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AHA Opposes Proposed Medicaid Rule

Obtaining Medicare Provider Number is Vital

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Helpful Monographs for Governance Boards

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AHA Mourns Passing of Dan Gathright

Administrators’ Forum/AHEF Conference

Call for 2007 Diamond Award Entries

New Utilization Rates for Hospitals Released

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2006 PAC Contributions Recognized

National Hospital Week – May 6-12

Average Nurse Age on the Rise

Coalition Sponsors Public Education Campaign

ABN Revision Announced
It’s Up to Each of Us

In recent days, you have probably received a phone call or email asking you to contact your state representatives and senators (as well as our Congressional delegation in Washington, DC) regarding healthcare issues vital to Arkansas hospitals. I want to personally thank each of you who has taken the time to let your opinions be known, and to help us work for reasonable healthcare policy, both in our state’s and our nation’s capitals.

It is vital that your locally elected leaders understand the ramifications their actions might have on Arkansas hospitals and the local hospital’s ability to continue serving the citizens of Arkansas with the quality healthcare they deserve. Sometimes, bills are proposed which would have unintended consequences dire to the operation of local healthcare facilities. It is at those times that your words, as local healthcare leaders, are most important.

As the Arkansas General Assembly winds down this session, please do not think your responsibility to keep in contact with local officials can be put on the shelf. Your voice is needed on a regular basis, helping our elected officials understand the state of healthcare, the effects of healthcare policy, and the necessity for our hospitals to work together with lawmakers to create the best healthcare environment possible.

Many of you took part in the February 20 meeting in Little Rock with the American Hospital Association, as together we learned about proposed national healthcare policy and the need for all of us to band together to build the best policy possible. It is imperative that balance be achieved: balance that weighs the needs of the nation’s patients, its hospitals, and, yes, our national budget.

At this meeting with the American Hospital Association, we were reminded once again of the necessity to keep communication lines with our elected officials and their staffs open, helping them to understand what is needed in the “real world” of healthcare outside the Washington beltway.

I urge you to consider joining your Arkansas Hospital Association staff members and fellow administrators at the American Hospital Association’s annual meeting in Washington, DC May 6-9. We will not only be attending the annual meeting to further sound our voices and work on national healthcare policy, we also will be visiting with Congressmen Berry, Boozman, Snyder and Ross and Senators Lincoln and Pryor to discuss the very real needs of Arkansas hospitals, particularly as these lawmakers discuss and decide policy relating to the president’s proposed drastic cuts in Medicare and Medicaid funding.

After all, the policies made in Washington directly affect your hospital’s Medicare and Medicaid reimbursements, the single highest revenue generators in most of our state’s healthcare facilities.

To underline the importance of as many Arkansas hospital administrators as possible attending these face-to-face meetings, the AHA board has set aside funds to reimburse air fare and meeting registration fees for all administrators attending the AHA annual meeting and these legislative visits. It is the board’s way of urging each and every Arkansas hospital CEO to become involved with this national discussion...a national discussion that directly impacts every hospital in America.

Can you afford NOT to be involved? The future of our hospitals depends on each of us entering state and national healthcare policy discussions. Please do your part, and let your voice be heard!
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Education CALENDAR

March 30, Little Rock
Patient Falls Workshop

April 5-6, Hot Springs
Healthcare Financial Management Association Annual Meeting

April 16, Little Rock
Arkansas Health Executives Forum Spring Meeting

April 19-20, Nashville, Tennessee
Southeast Governance Conference

April 25, Little Rock
Leaping from Staff to Management: Mid-Management Certificate Series

April 26, Little Rock
Leaping from Staff to Management…the Next Steps: Mid-Management Certificate Series

May 6-9, Washington, DC
American Hospital Association Annual Membership Meeting

May 9-11, Hot Springs
Arkansas Association for Healthcare Engineering Annual Meeting

May 15, Little Rock
Behavior-Based Interviewing: Mid-Management Certificate Series

May 16-18, Hot Springs
Society for Arkansas Hospital Purchasing and Materials Management Annual Meeting and Trade Show

May 17, Little Rock
Emergency Readiness Workshop

May 18, Little Rock
Chargemaster Workshop

May 23, Little Rock
Nursing Law Update

May 31, Little Rock
Arkansas Foundation for Medical Care Quality Forum

June 20-22, Hot Springs
Arkansas Hospital Administrators Forum Summer Leadership Conference


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Ben E. Owens, FACHE, president and CEO of St. Bernards Healthcare in Jonesboro, was recognized recently as the Not-for-Profit Business Person of the Year by the Northeast Arkansas Business Today Awards Show in Jonesboro. Owens is a former chairman of the Arkansas Hospital Association and recipient of the A. Allen Weintraub Memorial Award and the ACHE Regents Award.

