening a palliative care program,” Weissman says. “It gets them organized, answers all the common questions, and provides a structure for how to think through the common barriers to program implementation and growth.”

Ellen Katz, a trustee of Mount Sinai Medical Center and a strong proponent of palliative medicine, says that once someone sees palliative care in action, it’s hard to imagine healthcare without it. “It’s a critical component of hospital care if you want to provide the best care possible to your patients,” she says. “It allows clinicians to play a kinder, more sensitive and supportive role in caring for patients and their families. Everyone wins because everyone gains a better sense of satisfaction – from the patients and families, to the professional caregivers.”

This article is reprinted from the May 2007 issue of Trustee Magazine, and is copyrighted. Author Susan Meyers is a writer based in Omaha, Nebraska.
For the past 50 years, union membership in private industry has been steadily declining. In the mid-1950s, more than one-third of all workers were union-represented; today, less than 7.5 percent of workers in private industry are unionized.

Alarmed by declining membership and diminished revenues, unions have begun to market themselves more strategically, focusing their organizing efforts on industries that are not now heavily unionized (particularly healthcare), on areas of the country that are largely union-free (particularly Florida, Texas, and Colorado) and on multiple-facility health systems that would quickly yield a large number of new dues-paying members.

At the same time, unions also have developed a new approach to organizing that is quite different than the traditional “grass-roots” approach that depends on building support among employees, convincing them to sign union authorization cards, and then winning a secret ballot election conducted by the National Labor Relations Board. Today, many unions are “convincing” the leadership of health care organizations to allow them to unionize employees without opposition, often without a secret ballot election.

The experience of one health system in the Midwest has been typical. In January 2003, their CEO received a FedEx envelope from the international headquarters of the Service Employees International Union in Washington, D.C. Inside the envelope was a bound, professionally printed proposal for a “partnership” between the health system and the SEIU.

A few days later, at the request of the SEIU, union leaders met with the health system’s senior executives to discuss the proposed “partnership.” The SEIU laid out their terms: the health system would 1) provide the SEIU with the names and home addresses of all 25,000 of their employees; 2) give SEIU representatives unlimited access to all facilities to talk to employees about why they should unionize; 3) “remain neutral” (that is, say nothing) concerning the SEIU or the potential impact of unionization; and 4) agree to recognize the SEIU as employees’ legal representative whenever a majority of the employees signed documents saying they wanted the union to represent them – no secret ballot election would be held.

The health system executives expressed great reluctance to violate their employees’ rights to privacy, allow union representatives to disrupt patient care, remain silent on so important an issue, and deny employees their rights to a secret ballot vote. They then
asked, “What if we don’t agree to your proposed partnership?” The SEIU officials answered, “Well, then we’ll have a war.” In this and other health systems, this “war” (called a “corporate campaign”) has been waged to force health system leaders to accept the “partnership” unions are demanding.

Some health systems that have experienced “corporate campaigns” include Catholic Healthcare West, Catholic Healthcare Partners, HCA, Tenet, Resurrection Health Care in Chicago, Advocate Healthcare in Chicago, Kaiser, Yale Medical Center, Beverly Enterprises, and dozens of others. In each case, a variety of strategies and activities were used by one or more unions to “convince” health system leadership to accept their “partnership” proposal. These have included:

- **In-depth reports:** the SEIU particularly prepares in-depth analyses of health system practices, and then distributes the glossy, multi-page booklets to community leaders, political leaders, religious leaders, and others. Typically, these reports accuse the health system of “discriminatory pricing” (charging patients without health insurance more than patients with insurance are charged), “aggressive” debt collection practices, executive greed, racist spending (investing more money in facilities serving suburban communities than in facilities serving inner-city, largely minority communities), violating church teachings regarding employee unionization, and many other offenses, real or imagined.

- **Attacks in the media:** unions use every available outlet to publicize criticisms of how target health systems provide care, staff their facilities, treat their employees, or fulfill their mission to their communities. Many unions set up Web sites (see, for example, www.tenetwatch.com) to attack their targets.

- **Picketing and demonstrations:** union supporters often picket and demonstrate in front of health system facilities and occasionally in front of individual executive’s homes. On occasion, demonstrators will picket in front of a hospital, and then go to the Emergency Room and demand to be treated for various ailments. Then the union publicizes how overcrowded health system emergency rooms are and how long patients have to wait to be seen.

- **Agency investigations:** unions call various agencies, such as OSHA, EPA, Department of Labor, Department of Public Health, or the Department of Transportation, and ask them to investigate health system practices. Then they publicize the fact that investigations are taking place, damaging the reputation of the health system even when the investigations reveal no wrongdoing.

- **Pressuring the business:** unions often picket and disrupt fund raising activities, fight hospitals’ efforts to obtain Certificates of Need for expansion, organize patient boycotts, flood facility switchboards, and do anything else they can to disrupt the operations of health system facilities.

- **Pressure from payers:** unions often contact insurance companies and other payers to claim that the target health system over-charges for some procedures, encouraging the payers in turn to pressure the health system to lower their prices and, consequently, their revenue.

Through these and many other strategies, unions try to force targeted health systems to accept their “partnership” terms, thereby allowing the union to organize their employees without opposition. In many cases, these “corporate campaigns” have been successful, forcing such systems as Catholic Healthcare West, Kaiser, Tenet, and others to accept “neutrality agreements” with one or more unions. Employees in those health systems’ facilities quickly were unionized and started paying union dues.

While there is no sure-fire way to prevent or combat a corporate campaign waged by one or more unions, health system leaders can take some proactive steps, before a union “partnership” is proposed to their organization. For example, they can and should:

- Educate all key constituencies, including physicians, employees, board members, local media, and local community leaders, concerning what “corporate campaigns” are intended to do and how they are being used today in healthcare.

- Study the attacks unions are making on target organizations elsewhere and then examine their own practices regarding these issues, such as billing and collection practices, pricing structures, executive compensation, and so on to assess and rectify possible vulnerabilities.

- Develop and communicate a philosophy concerning unions and why the organization believes remaining union-free is beneficial to employees and the patients and physicians they serve.

Given the success of “top-down” organizing in healthcare, it seems likely that unions will expand the use of this strategy to other targeted health systems in the near future. Thus, it is important that system leaders begin now, proactively, to prepare for the “war” a union soon may wage on them.

John Baird presented a workshop on union organizing as part of the AHA’s Mid-Management Certificate Series. For more information about his company see www.bairdborling.com.
Arkansas Hospitals

Thirty-five Arkansas hospitals, some winning awards in multiple categories, were among the recipients of 95 Quality Improvement Awards handed out May 31 during the Arkansas Foundation for Medical Care’s (AFMC) 14th Quality Conference, which was held at the Statehouse Convention Center in Little Rock.

AFMC presented its Quality Achievement Awards to recognize improvement in one or more of its hospital quality improvement areas.

Northwest Medical Center of Bentonville and St. Mary’s Hospital-Rogers were recognized for Best Achievement Awards as Medicare prospective payment system (PPS) hospitals. Mercy Hospital/Turner Memorial (Ozark) and St. Anthony’s Medical Center (Morrilton) received Best Achievement Awards in the Critical Access Hospital (CAH) category.

Most Improved Achievement Awards were presented to Northwest Medical Center of Bentonville and Saint Mary’s Regional Medical Center (Russellville) in the PPS hospital category, while St. Anthony’s Medical Center and CrossRidge Community Hospital (Wynne) were named winners among the state’s CAHs.

Validation Awards went to Medical Center of South Arkansas (El Dorado, PPS), St. Bernards Medical Center (Jonesboro, PPS), CrossRidge Community Hospital (Wynne, CAH), Lawrence Memorial Hospital (Walnut Ridge, CAH), Ozark Health Medical Center (Clinton, CAH), and Piggott Community Hospital (CAH).

In addition, the following hospitals received Innovator Awards:
- Arkansas Methodist Medical Center, Paragould
- Baptist Health Medical Center, Heber Springs
- Baptist Health Medical Center, Little Rock
- Baptist Health Medical Center, North Little Rock
- Baxter Regional Medical Center, Mountain Home
- Conway Regional Health System
- CrossRidge Community Hospital, Wynne
- Jefferson Regional Medical Center, Pine Bluff
- Lawrence Memorial Hospital, Walnut Ridge
- Magnolia Hospital
- Medical Center of South Arkansas, El Dorado
- Medical Park Hospital, Hope
- Mercy Hospital/Turner Memorial, Ozark
- National Park Medical Center, Hot Springs
- NEA Medical Center, Jonesboro
- Ozark Health Medical Center, Clinton
- St. Anthony’s Medical Center, Morrilton
- St. Bernards Medical Center, Jonesboro
- St. Edward Mercy Medical Center, Fort Smith
- St. Joseph’s Mercy Health Center, Hot Springs
- St. Vincent Infirmary Medical Center, Little Rock
- Stuttgart Regional Medical Center
- Summit Medical Center, Van Buren

Hospital-based services recognized for their quality included:
- Baptist Home Health Network (Innovator)
- Bradley County Medical Center Home Health Agency (Warren, Innovator)
- Crittenden Regional Hospital Homecare (West Memphis, Innovator)
- Ouachita County Medical Center Doctors Home Care (Camden, Innovator, Best Achievement)
- National Park Medical Center Home Touch Healthcare (Innovator)
- Communities Home Health of Northwest Medical Center, Springdale (Innovator)

In addition, St. Bernards Senior Health Clinic took home a Best Achievement Award in the Physician Office category, while Lawrence Hall Nursing Center was awarded Best Achievement, and St. Joseph’s Mercy Health Center Transitional Care Unit received an Innovator Award for Nursing Home Care.
Elisa White Joins AHA Staff; Other Promotions, Additions

Elisa White, who has served as outside legal counsel for the Arkansas Hospital Association (AHA) since July 2005, became the newest member of the AHA executive team July 16, when she joined the association as its vice president and general counsel.