Kurt Meyer, CEO of Rebsamen Medical Center in Jacksonville, has resigned effective February 8 after accepting a new position in Dallas as vice president of community health services with PHNS, a privately-owned company that provides a suite of strategic healthcare services. Scott Landrum has been named interim CEO while QHR, Rebsamen’s management company, searches for a successor. Landrum was previously CEO of Campbell Health System in Weatherford, Texas.

Richard A. Pierson, vice chancellor for clinical programs at UAMS Medical Center in Little Rock, has been appointed to the board of directors of the National Resident Matching Program. The three-year term begins July 1 and expires June 30, 2010. Pierson was also reappointed to the Committee on Health Professions, an American Hospital Association board committee that addresses issues in clinical education and health manpower.

Following the recent death of Dan Gatright of Arkadelphia, John Neal, CEO/administrator of Stuttgart Regional Medical Center, has been appointed Arkansas’ Delegate to the American Hospital Association Regional Policy Board 7 to fulfill Gatright’s unexpired term. Neal was previously the Alternate Delegate. Tim Hill, president and CEO of North Arkansas Regional Medical Center in Harrison, has been elected by the Arkansas Hospital Association board of directors to serve as Alternate Delegate. Both terms expire December 2007.

Christina “Christy” P. Hockaday, FACHE, has been named CEO of St. Anthony’s Medical Center in Morrilton. She succeeds Jonathan Davis who accepted a similar position with a Kansas facility in November. Hockaday is a former corporate director of business development and administrative services at Conway Regional Medical Center. She previously held administrative positions at Sparks Health System in Fort Smith and received the ACHE Regent’s Award for Early Career Healthcare Executive in 2006. She is a past president of the Arkansas Health Executives Forum and is also an Adjunct Faculty Member at UAMS College of Public Health in the Graduate Program for Health Services Administration.

Russ Sword, CHE, CEO, Ashley County Medical Center in Crossett, has been reappointed to a second four-year term on the Arkansas Board of Health. His term expires in January 2011. By virtue of that appointment, he also serves on the Arkansas Hospital Association’s board of directors. Sword received the AHA’s A. Allen Weintraub Memorial Award in October 2006.

Five hospital executives were recently named to Arkansas Business’ “Power List,” which is composed of the “largest and most influential companies or institutions in 20 different industries or professions.” They are: Jonathan Bates, M.D., president, Arkansas Children’s Hospital, Little Rock; Randall Fale, president/CEO of St. Joseph’s Mercy Health Center, Hot Springs; John Guest, CEO, Sparks Health System, Fort Smith; Russell D. Harrington, Jr., president, Baptist Health, Little Rock; and Richard Pierson, executive director, UAMS Medical Center, Little Rock.

Michael R. Winn has been appointed medical center director at the Central Arkansas Veterans Healthcare System (CAVHS). Winn, who was previously director of the Fayetteville VA Medical Center, is responsible for managing CAVHS’ Little Rock and North Little Rock campuses and its four community-based outpatient clinics. He succeeds Sallie House-Hanfelder who was acting medical director for the past few months.

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

Scott Peek, CEO of Chambers Memorial Hospital in Danville, has been appointed to the Arkansas Hospital Association Workers Compensation Self-Insured Trust (AHAWCSIT) board fulfilling the unexpired term of Kurt Meyer who accepted a position in Dallas. Larry Morse, administrator of Johnson Regional Medical Center in Clarksville, is AHAWCSIT chairman, and Phil Gilmore, president/CEO of HSC Medical Center in Malvern, is vice-chairman.

Nena Sanchez, vice president for Medicare and Medicaid operations at the Arkansas Foundation for Medical Care, was recently selected as a member of the steering committee for the National Quality Forum’s project, “National Voluntary Consensus Standards for Therapeutic Drug Management Quality.” The project concerns effective, evidence-based selection and planning for medication therapy, safe use of prescription drugs, drug adherence and avoidance of drug errors.