As the new in-house legal counsel, White, formerly a partner in the Little Rock office of Kutak Rock, LLP, advises the AHA board and membership on legal issues that may potentially affect all or certain subgroups of the state’s hospitals. She is directly involved with matters related to compliance; fraud and abuse; Medicare, Medicaid and third party reimbursement; licensure; managed care; medical staff and patient care issues; state and federal regulations; quality and patient safety; as well as other concerns.

A former teacher, she graduated from Arkansas State University with bachelor’s and master’s degrees, and holds a Juris Doctorate from the University of Arkansas at Little Rock School of Law. She lives in Little Rock with her husband, David.

Other recent changes in the AHA staff include the promotions of Lyndsey Dumas to the position of Director of Educational Services and Amber Estrada to the position of Administrative Assistant and Webmaster. Kensey Reynolds Honey has been hired as receptionist.

Lyndsey Dumas has been with the Arkansas Hospital Association for three years, and graduated from the University of Central Arkansas with both bachelor’s and master’s degrees in Business Administration.

Amber Estrada, who joined the AHA this year, is a sophomore at Ashford University in its online degree program, and is pursuing a degree in Organizational Management.

Kensey Reynolds Honey joined the AHA in July, and has attended both the University of Arkansas and the University of Arkansas at Little Rock.

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Arkansas is leading the way in improving U.S. healthcare with an innovative new program that ties Medicaid payment to hospital clinical performance. The Arkansas Medicaid Inpatient Quality Incentive (IQI) is one of only two programs in the country to reward hospitals that improve care, and state healthcare leaders believe the incentive is a strong step toward strengthening healthcare quality, accountability, and financing.

In May 2006, an Arkansas Hospital Association committee composed of quality review professionals from member hospitals began working in conjunction with state Medicaid officials and representatives from the Arkansas Foundation for Medical Care (AFMC) to design a Medicaid pay-for-performance (P4P) program. The program was designed to tie incentive payments of up to $50 per day to hospital clinical performance in meeting certain quality thresholds.

Arkansas’ project is gaining national recognition as well. Representatives from the Arkansas Foundation for Medical Care and program, co-presented in the session “Value Driven Healthcare and Pay-For-Performance in Medicaid,” which was well-received with many questions from the audience. The P4P program was officially implemented March 24, 2007, when the Centers for Medicare & Medicaid Services (CMS) gave its approval for the state Medicaid Plan amendment allowing an inpatient rate increase and the incentive payments.

“This program has helped us to focus on specific quality indicators, and to make sure each one is implemented on every patient. This has definitely had a positive impact overall on patient outcomes,” said Dr. David Hall, senior vice president for medical affairs at St. Vincent Health System in Little Rock. St. Vincent Health System is one of several hospitals that has seen not only quality improvement, but also financial rewards, from IQI.

This summer, Arkansas Governor Mike Beebe hosted a ceremony at the State Capitol recognizing 29 participating hospitals that qualified for the incentive payments for the year ending June 30, 2007. Combined, the bonus payments, which were based on a hospital’s level of achievement and validation scores on pneumonia and heart failure quality measures, totaled $3.9 million.

Qualifications were determined from data submitted by participating hospitals to the QualityNet Clinical Warehouse, the national repository that stores information about quality of care. AFMC, the designated federal Medicare Quality Improvement Organization for Arkansas and the state’s medical review contractor, then validated data specific to Medicaid recipients and determined the level of achievement.

• Of the 29 hospitals, 21 exceeded the bonus payment requirements: four met the criteria for all seven
Once again, Arkansas will receive funds targeted toward improving emergency preparedness in the state. Of most interest to hospitals are grant funds to be distributed by the Arkansas Department of Health (ADH). The ADH is scheduled to receive $9,389,729 from Health and Human Services’ (HHS) Centers for Disease Control and Prevention for public health emergency preparedness and supplemental pandemic planning, as well as $4,063,403 from the HHS Assistant Secretary for Preparedness and Response Hospital Preparedness Program (formerly known as HRSA or Health Resources and Services Administration).

It is hoped that there will be increased funding for hospitals to participate in regional and state planning, drills, education, and training. As it has for the past five years, the Arkansas Hospital Association worked closely with the ADH to protect the funding for our membership.

The Arkansas Hospital Association is aware that hospital emergency preparedness takes a lot of time and effort on the part of each hospital’s bioterrorism coordinator as well as administration, and appreciates the effort and participation from hospitals.

John Neal, former CEO of Stuttgart Regional Medical Center and a member of the hospital grant’s Rules and Standards Committee, says about hospital participation:

“Healthcare delivery involves routine medical services, prevention, and education for our patients and communities. But the healthcare delivery systems we all develop do not include mass trauma, casualty and treatments for the numbers of people who may be affected by terrorist acts or viral outbreaks caused by terrorism. Hospitals acting alone cannot sufficiently plan for or treat the numbers of people that would be affected in a short period of time. Cooperative efforts of Arkansas hospitals utilizing the grant funding we have received over the past five years have enabled us all to be better prepared.

“While we are not ready to face 500, 1000 or tens of thousands of people looking to us as the provider of treatment and protection, we are definitely better off than we were. I personally cannot imagine any CEO, administrator, or facility management team not making this a priority in their planning and devoting the time that is necessary to be better prepared for the reality of mass casualty or unexpected treatment. The necessary time and personnel devoted to the training, planning and cooperative efforts of all healthcare providers striving to meet the unknown demands of mass casualty is an investment that helps us all be better prepared to meet our local and statewide healthcare missions.”

Arkansas to Receive Emergency Preparedness Improvement Grants
Arkansas Hospital Association Headquarters Begins Expansion Project

At its April 13 meeting, the Arkansas Hospital Association board of directors approved an expansion/renovation of the existing AHA headquarters in Little Rock. The approximately 4,200 square-foot addition will include a state-of-the-art educational center that will accommodate at least 60 individuals, a new board room, an AHA Services suite, additional office space, and a small conference room. Renovations of the existing building will include a reception room, office space, kitchen, and work room remodel. Construction is expected to begin in October 2007, with a completion date in fall 2008.

Arkansas Lawmakers Demonstrate Hospital Support

During May’s American Hospital Association Membership Meeting in Washington D.C., hospital representatives from Arkansas expressed their concerns to the state’s lawmakers about the potential effects of Medicare’s proposed inpatient prospective payment system (IPPS) rule for Fiscal Year 2008. Chief among the concerns was the effect the IPPS rule could have on their hospitals. Arkansas’ hospital leaders sought support from the state’s senators and representatives in preventing those measures.

All members of Arkansas’ congressional delegation, including Senators Blanche Lincoln and Mark Pryor and Congressmen Marion Berry, Vic Snyder, John Boozman, and Mike Ross, signed on to “Dear Colleague” letters in their respective chambers opposing provisions in the proposed rule that would cut Medicare payment for hospital services nationwide by nearly $25 billion over five years.

Though the final rule did not reflect changes requested by hospital leaders nationwide, the Arkansas Hospital Association once again expresses its appreciation to each member of the Arkansas congressional delegation for the assistance and support shown to the state’s hospital community.

Arkansas Hospital Administrators Forum Disbands after 44 Years

During its June 22 annual business meeting, members of the Arkansas Hospital Administrators Forum voted to disband the organization.

Formed in 1963, the primary purpose of the Forum was to provide “professional improvement of hospital administrators.” It historically has sponsored the Summer Leadership Conference each year and previously acted as the Arkansas chapter of the American College of Healthcare Executives (ACHE).

In recent years, the Forum has delegated all duties for the summer conference to the Arkansas Hospital Association.

In 2002, the Arkansas Health Executives Forum was named the state’s recognized ACHE chapter and became a co-sponsor of the summer event. As a result, the Forum really has no need to continue existing as a separate entity.

Under the dissolution move, the Forum transfers all existing funds to the Arkansas Hospital Education and Research Trust, which will finance the annual Summer Leadership Conference beginning in June 2008. Members and participants will not see any changes, other than the name of the organization.
On August 1, the Centers for Medicare & Medicaid Services (CMS) released its final rule covering the Medicare hospital inpatient prospective payment system for Fiscal Year (FY) 2008. Under the rule, hospitals will get a 3.3 percent market basket rate increase for the year.

However, CMS all but negates the increase by refusing to bend on the most controversial part of the rule that was first pitched last April. So, it will proceed, at least for now, with a demoralizing plan to cut hospital payments nationwide by $1.6 billion in FY 2008, and more than $20 billion over five years, through a prospectively imposed 2.4 percent “behavioral offset.” The offset is expected to cost Arkansas hospitals an estimated $14 million in Medicare reimbursements during FY 2008 and $220 million through FY 2012.

CMS included the offset as a pre-emptive measure to counter concerns that the new set of Medicare Severity-Diagnosis Related Groups (MS-DRGs) will provide opportunities for hospitals to document and code information contained in the medical record in a way that may result in higher payments. In a statement colored with Pinocchioan hyperbole, CMS said that changes incorporated in the final rule were “widely praised in the public comments” and are “consistent with commenters’ views on how program reforms should occur.” That would seem to overlook comments from the nation’s hospitals, which were generally united in their opposition to the offset, as were a majority of U.S. senators and congressmen who signed a letter urging CMS not to implement the cuts. The House even voted 412-12 to restrict CMS from spending money on the prospective implementation of the behavioral offset.

Expect to hear more on the matter as the hospital community works with Congress to overturn those particular cuts.

The rule also includes provisions to prohibit Medicare from paying the additional costs of certain preventable conditions (including certain infections) acquired in the hospital, expands the list of publicly reported quality measures, and reduces Medicare’s payment when a hospital replaces a device that is supplied to the hospital at no or reduced cost.

In addition, CMS eliminates the three percent add-on capital payment to large urban hospitals, and phases out the indirect medical education adjustment to capital payments over three years.

Highlights of the Final Rule include:

- MS-DRGs. 745 new severity-adjusted diagnosis-related groups (Medicare Severity DRGs or MS-DRGs) will replace the current 538 DRGs. Payments will increase for hospitals serving more severely ill patients and decrease for those serving patients who are less severely ill. (This is intended to remove incentives for “cherry-picking.”) Aggregate program payments should not change.
- No pay for “never” events. The rule implements a provision of the Deficit Reduction Act of 2005 requiring hospitals to report secondary diagnoses that are present on the admission of patients discharged on or after October 1, 2007. Beginning in FY 2009, cases including these conditions would not be paid at a higher rate unless they were present on admission.
- Quality measures and reporting. Hospitals must report additional quality measures in calendar year (CY) 2008 in order to qualify for the full market basket update in FY 2009. Failure to report will result in a two percent penalty. CMS will measure 30-day mortality for Medicare patients with pneumonia and plans to adopt two measures relating to surgical care improvement in the CY 2008 outpatient prospective payment system final rule. In addition, CMS will finalize two additional surgical care improvement measures by program notice after they receive NQF endorsement.
- Replacement medical device reimbursement. Payments for replaced medical devices that were recalled and replaced by manufacturers below cost will be reduced.
- Specialty hospitals. In keeping with the plan contained in CMS’ August 2006 Report (http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp) to Congress on specialty hospitals, the rule creates new disclosure requirements for these hospitals and allows CMS to terminate a provider agreement for noncompliance with those requirements.

Click on http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf to access the full text of the rule.
Arkansas QIO Offers Help with Hospital Payment Monitoring Program

Problems with the proper utilization of Medicare observation continue to be identified on AFMC Medicare inpatient review. The information below focuses on one area of confusion that appears to be ever-growing.

Changing Observation to Inpatient, and Inpatient to Observation
(Condition Code 44 - it only goes one way!)

Medicare review under the Hospital Payment Monitoring Program (HPMP) continues to identify more and more occurrences of observation misunderstanding and incorrect billing. Perhaps the implementation of Medicare Condition Code 44 has “muddied” the water.

Condition Code 44, “Inpatient Admission Changed to Outpatient,” implemented on October 12, 2004, allows physicians and hospitals to change a Medicare patient’s admission status from inpatient to outpatient/observation under certain conditions. However, it is important that physicians, case managers, utilization review staff, and hospital billing staff understand that this policy cannot be applied in reverse. At no time can the admission status of a Medicare patient who has been admitted to observation be retroactively changed to inpatient. In other words, a physician cannot write an order to go back and retroactively change observation services that have already been provided, to inpatient services.

Condition Code 44 Policy (changing inpatient to observation)

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital’s inpatient criteria, the hospital may change the beneficiary’s status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital.
- The hospital has not submitted a claim to Medicare for the inpatient admission.
- A physician concurs with the utilization review committee’s decision.
- The physician’s concurrence with the utilization review committee’s decision is documented in the patient’s medical record.

When a hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.
Changing observation to inpatient

A Medicare patient’s status can be changed from observation to inpatient at any time following the order for observation, but, as stated above, never after the fact. When observation is changed to inpatient, the claim must reflect the true/actual circumstances of the admission and the following rules apply:

- The inpatient admit date is the date (real time) the status change was made.
- The principal diagnosis is the condition, after study, that caused the inpatient admission (possibly not the reason for the admission to observation).
- The hours the patient was treated in observation, prior to being changed to inpatient status, must be shown on the inpatient claim using revenue code 0762.

What we see on review

Incorrect status change orders and incorrectly billed observation days are becoming more common. The most common error is an order written at some point following the observation order to “make the patient inpatient from the beginning.” This cannot be done. Observation services that have already been provided cannot be retroactively changed to inpatient services. An order to “make the patient inpatient from the beginning” can only be interpreted as “make the patient inpatient now.” Again, the inpatient admit date reflected on the claim, in this case, must be the date the “make the patient inpatient” order is written, and the inpatient claim must show the hours the patient was managed in observation under revenue code 0762.

Another common error seen on review is an order to “change a patient’s status from observation to inpatient from the beginning” that is written at the time of discharge so that the admission is billed as an inpatient. This is a billing error. In this situation, it is only correct to bill this case as observation, as observation cannot be changed to inpatient after the fact.

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ACEP Summit on the IOM Future of Emergency Care Reports

The Institute of Medicine’s reports, *The Future of Emergency Care*, constitute a comprehensive review and analysis of the delivery of emergency care in the United States. The three reports were released in June 2006 and the IOM subsequently convened workshops in Salt Lake City, Chicago, New Orleans, and Washington, DC, to disseminate the findings and recommendations, and to receive feedback from interested parties.

In the spring, ACEP convened a summit of organizations involved in emergency care. Joining ACEP in the Summit were the American College of Surgeons, Society of Academic Emergency Medicine, American Academy of Neurological Surgeons/Congress of Neurosurgeons, American Academy of Orthopaedic Surgeons, American Academy of Family Physicians, American Academy of Emergency Medicine, American Trauma Society, American Public Health Association, American Academy of Pediatrics, Emergency Medicine Residents’ Association, Emergency Nurses Association, National Association of EMS Physicians, National Association of EMTs, and the National Association of State EMS Officials.

The Summit’s objective was to develop a group consensus about the priorities of the IOM recommendations. More specifically, the 15 organizations met to identify at least one priority recommendation in each of five key areas that would serve as the basis of a joint federal legislative/regulatory agenda:

- Emergency care research
- Hospital-based care
- Pediatric emergency medicine
- Trauma
- Emergency medical services

Throughout the daylong discussions about the recommendations, a robust debate emerged over the specifics of the IOM recommendations and what participants viewed as appropriate modifications. Strong cases were made for recommendations that seemed to have ramifications that crossed all areas of the report (such as Pediatrics Report Recommendation 7.1, calling on the Secretary of Health and Human Services to examine gaps in emergency care research, including pediatric emergency care).

Summit participants agreed on six recommendations, one for each of the five specific areas originally identified and one that is overarching. Participating organizations are reviewing these recommendations with their respective boards. Once each group has indicated its approval of these recommendations, the government relations staff of the respective organizations will develop a strategic plan to implement the agreement.

**Consensus Agreement from the IOM Summit**

Summit participants agreed to jointly advocate for these six recommendations:

1. **Emergency Medicine Research**
   
   Hospital-Based Report Recommendation 8.2. The Secretary of the Department of Health and Human Services should conduct a study to examine the gaps and opportunities in emergency and trauma care research, and recommend a strategy for the optimal organization and funding of the research effort. This study should include consideration of: training of new investigators; development of multi-center research networks; funding of General Clinical Research Centers (GCRC’s) that specifically include an emergency and trauma care component; involvement of emergency and trauma care researchers in the grant review and research advisory processes; and improved research coordination through a dedicated center or institute. Congress and federal agencies involved in emergency care research (including DOT, DHHS, DHS, and DoD) should implement the study’s recommendations.

2. **Hospital-Based Care**
   
   Hospital-Based Report Recommendation 2.1. Congress should establish dedicated funding, separate from DSH payments, to reimburse hospitals that provide significant amounts of uncompensated emergency and trauma care for financial losses incurred by providing those services.
   
   a. Congress should initially appropriate $50 million for the purpose, to be administered by the Centers for Medicare and Medicaid Services.
   
   b. CMS should establish a working group to determine the allocation of those funds, which should be targeted to providers and localities at greatest risk; the working group should then determine funding needs for subsequent years.