Robert “Bob” J. Hughes, Jr., CPA, 55, partner in Hughes, Welch & Milligan in Batesville, was killed February 24 in a tragic accident during a “whiteout” snowstorm in Kansas. Hughes was a valuable resource to critical access and rural hospitals, as well as hospital-based home health agencies throughout Arkansas. He leaves his wife, Jan, one son, two stepchildren and one grandson.
When Terry Amstutz goes to work each morning, he envisions limitless possibilities for ways Magnolia Hospital can serve its community. As CEO of the 70-bed hospital since July of 2005, Amstutz has put into place a new Life Smart Center (wellness and physical therapy facility) and regularly discusses current plans for hospital expansion with the mayor and town council, community groups, and citizen groups of all shapes and sizes.

“We have a ballot initiative on the May 2007 ballot, asking our citizens to approve a 1-1/8¢ sales tax for hospital expansion,” Amstutz says. “We are taking the plans, ideas and financial statistics to the people of Magnolia every chance we get.” He cites special public meetings scheduled to allow the people of Magnolia to see expansion plans, look over the financial projections, and ask questions about the proposed expansion.

“Today’s facility is not easy to manage operationally, and certainly is not convenient from our patients’ standpoint,” he says. But when a hospital has literally grown to accommodate medical breakthroughs in treatment over a seventy-year period, it is not difficult to see how treatment areas were added here and there, wherever space could be found, making patient services expand in a honeycombed approach.

“In our planned facility, the patients served by Magnolia Hospital will see designated areas for inpatient and outpatient care; radiology services will be gathered together in one space, and people will no longer have to go from one end of the hospital to the other just to find the places where their medical tests are done,” he says.

Today, Amstutz says many potential area patients choose to go to other hospitals for their medical care. It is the hope and projection of the hospital’s administrative team that with the new facility and its increased services and medical staff, more people will select Magnolia Hospital as their medical facility of choice.

“Our demographics are similar to those of Batesville and Harrison, but our medical facilities today do not compare favorably with those communities,” he says. “We believe that with the new facility will come more physicians, more in-community services and expanded medical opportunities for our citizens. But this will not be accomplished overnight,” he says. “We have both 5- and 10-year plans, and in the end, Magnolia Hospital’s story will be a great one to tell!”

Amstutz is well suited to telling the story of the hospital today, its planned expansion, and the community’s dreams for the future. Receiving his undergraduate degree in English and Journalism from Illinois Wesleyan University, his first career involved working for local newspapers in Illinois and Colorado.

His communication skills then took him to a career with the Granada
Hospital Group, where he served for several years as division director of communication and technology services to hospitals within the Granada group. During this time, he worked with hospitals from Chicago to the Mid-Atlantic States, from Michigan to New England. “My division served the communication and technology needs for 100 hospitals, mostly up and down the Atlantic sea coast,” he says.

But the ties of home began calling, and at age 31, he decided to move closer to Illinois. “There comes a time when you want to settle down,” he says. “I liked the hospital environment, and was determined to stay involved in healthcare.”

Because of his experience in the management of hospital operations, he was named CEO of Calico Rock’s Community Medical Center of Izard County. “I was much closer to my home in Illinois, and able to begin my career in hospital administration,” he says. He stayed there for 11 years, helping the hospital make a transition to Critical Access Hospital designation while raising two young children as a single dad.

“We had such a great medical staff and group of employees at Calico Rock,” he says. “We all worked together to earn CAH designation, and pulled the hospital out of some bleak financial times to more stability.”

Amstutz earned his master’s degree in healthcare services while working as an administrator at Calico Rock, attending the West Plains, Missouri campus of Central Michigan University. He says commuting to West Plains with fellow administrator Frank Wise of Salem as they worked toward their master’s degrees together are some of his fondest memories.

It was while serving as administrator at Calico Rock that he became involved with the Arkansas Hospital Association, serving as the North Central District’s representative to the AHA Board, and as secretary and president of the North Central District itself.

In 2001, he joined the Trinity Health/Mercy Medical Center family, managing its Morrison Community Hospital in Morrison, Illinois. He returned to Arkansas in 2005, when CHRISTUS St. Michael recruited him to come in as CEO of Magnolia Hospital.

“The hospital currently has 70 beds, but after the proposed expansion, we’ll have 49 single, one-person rooms and greatly expanded ER, radiology and specialty care services,” he says. “I feel very positive about the community’s support for this expansion. We believe it will mean keeping our focus on primary care for our citizens, but also being able to offer them more in the way of ENT, orthopedic, ophthalmology and cardiac services, as well as urology, podiatry and other specialty services.” He sees the proposed new facility as a recruitment draw for physicians, and as a convenience for local citizens.

“Assuming we receive approval by our citizens for the 1-1/8¢ sales tax this May, we will begin construction on the new facility this fall, with completion slated 18 months later,” he says. The sales tax is projected to raise $2.5 million a year, with a 20-year maximum payoff. “Our project management team has been extremely careful in enumerating costs, keeping the plan both manageable and affordable,” he says. “We have been open with the community on how much each part of the construction is going to cost, and the public has been very accepting of the plan.”

The community has seen positive changes in the hospital’s bottom line the past two years, with financials running in the black and customer satisfaction ratings beginning to rise. “This is such a welcoming community, and we have worked hard on our relations with our physicians,” he says. “We have increased utilization of our hospital, and believe the new facility will only cause utilization to further increase.”

Terry and his wife, Julie, are committed to the community of Magnolia. “Julie was born and raised in Corning, attended Ouachita Baptist University for her undergraduate degree, and both UCA and Western Illinois Universities for dual master’s degrees,” he says. Julie serves as assistant principal at Central Elementary.

“I believe we are on the cusp of our hospital’s new reality.”
School in Magnolia. Their son, Samuel, is 10, and a fourth grader. Daughter Carly is now 20, and son Joe, 17.

“All of the hospital employees and staff are such great people, and I love working with them,” he says. “Our goal, as a hospital team, is to make our hospital the best we can – not trying to have all of the highest-tech gadgets possible, but having the equipment and services that are appropriate for a regional hospital,” he says. “We are building momentum, and that is a great source of satisfaction for us all.”

He credits his administrative team with many of the successes Magnolia Hospital sees today. “It is great to see people come together to meet goals and to start to see results of their hard work,” he says. “We see our role as improving our census by improving our quality and patient satisfaction, and doing it in the right order.”

He also credits the AHA with contributing to some of Magnolia Hospital’s successes. “AHA provides tremendous educational programs and opportunities,” he says. “In just the past few months, we have sent people from our team to coding workshops, and, of course, the educational discussions at the annual meeting. And AHA Services, Inc. is a great help to us with their insurance and recruiting programs.

“But it is AHA’s advocacy role that helps us the most,” he says. “Today, we are all concerned with pay-for-performance issues, national quality goals, workforce shortage issues, and the proposed cuts to Medicare and Medicaid funding. So much of our hospital’s revenue comes from these government reimbursements; without the AHA working to preserve these reimbursements, rural hospitals would truly be in trouble.”

As he looks forward to the special election in May, Amstutz also looks around him and thanks those on the hospital board and on his administrative team. “They have all, particularly our board, shown extraordinary vision in planning the hospital’s turnaround, in working with the community, and in their vision for the hospital’s expansion. They have been working toward this for the past five years, and I am glad to be working with them.”

And as for the projected election results? He says, “I believe we are on the cusp of our hospital’s new reality.”
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Following the priorities set by the Arkansas Hospital Association (AHA) board of directors in preparation for the 86th session of the Arkansas General Assembly, AHA staff members have been hard at work at the Capitol since the session convened January 8. Bo Ryall and Don Adams, in particular, are discussing healthcare and hospital needs with lawmakers as they seek to set healthcare policy for the state.

The AHA’s Council on Government Relations had previously recommended specific advocacy items, with its top priority assigned to securing adequate funds for the state Medicaid budget to allow an increase in hospital outpatient rates. Arkansas Medicaid program officials already have gained state approval to raise the inpatient hospital per diem cap from $675 per day to $850 and to include a small pay-for-performance program to allow hospitals an added incentive payment of up to $50 per day. The increase will be finalized when the Centers for Medicare & Medicaid Services gives its okay. Once that step is completed, the increase will be effective as of July 1, 2006.

AHA’s emphasis on the Medicaid front now is focused on increasing hospital outpatient rates, which have been unchanged since 1992. Late last year, the Arkansas Department of Finance and Administration (DF&A) unveiled its proposed budget for the state Department of Health and
Human Services covering state fiscal years (SFY) 2008 and 2009. That proposal included sufficient State General Revenues to yield $10.6 million for increased outpatient payments (including the federal match) for SFY 2008 and $11.4 million for SFY 2009.

It's less than AHA requested, but, if approved, Medicaid would be covering almost 60% of hospitals’ cost of providing the care versus current payments, which cover only about 40% of outpatient costs.

In addition, the AHA is working to:

- Gain support for legislation and funding for a statewide trauma system. The Governor’s Advisory Council on Trauma estimates that the state could raise about $15 million to go toward trauma care funding through a combination of increased fines on various traffic violations. With a portion of the money available for federal Medicaid matching dollars, total trauma funds could eventually be close to $30 million. At press time, this bill was in the Senate. The AHA was fighting a tough battle with cities and counties lobbying against the proposed funding stream.