   Summit participants support additional funding for care provided by hospitals and physicians that provide significant uncom-
pensated emergency and trauma care. The IOM’s specific funding level should only be regarded as a floor for additional support.

3. Pediatric Emergency Medicine

Pediatrics Report Recommendation 3.7. Congress should appropriate $37.5 million each year for the next five years to the EMS-C Program.

4. Trauma

Hospital-Based Report Recommendation 3.5/EMS Report 3.4. Congress should establish a demonstration program, administered by the Health Resources and Services Administration, to promote regionalized, coordinated, and accountable emergency care systems throughout the country, and appropriate $88 million over five years to this program.

5. EMS

EMS Report Recommendation 3.7. CMS should convene an ad hoc work group with expertise in emergency care, trauma, and EMS systems to evaluate the reimbursement of EMS and make recommendations regarding inclusion of readiness costs and permitting payment without transport.

6. Boarding

Hospital-Based Report Recommendation 4.5. Hospitals should end the practices of boarding patients in the ED and ambulance diversion, except in the most extreme cases, such as a community mass casualty event.

The Centers for Medicare & Medicaid Services should convene a working group that includes experts in emergency care, inpatient critical care, hospital operations management, nursing, and other relevant disciplines to develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring, and enforcement of these standards.

Summit participants recognized the severity of the crowding and boarding problem and agreed that this recommendation can serve as the basis for a strategy to address boarding and its causes.

The public finance experts at Crews & Associates enjoy a rich tradition of helping healthcare organizations throughout Arkansas. By tailoring innovative financial solutions designed just for you, we take pride in helping you deliver quality care. Contact Paul Phillips today at 501.978.6309 or 800.766.2000 and let our own team of healthcare experts prescribe the financial cure for your organization.
Cross-Cultural Curricula Recommended for All Graduate Medical Education Programs

A new report from the Commonwealth Fund recommends cross-cultural curricula be integrated into all graduate medical education to better prepare resident physicians to provide quality care to diverse populations.

The authors say the curricula should focus on practical tools and skills, and be based on standard principles that are useful across clinical disciplines. They say faculty should be trained in the same principles, and that evaluation of residents’ general and cross-cultural communication skills should be mandatory and formalized.

The recommendations are based on a 2003 national survey of resident physicians in their last year of training that found many felt unprepared to care for patients with specific cultural characteristics.

Carol Aschenbrener, M.D., executive vice president for the Association of American Medical College’s medical education division, commented, “Cultural competency is about understanding people and mutual understanding is key to effective patient care. AAMC is currently partnering with the California Endowment Fund and four California medical schools to explore how experiences that foster cross-cultural understanding could be incorporated into graduate medical education.”


AHA’S Online Governance Education Program Continues

The AHA’s Trustee Education Program, designed to help hospital and health system trustees provide effective strategic leadership to meet today’s dynamic and rapidly changing healthcare environment, continues with monthly Webinars through the end of the calendar year.

The convenient Webinars, presented by Larry Walker, president of The Walker Company, feature innovative distance learning powered by a Microsoft PowerPoint Net Conference™ program presented over the Internet and using a standard speaker phone.

Subscribers simply call a toll-free 800 number and simultaneously log onto a Web page that displays the presentation. Trustees listen to the speaker and watch the presentation on a screen in their own boardrooms, just as they would in a live presentation.

Upcoming presentations include:

- October 23, 12 noon, Central Time: Supercharging Your Hospital Governance Committees: This session will explore ways to maximize the role and value of board committees as a strategic development asset, and will highlight some of the ways leading healthcare organizations have re-energized their committee structures, processes, and leadership contributions.

- November 27, 12 noon, Central Time: Governing Leadership Essentials for a Complex Healthcare World: This session will explore the challenges and requirements of building a highly effective governance team and ensuring a dynamic and focused leadership environment.

- December 18, 12 noon, Central Time: Tough Leadership for Tough Times: Governing Through the Storms of Change: In this session, participants will learn how converging trends in government payments, regulation, technology, workforce, quality and patient safety, accountability and transparency, medical liability, and others intersect to create a storm of challenges to be overcome.

Webinar registration is available at www.arkhospitals.org/calendareducworkshops.htm, or contact Beth Ingram at bingram@arkhospitals.org for more information.
And Arkansas hospital patients are seeing the benefits.

Together with Arkansas Medicaid and the Arkansas Hospital Association, the Arkansas Foundation for Medical Care is leading an innovative new program called the Medicaid Inpatient Quality Incentive.

Through this program, 29 hospitals that treat Arkansas patients received merit payments for significantly improving care for heart failure and pneumonia patients. Their care now tops state and national averages.

As one of only two states to reward high-quality hospital care, Arkansas sets the standard when it comes to improving inpatient care.

We don’t provide health care. We help make it better.

As a national leader in health care quality improvement, AFMC is helping to ensure every patient gets the right care at the right time, every time.
Medical Benefits of Providing Interpretation Services

A new video from the Robert Wood Johnson Foundation’s Speaking Together project describes the role that language services play in delivering high quality healthcare.

This short video introduces Speaking Together’s efforts to:
• Improve the quality and availability of healthcare language services
• Integrate quality improvement with language services
• Pilot performance measures for evaluating language services
• Test interventions to improve the timeliness and quality of interpretive services; and
• Reduce healthcare disparities associated with language barriers.

The video features Cambridge Hospital in Massachusetts and Phoenix Children’s Hospital, where medically trained interpreters are contributing to safety and clinical outcomes for patients who speak or understand little English.

The hospitals are participants in the national project to improve healthcare language services and reduce healthcare disparities associated with language barriers.

To view the video and access a guide for its use, go to http://www.speakingtogether.org/5667/179591.

Another initiative supporting hospitals with language assistance resources is the Missouri Hospital Association’s www.healthtranslations.com Web site.

Plan Designed to Distribute/Explain 500,000 Advance Directives

Aging with Dignity, the United Health Foundation, AHA, and other national and local organizations will distribute 500,000 advance directives in the coming year in a campaign to help patients and families make important advance decisions about their end-of-life care.

The “Five Wishes” directive, now available in 20 languages, addresses an individual’s medical, personal, emotional, and spiritual needs before a healthcare crisis. It is recognized as a legal and binding document in 40 states and used as a model to prepare directives in the other ten.

Ruth Sullivan, president-elect of the Society for Healthcare Consumer Advocacy and director of patient and family advocacy for Shore Health System in Eastern Maryland, told reporters at a briefing on the campaign, “The conversations need to be with families, so at the end of life, families are not torn apart.”

SHCA is an American Hospital Association affiliate. Copies of the translated Five Wishes documents were sent in June to all U.S. hospitals, as well as hospital consumer advocates and volunteers.

To learn more, go to http://www.agingwithdignity.org.
**IRS Releases Revised Form 990**

The Internal Revenue Service (IRS) has been grappling for several years with the question of how to improve oversight of the approximately 1.3 million public charities or other types of non-charitable organizations in the U.S. that are exempt from paying state and federal income taxes. These include public charities (not including churches), non-charitable tax-exempt organizations, and private foundations.

The agency decided in 2005 that its best move would be to revise the IRS Form 990. On June 13, the agency released its long-awaited draft revision of the new form, which will be completed by all tax-exempt organizations, including hospitals, and also released 15 specific schedules that organizations must complete depending on the types of activities they engage in, and instructions for each.

Hospitals will be especially interested in Schedule H, which solicits numerical and financial information related to community benefit, billing and collections, and management companies and joint ventures. Also included are activity-specific schedules that involve executive compensation, related organizations, asset transfer/termination of exempt entity, governance, and tax-exempt bonds.

The IRS proposes to finalize the form and schedules by December 31, 2007. Although instructions are not expected to be final until summer of 2008, plans call for implementing the new form and schedules for tax year 2008.

Click on [http://www.irs.gov/charities/article/0,,id=171216,00.html](http://www.irs.gov/charities/article/0,,id=171216,00.html) to see the proposed form and schedules.

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**“Card Check” Fails in U.S. Senate**

The Employee Free Choice Act (S. 1041/ H.R. 800) - the “card check” bill - failed in the Senate June 26. During a procedural vote to determine whether the bill itself would be brought up for consideration, supporters failed to attract the necessary 60 “yeas,” instead garnering only 51.

The bill, which passed the House March 1 by a wide margin despite a veto threat from the White House, would have amended the National Labor Relations Act to require employers to recognize a labor union solely through the card check process.

That would change the current union election system that is based on the bedrock principle of democracy: free and fair elections where ballots are cast in private, free from interference or influence by either side.

It is possible the bill could re-emerge at a later date, but it is unlikely that it will reappear this year.

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**Governor Appoints State’s First Surgeon General**

Arkansas Governor Mike Beebe in early July named Dr. Joe Thompson of Little Rock as Arkansas’s first Surgeon General.

“Arkansas’s Surgeon General will be the pre-eminent champion for health education in our state,” Beebe said. “Joe has long been a leader in the tireless effort to improve the health and healthcare of our people and is a natural fit to be the first Arkansan to hold this position.”

Dr. Thompson has served as the state’s chief health officer for the past two years. The state Legislature abolished the “chief health officer” position during the 2007 General Assembly, replacing it with the post of Surgeon General.

Thompson will continue to serve as a director of the Arkansas Center for Health Improvement, which supports public- and private-sector efforts to improve health.

Thompson, who has a pediatric practice at Arkansas Children’s Hospital and serves on the faculty at the University of Arkansas for Medical Sciences, was one of the architects of the state’s Tobacco Settlement Proceeds Act. That Act directed money from the tobacco settlement agreement in Arkansas to health-related programs.
2007 Diamond Award Winners Announced, Honor Hospital Public Relations and Marketing Efforts

Recipients of the Arkansas Hospital Association’s 2007 Diamond Awards have been selected. The competition, co-sponsored by the Arkansas Society for Healthcare Marketing and Public Relations, is designed to recognize excellence in hospital public relations and marketing.

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 twelve categories.

The competition drew 184 entries – a record number since the competition began in 1995.

The top awards, Diamond, will be presented during the Arkansas Hospital Association’s 77th Annual Meeting and Trade Show at the Peabody Hotel in Little Rock. The Awards Dinner will be Thursday evening, October 11, 2007.

The two other awards, Certificate of Excellence and Judges’ Merit, will be mailed to recipients following the annual meeting.

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.

The award-winning hospitals for all three awards are:
- Arkansas Children’s Hospital, Little Rock
- Arkansas Heart Hospital, Little Rock
- Arkansas Hospice, Little Rock
- Arkansas Methodist Medical Center, Paragould
- Baptist Health Medical Center, Little Rock
- Baxter Regional Medical Center, Mountain Home
- CARTI, Little Rock
- Conway Regional Health System
- HSC Medical Center, Malvern
- Jefferson Regional Medical Center, Pine Bluff
- Magnolia Hospital
- Medical Center of South Arkansas, El Dorado
- North Arkansas Regional Medical Center, Harrison
- Saline Memorial Hospital, Benton
- St. Bernard’s Medical Center, Jonesboro
- St. Edward Mercy Medical Center, Fort Smith
- St. Joseph’s Mercy Health Center, Hot Springs
- St. Vincent Health System, Little Rock
- Stuttgart Regional Medical Center
- UAMS Medical Center, Little Rock
- Washington Regional Medical System, Fayetteville
- White County Medical Center, Searcy
- White River Health System, Batesville

Congratulations to all the 2007 Diamond Award Winners!

Arkansas Hospital Association Earns National Recognition for Marketing Excellence

The Arkansas Hospital Association (AHA) recently was named a winner in two categories of a national competition sponsored by the Healthcare Marketing Report, a national newspaper for healthcare marketing.

The AHA received a certificate as a Silver Winner for a poster developed in conjunction with its Smoke Free Campus campaign and a Bronze Winner certificate for the AHA image campaign featuring hospital testimonials along with signs indicating various hospital services.

The association worked with Exit Marketing of Little Rock to develop the ads.
Governor Beebe Provides Tornado-Damaged Hospital Financial Assistance

The tornado that blew through Dumas, Arkansas on February 24 of this year spared the new Delta Memorial Hospital (DMH) from major damage, but the critical access hospital has encountered its own set of difficulties in the wake of the storm.

The tornado destroyed more than two-dozen businesses and left about 800 area residents without jobs. As a result, DMH has seen a steep rise in the number of uninsured patients. Officials at Delta Memorial expect the trend to continue over the next year, especially for patients needing primary care, obstetrics, and inpatient and outpatient services.

Arkansas Governor Mike Beebe recognized the problem and, during a July 5 tour of Dumas to assess recovery efforts, presented DMH CEO James Fairchild with a $250,000 check from the Governor’s Emergency Fund to provide some much-needed financial assistance. In his remarks, Governor Beebe said, “The folks at Delta Memorial have been taking care of storm victims for more than four months, oftentimes without compensation. We want to ensure that they can continue providing these vital healthcare services in the future.”

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Hospital On-Call Pay Practices Reported

In May, the Arkansas Hospital Association surveyed member hospitals regarding their policies covering on-call pay for emergency room coverage. The results showed that about 25 percent of the responding hospitals reported that they pay a per diem or a fixed annual amount for on-call coverage.

That differs from a recent survey conducted by the American Hospital Association, in which more than one-third of hospital leaders surveyed reported paying for some physician specialty emergency department (ED) call coverage.

The report on the survey findings, 2007 State of America’s Hospitals – Taking the Pulse, also found 55 percent of hospitals experienced gaps in physician specialty coverage, with coverage issues most prevalent in orthopedics and neurosurgery. In addition, nearly half of EDs are “at” or “over” capacity, with a majority of urban hospitals experiencing time on diversion.

Hospital leaders cited a lack of staffed critical care beds as the most common reason for diversion. The survey also found that hospital workforce shortages, including an estimated 116,000 registered nurse vacancies as of December 2006, are affecting patient care.

Regarding disaster readiness, hospitals are taking a variety of actions to bolster preparedness, including participating in large-scale drills, establishing back-up communication plans and developing resource plans with other hospitals.

The survey, which had a 17 percent response rate, was sent to about 5,000 community hospital CEOs in late February 2007 via fax and email.

See the survey results on the American Hospital Association Web site at http://www.aha.org/aha_app/index.jsp?SSO_COOKIE_ID=0a2f011430e2637602573e04fdeb96b9fcc43afb2d2.

UAMS will Establish a New North Central Area Health Education Center

The University of Arkansas for Medical Sciences (UAMS) plans to establish the state’s eighth Area Health Education Center (AHEC) through a one-of-a-kind collaborative arrangement that will utilize the resources of two separate community colleges and hospitals located in those same communities.

The new AHEC North Central will operate in conjunction with the University of Arkansas Community College at Batesville and Arkansas State University — Mountain Home. In addition to the local higher education facilities, White River Medical Center in Batesville and Baxter Regional Medical Center in Mountain Home will play key roles in the AHEC.

The AHEC will serve ten counties in north central Arkansas: Baxter, Fulton, Sharp, Independence, Stone, Cleburne, Van Buren, Searcy, Marion, and Izard.

Charles O. Cranford, D.D.S., vice chancellor for regional programs and executive director of the AHEC Program, said that the addition will serve the dual purpose of expanding UAMS’ services into an underserved part of the state, while increasing the number of health-care providers and improving the quality of healthcare, especially in small and rural communities.

The Arkansas Legislature earlier this year approved two years of funding for the new AHEC totaling $2.6 million. The two colleges will provide space for the AHEC in new buildings being constructed on each campus. Until those facilities are completed, the AHEC will occupy temporary space as programs are selected and put in place.

The local hospitals will be the clinical training grounds for rotations of UAMS students of medicine, pharmacy, nursing, and other healthcare professions. UAMS currently operates AHECs in El Dorado, Fayetteville/Springdale, Fort Smith, Helena/West Memphis, Jonesboro, Pine Bluff, and Texarkana.
Determining Consent for Minors

Under certain, limited circumstances, a minor may consent to his or her own treatment without the need for an adult's consent. These circumstances include marriage, court-ordered emancipation, incarceration, and treatment for certain conditions.

Otherwise, non-emergency treatment of a minor requires the consent of an adult.

According to Ark. Code Ann. § 20-9602, any guardian or parent may consent to treatment of a minor child. A “parent” includes an adoptive parent, stepparent, and/or foster parent. Although no distinction is made between a custodial and non-custodial parent, the statute states that the father of an illegitimate child cannot consent for the child based solely on his status as a parent.

As long as the mother is authorized to consent to treatment, the child’s maternal grandparent(s) may consent in the parents’ absence. The same is true of the child’s paternal grandparent(s) if the father is authorized to consent.

Finally, in cases where someone other than a parent is standing in loco parentis, that person may consent to treatment. The Arkansas Supreme Court has defined a person standing in loco parentis as someone who “puts himself or herself in the situation of a legal parent by assuming the obligations incident to the parental relation without going through the formalities of adoption.” See, e.g., Babb v. Matlock, 340 Ark. 263 (2000). Whether someone is standing in loco parentis depends upon the facts of the situation.

AHA DATABANK Program

The Arkansas Hospital Association (AHA) has offered its member hospitals access to a free one-of-a-kind online database of timely hospital utilization and financial performance indicators since 2002. The AHA is one of more than 30 state hospital associations that offer this program through the Colorado Hospital Association (CHA), which developed the DATABANK program more than 20 years ago.

Because many of the state’s hospitals do not participate, the AHA, in conjunction with CHA, is making a renewed effort to expand participation to make DATABANK a more valuable tool.

CHA has assumed full operation of the Arkansas DATABANK program, including an increase in the number of educational opportunities related to the program, which is a Web-based benchmarking database that provides users information on management indicators like average length of stay, outpatient statistics, charges and expenses per day and per stay, uncollected charges, number of days in accounts receivable gross, profitability, and a number of personnel statistics.