- Pass legislation that would allow the AHA to obtain information from the state’s hospital discharge database. This would allow the association to populate its new hospital transparency Web site with all-payer data rather than Medicare-only data. At press time, the bill had passed the House and was in the Senate Public Health Committee.

- Change the state’s “deemed status” law to add other groups to the definition of “accrediting organization” to give hospitals flexibility in their choice of alternatives to Joint Commission accreditation. This is now ACT 136.

- Amend the state Workers’ Compensation law as it relates to positive results of drug and alcohol screenings given to employees when they are sent to a healthcare provider for an injury. Currently, if the employee tests positive for drugs/alcohol, the healthcare provider does not receive payment from Workers’ Compensation for services rendered. AHA hopes to remove that provision so that hospitals can be paid for the services they render. At press time, the AHA’s bill died in the House of Representatives. AHA lobbyists were attempting to add language contained in the original bill to another bill in a House committee and have it voted on one more time. The AHA was asking that hospitals be paid for treating these individuals.

Senators Shane Broadway, Ed Wilkinson, Bobby L. Glover, John Paul Capps and Tracy Steele take their oaths of office on the first day of the 2007 regular session. Chief Justice Jim Hannah of the Arkansas Supreme Court swears them in.
Join Us May 6-9 in Washington, DC for National Healthcare Policy Discussions

“America’s Hospitals: Building Better Lives and Healthier Communities” is the theme for the American Hospital Association’s (AHA) annual membership meeting May 6-9 in Washington, DC. This meeting provides a great opportunity for hospital execs and trustees to learn firsthand about AHA’s advocacy agenda and strategy for 2007. Plus, attendees have the opportunity to visit personally with their congressman and the state’s two senators to deliver their messages on how federal legislative and regulatory issues are affecting their hospitals and local communities.

The 2007 meeting became even more important when President George W. Bush released his proposed Fiscal Year 2008 budget recently, calling for $100 billion in Medicare and Medicaid reductions. To demonstrate the importance of attending this year’s meeting, the Arkansas Hospital Association will reimburse each hospital CEO for his/her registration fee and airline ticket.

During the meeting, participants will have the opportunity to attain American College of Healthcare Executives Category I credit through a workshop on “hiring right and avoiding wrong.” Other educational opportunities will be available for hospital trustees covering issues such as disruptive governance; exceptional governance, exceptional service; and the role of physicians on hospital boards.

Executive briefings are planned on topics such as incentives for improvement, healthcare reform and hardwiring organizations. Other sessions are dedicated to information technology, chronic disease management and leadership during crises. Attendees also will hear presentations from Alan Greenspan, former chairman of the Federal Reserve, and a federal relations forum with leaders from Congress and the Administration.

However, the most important events are the times set aside to meet with the state’s Washington delegation and their key aides on health matters. The AHA will host a reception for congressional aides Monday evening, May 7; and on Wednesday, May 9, attendees from each congressional district will meet as a group with their respective congressman in his Capitol Hill office. Following those meetings, the AHA group will host a luncheon for Senators Blanche Lincoln and Mark Pryor.

Meeting and registration information has been mailed to American Hospital Association members, or you may register online at www.aha.org. Please fax a copy of your meeting registration form to Beth Ingram at the Arkansas Hospital Association (501-224-0519) to receive special mailings detailing Arkansas events. You may also email attendance plans to bingram@arkhospitals.org.

Tax Relief Legislation Includes Medicare, Medicaid Provisions and Temporary Pathology Billing Solution

President Bush on Dec. 20 signed into law the Tax Relief and Health Care Act, which prevents a scheduled cut in Medicare payments to physicians for 2007, and implements a 1.5% bonus incentive for physicians who participate in a voluntary quality reporting system. Lawmakers approved the legislation Dec. 15 during the waning hours of the 109th Congress.

The legislation also established the maximum Medicaid provider tax rate at 5.5%. Medicaid regulations previously allowed states to tax hospitals, nursing homes and pharmacies up to 6% of their gross revenue. The administration had proposed reducing the maximum tax rate from 6% to 3%, which would have reduced the scope of a proposed Medicaid cut by some $3 billion over five years.

On a hospital workforce issue, the legislation extended for two years the State 30/J-1 Visa Waiver program, which allows state health agencies to hire up to 30 foreign physicians annually to practice in rural and inner-city communities that often have difficulty recruiting physicians. The State 30/J-1 Visa Waiver program expired June 1, 2006. Without the reauthorization, physicians who have entered the U.S. on J-1 visas since June 1 could not have received a waiver to remain in the country after their training is completed.