Hospitals that choose to participate submit specific data on a monthly basis and, in return, are able to receive a series of reports about their own operations immediately. Peer group comparisons also can be viewed and printed online once certain peer group thresholds have been met.

The data contained on the DATABANK reports can be used for budgeting, marketing, and internal management purposes within the hospital. More information about the Arkansas DATABANK program changes will be distributed by the AHA and CHA.

IRS Reports Community Benefit Practices

A new 63-page interim report from the Internal Revenue Service, released on July 18, summarizes responses from almost 500 tax-exempt hospitals to a May 2006 questionnaire about how they provide and report benefits to the community.

The report indicates the surveyed hospitals provided a combined $9.3 billion in community benefit spending. The most often cited type of community benefit was uncompensated care, with 97 percent of responding hospitals noting the uncompensated care that they give to low-income patients.

After uncompensated care, the next largest community benefit expenditure categories were medical education and training, research, and community programs.


On the same day, staffers from the Senate Finance Committee issued a “discussion draft” divided into recommendations aimed at four separate hospital groups: hospitals exempt under 501(c)(3); hospitals exempt under 501(c)(4); hospitals exempt under 501(c)(3) and (c)(4); and, all hospitals (nonprofit, for-profit, and government).

Arkansas Medicaid NPI Deadline

EDS, the state’s Medicaid claims contractor, notified all Medicaid providers who have not yet reported their National Provider Identifier (NPI) number and/or taxonomy code to the Medicaid program, notifying them that, as of October 15th, Arkansas Medicaid will no longer accept electronic claims if they don’t include the provider’s NPI. In order to avoid interruption in claims processing and payment from Arkansas Medicaid, this information must be filed with the state before October 14, 2007. Once reported, EDS will be able to successfully link the NPI number with the Arkansas Medicaid provider number.

Arkansas Medicaid recommends that those providers who have not reported an NPI use its Web site, https://www.medicaid.state.ar.us/, to facilitate reporting. After accessing the page, first double click on the “Provider” icon to enter your Arkansas Medicaid Provider number and password and follow the steps to report the NPI.

Providers are also urged to print and maintain the NPI information that they report, as all information submitted when billing claims electronically must appear exactly as shown in the NPI Reporting Summary section of the NPI tool. To print this information, go to https://www.medicaid.state.ar.us/ and double click on the “Provider” icon to enter your Arkansas Medicaid Provider number and password. Next click on “Report NPI” and enter your Tax ID or SSN. You will then be able to select “Print” to view the NPI Reporting Summary.

Questions or problems regarding NPI numbers should be directed to the NPI Help Desk at (501) 301-7611 (for local or out-of-state calls) or toll free at (866) 311-5502.

Tamper-Resistant RX Pads Required

Beginning October 1, a new law intended to stop or reduce Medicaid prescription fraud will go into effect, requiring physicians to begin using electronic prescribing or tamper-resistant prescription pads for their Medicaid patients. The law, which was tucked away in section 7002(b) of the U.S. Troop Readiness, Veteran’s Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, which the president signed last spring, will deny federal reimbursement to states for Medicaid patients’ prescriptions that are not written on the tamper-resistant pads. The law was designed to make it more difficult for patients to obtain controlled substances through forged prescriptions and to save the government money.

President Bush first recommended the tamper-resistant pads in his 2008 budget and projected that the prevention of fraudulent prescriptions could save taxpayers an estimated $510 million over 10 years. Pharmacist and physician groups are concerned that there is too little time to prepare for implementing the law. Most doctors are probably not even aware of the law and do not use the pads. The American Pharmacists Association on July 17, 2007, made a formal request to delay implementation. The request might be honored, since the law can’t be implemented until final regulations are issued. At press time, CMS has not yet published even proposed rules for the measure.

The Arkansas Hospital Association (AHA) is aware of several national suppliers who have the tamper-resistant pads. However, in order to ensure the availability of a local supplier, the AHA and the Arkansas Medical Society have partnered with Custom Printing, Inc., of North Little Rock. Custom Printing provides online ordering which allows a physician office to key in the specific information it needs on the pad and view a sample prior to ordering. These prescription pads meet all three industry recognized tamper-resistant features. Custom Printing is also providing AHA members a 5% discount off their standard pricing as well as a flat-rate shipping charge. Interested parties may order online at www.custom-printing.com or by phone at 501-375-7311.

In a letter to state Medicaid Directors, CMS advises that a state can elect to reimburse physicians for the cost of the prescription pads as an administrative expense. Arkansas Medicaid realizes the burden this has caused and wants to provide reimbursement for the purchase of these pads. However, a mechanism by which a claim can be submitted for the cost of the pads has yet to be determined.
Legal Note:
Seclusion and Restraint

The Medicare Conditions of Participation require that hospitals report restraint or seclusion-related deaths. See 42 C.F.R. §482.13(g). These include deaths that occur while the patient is in restraint or seclusion or within 24 hours after the patient has been removed from restraint or seclusion.

Hospitals also must report deaths that occur within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death, including, but not limited to, deaths related to restrictions of movement for prolonged periods of time or related to chest compression, restriction of breathing, or asphyxiation.

Arkansas hospitals should report these deaths no later than the close of business the next business day following knowledge of the patient’s death to the CMS Regional Office in Dallas. Juanita Cortez is the contact person at the CMS Regional Office for these reports. Her contact information is: Juanita Cortez, fax: (214) 767-0270, E-Mail: juanita.cortez@cms.hhs.gov.

Although the regulation states that the report to CMS must be made by telephone, Ms. Cortez has informed the AHA that with hospitals in five states calling, it is sometimes very difficult to get through to her. So, Ms. Cortez suggests that hospitals e-mail or fax a “Hospital Restraint/Seclusion Death Report Worksheet” to her if a report is needed. She prefers that the worksheet be e-mailed, but she will accept a fax report.

However, if the hospital sends the worksheet by fax, it must call Ms. Cortez and leave the following information: (a) patient’s name; (b) date of death; and (c) name and telephone number of hospital contact person. The date and time the death was reported to the CMS Regional Office must be documented in the patient’s medical record.

All worksheets are sent to the CMS Central Office when they are received. When a report of a restraint or seclusion-related death is received, Ms. Cortez will evaluate the facts of the case and determine whether an investigation is necessary.

Seven Medicare Part C Vendors Suspend Selling

The Centers for Medicare and Medicaid Services (CMS) announced during a June 15 telephone briefing that seven insurers with a huge majority of the Medicare Advantage (Part C) private fee-for-service plan market have agreed to suspend marketing of the plans.

The announcement followed CMS’ receipt of more than 2,700 complaints about the fee-for-service plans that were registered by Medicare beneficiaries during the five months which ended April 30, 2007. The beneficiaries charged that they were duped or strong-armed by the companies’ sales agents into joining the plans without understanding how they worked or the restrictions involved.

The seven insurers are Humana, United Healthcare, Wellcare, Universal American Financial Corporation, Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee. Combined, they have 1.5 million Medicare enrollees in private fee-for-service plans, 200,000 of which signed up as a part of company or union retirement health benefit plans. The other 1.3 million are in the individual, “non-group” market.

According to CMS, the companies are working with Medicare officials on new marketing guidelines for the elderly and disabled. The agency has allowed the plans until October 15 to comply.

The voluntary sales suspension, which does not apply to the Part C HMO and PPO plans, will end as CMS certifies that each company has adopted the guidelines, which include making information about the health plans readily available to medical providers and contacting beneficiaries to ensure they understand the plans.

To have the suspension lifted, a plan must provide a complete list of sales representatives, if requested to do so by CMS, and must authorize the agency – if it seeks to do so – to make the list available to state insurance departments. Sales reps will have to pass a written test showing their familiarity with Medicare and the product they are selling. Lists of planned sales events provided to CMS must include “delegated” brokers and agents as well as those sponsored by the plan.

For more information, see http://www.seniorjournal.com/NEWS/Medicare/2007/7-06-16-SevenCompanies.htm.

Proposed 2008 Physician Fees: Expect a Drop

The Centers for Medicare & Medicaid Services in early July proposed an estimated Medicare payment update for physicians that would cut fees by 9.9 percent in 2008, based on Medicare’s controversial sustainable growth rate formula.

The proposed rule, which can be found at http://www.cms.hhs.gov/PhysicianFeeSched/PFSRNI1temdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending, also outlines proposed payment changes for Part B drugs and other services under the physician fee schedule. 2008 quality measures for physicians are also outlined.

Detailed Notice of Discharge Form is Available Online

The Centers for Medicare & Medicaid Services (CMS) recently posted to its Web site the final form hospitals must use (effective date was July 2) to notify Medicare beneficiaries about their discharge appeal rights.

In addition, the final versions of the “Important Message from Medicare” and the “Detailed Notice of Discharge” are posted along with the Manual Instructions for this process. Also posted is the Notice of Hospital Requested Review (HRR), which replaces HINN 10. The HRR should be issued by hospitals to beneficiaries in Original Medicare whenever a hospital requests QIO review of a discharge decision without physician concurrence.