“We have trouble getting doctors to practice in rural areas that need them and this program is incredibly important for rural health,” Rep. Earl Pomeroy (D-ND) said during House
consideration of the bill in December. “Without this program, you will have hospitals without doctors … you will have lives lost.”

Among other provisions, the legislation:
- Extends for one year the requirement that Medicare pay labs directly for the technical component of physician pathology services furnished to hospital patients. It also continues reasonable cost reimbursement for outpatient lab payments for rural hospitals under 50 beds,
- Extends Section 508 of the Medicare Modernization Act, which allows for geographic reclassification for six months. It also reduces the annual update by 2 percentage points for outpatient services provided by hospitals and ambulatory service centers that fail to report certain quality measures, starting in 2009, and
- Includes a one-year extension of the Mental Health Parity Act, which requires insurers to treat coverage of mental and physical health disorders similarly. The law requires insurance companies to place at least equal annual and lifetime benefit dollar caps on mental health services with physical health services.

To be clear, the pathology legislation is for a one-year duration. A more permanent solution is currently being sought by a joint collaboration of the American Hospital Association and national pathologists’ groups (at the suggestion of the Arkansas Hospital Association). What is desired is a solution continuing to allow the technical component to be reimbursed directly.

The Arkansas Hospital Association reports excellent support from Arkansas’ congressional delegation on this healthcare package, specifically on the pathology issue.

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**AHA Hosts American Hospital Association in Discussion of National Healthcare Policy**

The Arkansas Hospital Association hosted an informative overview and spirited discussion on national healthcare policy Feb. 20 at the Embassy Suites in Little Rock. American Hospital Association board member Tucker Bonner, President and CEO of King’s Daughter’s Hospital in Temple, TX, presented the program. The purpose of the Arkansas meeting, similar to those being held with hospital associations and their members in all 50 states, was to create an opportunity for hospital association members to help develop and recommend a unified healthcare policy to policy makers in the nation’s capital.

A key element of the presentation focused on the need to promote wellness among America’s citizens, rather than pay the costly hospitalization and clinic fees accrued when patients do not take care of themselves, allowing chronic illness to intensify.

Other elements included forging better relationships among all care-giving entities to reduce duplication of medical services and enhance patient care, creating accountability systems related to improvement of quality, safety and efficiency, resulting in better value for America’s patients, enabling health IT and the expectation of portable electronic health records to enable better access to patient information, and a plan to create universal health insurance coverage in a format that would be supportable by Congress, the president, and all Americans.

To show the complexity of building such a healthcare policy, a “stakeholders’ wheel” was developed, showing the most-often mentioned participants in the nation’s healthcare policy discussions.

Other goals highlighted in the discussion included creating a safe care environment in all of the nation’s hospitals, reducing variation in the practice of medicine, reducing patient waiting times, embracing transparency in all areas of healthcare, and promoting wellness.
NPI Reminder: May 22 is Deadline for Obtaining National Provider Identifier

Hospitals are required to obtain a national provider identifier (NPI), which will replace the provider identification numbers that hospitals use today in the Health Insurance Portability and Accountability Act (HIPAA) standard transactions that they conduct with health plans. Any hospital that has not obtained an NPI needs to do so immediately in order to begin the implementation and testing process.

Standard transactions conducted with health plans that will require an NPI include the electronic claim, eligibility inquiry and response, claim status inquiry and response, payment and remittance advice, prior authorization/referral and coordination of benefits transactions.

Providers who conduct any of those electronic transactions must have their NPIs and be ready to use them to identify themselves, and possibly other providers, in those transactions before May 23 this year. Some health plans may be ready to accept NPIs much earlier than May. The health plans will inform hospitals as to when they may begin using NPIs in these electronic transactions.

Providers can obtain NPIs by:

- Going to the Web at https://nppes.cms.hhs.gov and filling out their application online.
- Obtaining a paper application form, filling it out and mailing it to the NPI enumerator. They can obtain the paper application form (CMS-10114) by downloading it from www.cms.hhs.gov/forms or by calling the NPI enumerator at (800) 465-3203 and requesting a copy.
- Submitting an application through electronic file interchange (EFI). EFI allows an approved organization, after obtaining the permission of a provider, to send the provider’s NPI application data in an electronic file.

Continuing through May 22, Medicare will accept the NPI or Medicare provider number (legacy provider number) on the claims it receives from providers. If there is any issue with the provider’s NPI and no Medicare provider number is included on the claim, the provider might not be paid. Therefore, Medicare strongly recommends that providers, clearinghouses and billing services continue to submit the Medicare provider number (legacy provider number) as a secondary identifier until May 22.

Once receiving an NPI, there is no “special process” or any need to call to communicate the identifier to the Medicare program. NPIs can be shared with the Medicare program by using them on your claims along with your legacy identifier. Also, providers applying for Medicare enrollment must provide their NPI on the CMS-855 enrollment application (along with a photocopy of the NPI notification received by the provider from the National Plan and Provider Enumeration System or from an EFI). Existing Medicare providers must provide their NPIs when making any changes to their Medicare provider enrollment information.

However, under current rules, all providers, including Medicare providers that are HIPAA-covered providers, must share their NPI with other providers, health plans, clearinghouses and any entity that may need those NPIs for use in standard transactions, including the need to identify an ordering or a referring physician. Providers should also consider letting health plans or institutions for whom they work share their NPIs for them.

The Centers for Medicare & Medicaid Services (CMS) has posted many documents related to the NPI, including Medicare’s timetable for implementation of the NPI, on its Web page at www.cms.hhs.gov/NationalProvIdentStand.

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Medicaid Posts NPI Reporting Tool

EDS, the state’s Medicaid claims contractor, now has its tool for reporting National Provider Identifiers (NPI) to Medicaid on the Web. The “crosswalk” tool is designed to help providers transition to the NPI by the May 23, 2007 deadline. Hospitals can access it through the provider information portal at the Arkansas Medicaid Web site at https://www.medicaid.state.ar.us.

The tool provides a step-by-step sequence for entering the necessary data so Arkansas Medicaid can recognize providers’ new ID numbers. Hospitals having NPI questions specific to Medicaid should call the NPI Help Desk Numbers: (866) 311-5502 or (501) 301-7611. For more details, go to https://www.medicaid.state.ar.us/InternetSolution/provider/training/training.aspx.
Helpful Monographs for Hospital Governance Boards Now Available

The Center for Healthcare Governance recently released two new monographs for hospital trustees. The first, “Are You Rolling the Dice on CEO Succession?,” by Deborah J. Cornwall and Wilmot J. Gravenslund of The Corlund Group, aims to help trustees navigate the CEO selection process. The monograph contains a Leadership Continuity Risk Management Model to help trustees understand how to effectively define the requirements for a new CEO, assess candidates and approach the final selection process.

The second monograph, “The Board’s Fiduciary Role: Legal Responsibilities of Health Care Governing Boards,” provides a concise explanation of the basic legal duties and obligations of the boards of not-for-profit hospitals. This guidance can be used to support trustee recruitment and orientation, and as a reference tool for existing board members.

To order the monographs, contact the Center at (888) 540-6111 or e-mail info@american governance.com.

The Center for Healthcare Governance is the American Hospital Association’s resource for governance information and tools to promote excellence in healthcare governance.

AHEF Meeting – April 18

William C. Schoenhard, FACHE, chairman of the American College of Healthcare Executives (ACHE), will be the featured presenter at the Arkansas Health Executives Forum (AHEF) spring meeting on Wednesday, April 18. The AHEF is an independent chapter of ACHE. Schoenhard, who is executive vice president/COO of SSM Health Care in St. Louis, Missouri, will discuss “Leaders Who Care.”

The luncheon meeting begins at 11:30 a.m. in the Jackson Room of the Holiday Inn Select located at 201 S. Shackleford Road in Little Rock. The Arkansas Hospital Association will sponsor the luncheon. Program and registration information is available at http://arkhospitals.org/ahef/events.ht m. While there is no registration fee for AHEF members, there is a $10 fee for non-members.

A copy of the AHEF membership application is available by clicking on http://arkhospitals.org/ahef/AHEF%2 0PDFS/2005%20AHEF%20application.pdf. If you send in your application prior to the meeting, there will be no charge for the luncheon.

Register Now for 2007 Southeast Governance Conference

Members of the Arkansas Association of Hospital Trustees have a rare opportunity to meet and share ideas with hospital trustees from other southern states next month when the Southeast Governance Conference convenes April 19-20 at the Renaissance Nashville Hotel in Nashville, Tennessee.

The conference is being co-sponsored by the Arkansas Association of Hospital Trustees (AAHT) and hospital associations in Kentucky, Mississippi and Tennessee. It is an excellent opportunity for trustees who play a major role in addressing challenges that their hospitals face to learn more about issues including reimbursement, medical errors, nurse staffing and charity care.