To find the forms and manuals for their use, go to http://www.cms.hhs.gov/BN1/12_HospitalDischargeAppealNotices.asp.
Medicare Web Site Posts Answers to Discharge Form Questions

The Centers for Medicare & Medicaid Services in July posted to its Web site a series of questions and answers to help hospitals comply with the new “Important Message from Medicare” (IM) and “Detailed Notice of Discharge” forms that hospitals now must use to notify Medicare beneficiaries about their discharge appeal rights.

The Q&A notice addresses 13 topics, including implementation, authorized representatives, documentation of the IM follow-up copy, and inpatient-to-inpatient transfers.


Sharing of National Provider Identifiers is Made Easier

Healthcare providers looking for help in ways to share their National Provider Identifier (NPI) numbers should check into new information being offered by the Centers for Medicare & Medicaid Services (CMS).

The agency has placed a notice on its Web site describing how it will share NPI data with healthcare providers and others who need it to process claims for payment. The notice also describes which NPI data in the National Plan and Provider Enumeration System will be disclosed and under what conditions. CMS plans regular updates to the data.

Though the deadline has passed for healthcare providers and most health plans to implement NPIs for standard electronic transactions under the Health Insurance Portability and Accountability Act, entities that acted in “good faith” to become NPI compliant can accept legacy numbers through May 23, 2008, according to a recently announced CMS contingency plan.


Medicaid Now Accepting UB-04

Arkansas Medicaid began accepting the new HCFA-1500 (version 08/05) UB-04 (CMS1450) or the 2006 ADA Dental Claim Forms July 1, 2007. These forms accommodate the National Provider Identifier number and other important changes.

As of now, claims received on the old versions will be returned to the provider to resubmit on the new claim forms.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at 1-800-457-4454 (toll-free) within Arkansas or locally and out-of-state at (501) 376-2211.

While the rule grants a 3.2 percent market basket update for IRF payments, a total of about $150 million, CMS will not further delay its move back to fully implementing the “75 percent Rule” which governs qualified IRF admissions. That means as of July 1, 2008, 75 percent of admissions to an IRF must be patients having one of 13 qualifying conditions. Failure to meet the threshold will disqualify the hospital from participating in Medicare’s IRF prospective payment system.

Currently, the IRF rule contains a provision that allows a patient to count toward 75 percent Rule compliance if he/she is admitted for a co-morbidity that falls within the 13 qualifying admitting conditions and causes a significant decline in the patient’s functional ability. This provision is set to expire on July 1, 2008, when the 75 percent Rule becomes fully operational again.

CMS chose not to make it permanent, despite its own analysis that found that seven percent of cases from July 2005 through June 2006 – approximately 31,000 patients – were admitted to IRFs with qualifying co-morbidities.

Now, hospitals must depend on congressional action to put the brakes on CMS’ plans. The American Hospital Association is calling on lawmakers to cosponsor H.R. 1549/S. 543, the “Preserving Patient Access to Inpatient Rehabilitation Hospitals Act.” The bills would roll back the patient threshold level to 60 percent, rather than 75 percent.

The Arkansas Hospital Association expresses its appreciation to Senators Lincoln and Pryor and to Congressmen Berry, Snyder, Boozman, and Ross for their support on this matter. All have signed on as cosponsors for the bills in their respective chambers.

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule in the June 27 Federal Register that would allow the agency to charge revisit user fees to healthcare facilities cited for deficiencies during initial certification, recertification, or substantiated complaint surveys.

The proposed rule states that, consistent with the President’s long-term goal to promote quality of healthcare and to cut the deficit in half by fiscal year (FY) 2009, the FY 2007 Department of Health and Human Services’ (HHS) budget request included both new mandatory savings proposals and a requirement that user fees be applied to healthcare providers that have failed to comply with Federal quality of care requirements.

The “revisit user fees” would affect only those providers or suppliers for which CMS has identified deficient practices and requires a revisit to assure that corrections have been made.

The fees are estimated at $37.3 million annually and would recover the costs associated with the Medicare Survey and Certification program’s revisit surveys. The fees would take effect on the date of publication of the final rule, and would be available to CMS until expended.


The Centers for Medicare & Medicaid Services (CMS) in July released its proposed rule updating Medicare payment rates for hospital outpatient services in calendar year 2008. The agency also issued a final rule linking the Medicare payment system for ambulatory surgery centers (ASCs) to the hospital outpatient prospective payment system, effective for services in calendar year 2008, under which CMS would pay ASCs at approximately 65 percent of the outpatient hospital rate.

The proposed hospital outpatient rule includes a 3.3 percent inflation update in Medicare payment rates for services paid under the program’s outpatient prospective payment system in 2008. It also proposes ten hospital outpatient quality measures, which were previously adopted by the Hospital Quality Alliance, for public reporting. The measures include five emergency department acute myocardial infarction measures, two surgical care improvement measures, and one measure each for the treatment of heart failure, community-acquired pneumonia, and diabetes.

In 2009, hospitals that fail to report data for these measures would receive a two percent reduction in their payment update.

The American Hospital Association has posted a Special Bulletin detailing the proposals for member hospitals on its Web site at http://www.aha.org/aha_app/issues/Medicare/advocacy-medicare.jsp.

The 2007 Atlantic hurricane season is well underway, and the Hurricane Forecast Team at Colorado State University continues to believe it will be an active one.

Seventeen named storms were predicted to develop in the Atlantic basin between June 1 and November 30. Nine of the storms are expected to become hurricanes and, of those nine, five should develop into major hurricanes with sustained winds of 111 miles per hour or better.

Arkansas hospitals should be aware that if a major hurricane that could have an effect on Arkansas hospitals should occur this year, the National Disaster Medical System (NDMS) will activate the daily phone conferences which it conducted with the state’s NDMS facilities in the fall of 2005 following Hurricanes Katrina and Rita. (All of these facilities are located in central Arkansas.)

At the time, the calls were very helpful in keeping everyone posted and up-to-date on disaster preparations, NDMS activation, procedures, patient flow, etc.

The procedure for those daily calls, unless otherwise directed, will be as follows:

- The calls will be activated by the state’s VA Medical Director (Michael Winn) when it becomes apparent that central Arkansas is in line to receive patients, but hospitals have not been activated by NDMS. The first call will act as a “heads up” that evacuees may be coming and that medical care will be needed, and that there exists the possibility of NDMS activation.
- The same conference call number and participant code (800-244-2500; Participant code: 6109980#) will be used for each call. The Arkansas Hospital Association will absorb the cost of the calls.
- Calls will happen each day (including weekends if necessary) at 3 p.m. Participation is not mandatory, but each NDMS facility is encouraged to participate on each call.
- The VA Medical Director’s department will take charge of the call, along with the NDMS emergency manager, Rex Oxner.
- The VA Medical Director’s department will take minutes of each call and forward them to all participants within 24 hours of the conclusion of each call. That way, everyone will be kept completely up-to-date.
- The calls will end when it becomes apparent that the emergency is over.

If you have questions about the program, please contact Beth Ingram at (501) 224-7878 or at bingram@arkhospitals.org.

The Occupational Safety and Health Administration (OSHA) has released a new publication called Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers.

Although OSHA issued general guidance for workplaces in February, the new guidance focuses specifically on healthcare workers and their employers. It is consistent with all previous pandemic preparedness guidance issued by OSHA, the Centers for Disease Control and Prevention, and Department of Health and Human Services, the agency said.

The 104-page document addresses flu diagnosis and treatment, infection control, healthcare worker vaccination, personal protective equipment, preparedness planning, and OSHA standards.

Like the OSHA Best Practices for Hospital First Receivers guidance, this document is likely to become the inspection standard that OSHA will use in the future. This should become a “must read” for healthcare facility and organization infectious disease supervisors, healthcare managers, and healthcare professionals.

New Risk Management/Patient Safety Publication Now Available

The Arkansas Hospital Association announces publication of a new risk management newsletter, Strategies, which addresses risk management issues specific to physician practices and hospitals.

The monthly publication is developed by Sue Dill Calloway, RN, JD, of the OHIC Insurance Company in Columbus, Ohio. Calloway is a popular presenter with the AHA membership on a variety of compliance, nursing, risk management, legal, and documentation issues and is making this publication available to our membership.

Aerosol Hand-Rub Dispensers Okayed, Now Meet Fire Code

The International Fire Code (IFC) has been revised to allow aerosol alcohol-based hand rubs in hospital corridors.

Up to 18 ounces of Level 1 aerosol per dispenser and ten gallons of liquid or aerosol hand rub per area are allowed under the change, approved May 25 by the International Code Council (ICC). The IFC revision is consistent with other fire code and regulatory changes since 2002 to allow hand rubs in hospital corridors, as recommended by the Centers for Disease Control and Prevention to facilitate effective hand hygiene and reduce infection.

The American Society for Healthcare Engineering (ASHE), an American Hospital Association personal membership group, worked closely with the ICC, National Fire Protection Association, Joint Commission, Centers for Medicare & Medicaid Services, and others to promote the various code and regulatory changes.

For more on the IFC revision, see the ASHE member advisory at http://www.ashe.org/ashe/codes/handrub/pdfs/ABHRIFCrevjbdse.pdf.

Hospital Mortality Data is Posted

On June 21, The Hospital Quality Alliance, which includes the American Hospital Association, added to the Hospital Compare Web site mortality data for heart attack and heart failure patients. The data shows consumers how heart attack and heart failure patients fared 30 days after admission to a hospital, including time after discharge.

Hospitals are grouped as the same, better or worse than the national mortality rate for the two conditions. The 30-day risk-adjusted mortality rates are produced using a statistical model that relies on Medicare claims and enrollment information. The model predicts patient deaths for any cause within 30 days of hospital admission for heart attack or heart failure, whether the patients die while still in the hospital or after discharge.

The thirty-day mortality is used since this is the time period when deaths are most likely to be related to the care patients received in the hospital, as defined by the Centers for Medicare & Medicaid Services (CMS).

According to CMS, deaths that occur outside the hospital within 30 days are included along with deaths that occur in the hospital, because some hospitals discharge patients sooner than others. The rates are calculated using sophisticated risk-adjustment that takes into account one year of billing history for each patient.

Also added to the Web site were additional data on steps hospitals have taken to prevent surgical infections and pneumonia. Click on http://www.hospitalcompare.hhs.gov for more information.
AFMC Named Community Leader

The Arkansas Foundation for Medical Care (AFMC), the Medicare-designated Quality Improvement Organization (QIO) for Arkansas, was named a Community Leader for Value-Driven Health Care in April. Only three other QIOs in the nation have been named Community Leaders – those in Virginia, New York, and Alabama.

The Value-Driven Health Care Initiative is a nationwide, voluntary program launched in 2006 by the U.S. Department of Health and Human Services to improve quality and lower costs of healthcare. Based on the principles of health information technology, quality reporting, price reporting, and quality-driven incentives, the initiative calls on communities to develop stakeholder incentives, and to promote public availability of information on health quality and costs with the goal of improving healthcare in the region.

AFMC received the Community Leader designation in recognition of its role in convening stakeholders in the Regional Quality Improvement (RQI) Initiative in Arkansas, a partnership between AFMC and the Arkansas Medicaid program. RQI was launched in 2006 by the Center for Health Care Strategies, Inc. (CHCS), a national, nonprofit organization, which chose three regions – Arkansas, Rhode Island, and Rochester, New York – through a national selection process to receive grant funding and participate in the initiative.

Participants are exploring the use of shared data between Medicaid and other health plans, providers, and purchasers as a way to coordinate quality improvement strategies to help improve patient outcomes and reduce healthcare costs.

For a complete list of stakeholders participating with AFMC in the initiative, visit http://www.afmc.org/HTML/programs/quality_improve/rqi/measure.aspx.

HQA Adopts Outpatient Quality Indicators

America’s hospitals, which have been reporting quality of care indicators for inpatient services since 2003, are on the verge of adding outpatient quality measures to their reports.

The Hospital Quality Alliance (HQA) on July 11 adopted ten performance measures of hospital outpatient quality, which will join the 32 inpatient clinical process and outcome measures, as well as other patient experiences of care measures, that already are reported and displayed on the Hospital Compare Web site.

Although several of the new measures are similar to existing inpatient care measures, implementing them for patients who are not admitted to the reporting hospital will provide a broader view of care, particularly in smaller, often rural, hospitals.

Many U.S. hospitals have been providing information on inpatient quality measures through the HQA initiative since October 2003. Last year, Congress mandated that the Centers for Medicare & Medicaid Services establish a program for reporting quality of hospital outpatient care, as well. Under the program, hospitals must report the outpatient data to receive the full annual update to the hospital outpatient prospective payment system payment rate beginning in January 2009.

Hospitals that fail to report the outpatient quality data will incur a reduction in their annual payment update factor of 2.0 percentage points.

The new measures are considered preliminary, pending further work to complete definitions and specifications, and to finalize the National Quality Forum’s endorsement. As a result, the HQA may refine its recommended list as further information becomes available.

For now, the new outpatient measures and the type of care they relate to are:

- Heart Attack: (1) Aspirin at arrival for patients treated in the emergency department and then transferred; (2) Median time from emergency department arrival to electrocardiogram (ECG) for patients treated in the emergency department and then transferred; (5) Median time from emergency department arrival to transfer for primary percutaneous coronary intervention (PCI)
- Heart Failure: (6) Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) for left ventricular systolic dysfunction (LVSD)
- Surgical Care Improvement: (7) Timing of antibiotic prophylaxis; (8) Selection of prophylactic antibiotic – first or second generation cephalosporin
- Pneumonia: (9) Appropriate empiric antibiotic prescribed for community-acquired bacterial pneumonia
- Diabetes Mellitus: (10) Appropriate empiric antibiotic prescribed for community-acquired bacterial pneumonia
The federal Food and Drug Administration (FDA) has issued a notice to healthcare professionals about several clusters of patients who experienced chills, fever, and body aches shortly after receiving propofol for sedation or general anesthesia. Multiple vials and several lots of propofol used in patients who experienced these symptoms were tested and there was no evidence that the propofol vials or prefilled syringes used were contaminated with bacteria or endotoxins.

Propofol is an intravenous sedative-hypnotic agent for use in the induction and maintenance of anesthesia or sedation. To minimize the potential for bacterial contamination, propofol vials and prefilled syringes should be used within six hours of opening, and one vial should be used for one patient only. Patients who develop fever, chills, body aches, or other symptoms of acute febrile reactions shortly after receiving propofol should be evaluated for bacterial sepsis.

For more information, go to http://www.fda.gov/medwatch/safety/2007/safety07.htm - Diprivan.
Arkansas home health agencies and skilled nursing facilities should be aware of a coming change for electronically reporting Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS) data to the Arkansas Department of Health via AT&T’s dial-up service. In July, CMS began switching on a state-by-state basis from AT&T’s dial-up service for the assessment submissions and reports to broadband. Arkansas is scheduled to make the changeover in October.

In order to use the broadband service, HHAs and SNFs will need to update AT&T’s Global Network Client to version 7.0, dated May 24, 2007. Version 6.9 will work with Microsoft operating systems other than Vista. Check the current version in use by launching the client, left-click on “Help” on the top menu bar and select “About.” The version number and date will be displayed. To obtain a copy of the new client version, log onto the Quality Improvement and Evaluation System’s technical support office (QTSO) Web site, www.qtso.com, and click the MCDN Information link in the blue outlined box on the right side of the page.

As an alternative to downloading, you may request a CD copy by emailing mcdn.mco@palmettogba.com. Those on a corporate wide area network (WAN) or a local area network (LAN) will probably need to get the network administrator to configure the network to allow access to its broadband connection through the new client. Instructions for doing that are provided on the QTSO Web site.

Providers who are able to install the new client and begin using the broadband connection without assistance from AT&T may begin using the new client any time after July 1st. If you need assistance you will have to wait until your designated month to call AT&T. The Help Desk number for facilities is 800-905-2069. The Help Desk number for States is 877-486-7240. Providers in an area where there is no broadband service available will have to submit a waiver request to CMS to continue using the phone modem method. The waiver form is also on the QTSO Web site.
IRS Clarifies Permissible Health Information Technology Arrangements

The Internal Revenue Service (IRS) issued a June 22 question-and-answer document that clarifies its May 11 memorandum allowing tax-exempt hospitals to share health information technology with physicians.

The document explains that health IT arrangements between hospitals and medical staff physicians that are not entirely consistent with the conditions in the memorandum “will not necessarily result in any impermissible private benefit or inurement.”

The memorandum is not meant to describe the only permissible health IT arrangements, but the facts and circumstances of any such arrangements would need to be reviewed by the IRS to determine if it is permissible, the Q&A states.

Lawrence Hughes, American Hospital Association (AHA) regulatory counsel, said, “AHA is pleased that the IRS was responsive to its request to clear up misunderstandings that were circulating about the May 11 notice.”

The May 11 memorandum was issued in response to tax-exempt hospitals’ concerns that they risked their tax-exempt status if they shared health IT with physicians as new Stark and anti-kickback rules permit.


Three Arkansas Hospitals Make “Most Wired” List

The Agency for Healthcare Research and Quality (AHRQ), through the American Hospital Association, has released its 9th annual “100 Most Wired” list, which this year includes three Arkansas hospitals and health systems.

Baptist Health and UAMS, both located in Little Rock, and Stuttgart Regional Medical Center were all recognized for technology advancements. Baptist Health and UAMS made the “Most Wired” list; Stuttgart Regional was listed among the “Most Improved.”

The survey analyzed hospitals’ uses of technology, noting that those hospitals show better outcomes in key areas including mortality rates, patient safety, and average length of stay.

For more information, click on http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/07JUL2007/0707HHN_CoverStory_07Winners&domain=HHNMAG.
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