Two noted healthcare governance leaders, Jamie Orlikoff and Larry Walker, will lead the discussion. Orlikoff will discuss “Trends, Trials and Tribulations: Healthcare in the Future,” reviewing major trends, examining their causes and interconnectedness and providing specific examples of the impact of these trends on the hospital and its leadership. Walker will lead attendees through a “mock” board meeting during “Inside the Boardroom: Diagnosing and Treating Governance Disorder,” in which actual trustees grapple with various issues and challenges, commit “governance malpractice” and suffer from a variety of “governance diseases.” In addition, a representative from the American Hospital Association will weigh in with a federal update.

A program brochure with registration details has been mailed to all CEOs and AAHT members. It is also available at http://www.arkhospit als.org/calendartotal.html. For additional information, please call Beth Ingram at (501) 224-7878.
Arkansas Hospital Association Mourns Passing of Dan Gathright

Members of the Arkansas Hospital Association (AHA), its board and staff lost a great friend and colleague January 25, when Dan Gathright, SVP/Administrator of Baptist Health Medical Center-Arkadelphia, died following a brief illness. He was diagnosed in November 2006 with throat cancer.

Dan had a long and distinguished healthcare career in Arkansas, which included serving as Chairman of the Arkansas Hospital Association in 1996-1997. He was serving as delegate to the Regional Policy Board 7 (RPB) of the American Hospital Association at the time of his death. By virtue of his position on the RPB, he was also a member of the board of directors of the Arkansas Hospital Association. Dan previously served as a delegate for the Southwest District on the AHA board and was president of the Arkansas Hospital Administrator’s Forum in 2005-2006.

Dan had served at the helm of the Arkadelphia facility since 1979, after having held administrative positions at Washington Regional Medical Center in Fayetteville and Crittenden Regional Hospital in West Memphis for seven years. He also was a member of the American College of Healthcare Executives.

He is survived by his wife, Shayron, of 38 years; his son and daughter-in-law and two grandchildren.

Memorial services were held Saturday, January 27 in Arkadelphia. Memorials may be made to the First Baptist Church of Arkadelphia Building Fund.

Dan will be greatly missed by all who appreciated his dedication to his profession, his candor, his humor and his friendship.
Administrator’s Forum/AHEF Summer Leadership Conference to Focus on Healthcare Trends, Challenges and Opportunities

Join your peers for the annual Arkansas Hospital Administrators Forum/Arkansas Health Executives Forum Leadership Conference to be held June 20-22 at the Embassy Suites in Hot Springs National Park.

Highlights of this year’s meeting focus on healthcare trends, diversity and informed healthcare choices. The faculty is highlighted by James “Denny” Shelton, Chairman and CEO of Triad Hospitals, Inc., who will discuss the upcoming challenges and opportunities facing healthcare; and Wayne Sensor, CEO of Alegent Health in Omaha, Nebraska and a former Arkansas hospital CEO, who will discuss Alegent Health’s mission to empower consumers to make informed healthcare choices and improve their health. In addition, Hattie Hill, CEO, and Carole Smith, President, of Hattie Hill Enterprises of Dallas and Little Rock, will focus on leadership for diversity, looking at the business case for developing a culture of diversity and inclusion in our hospitals.

Along with the planned educational activities, Hot Springs offers many opportunities for family entertainment – golfing, shopping, fishing, boating, amusement parks, relaxing baths and spas, antiquing, art galleries and much, much more – which make the return trip to Hot Springs memorable. And, on Thursday evening, there will be a special reception and dinner at beautiful Garvan Woodland Gardens, the University of Arkansas’ Botanical Gardens, in Hot Springs.

Registration information is available at www.arkhospitals.org. Contact Beth Ingram at 501-224-7878 for additional information.

Call for 2007 Diamond Award Entries; Note New Spring Deadline of April 6!

In a departure from the competitions in past years, the 2007 Arkansas Hospital Association (AHA) Diamond Awards Call for Entries is being published early in the calendar year, with an April 6 deadline. The reason for the change from a summer deadline is to eliminate the need for participating hospitals to retain their previous year’s work for more than six months so that it may be entered in the Diamond Awards competition.

The open nominations are cosponsored by the Arkansas Hospital Association (AHA) and the Arkansas Society for Healthcare Marketing and Public Relations. Last year, 16 hospitals received awards presented at the AHA’s Annual Awards Dinner held in conjunction with the AHA Annual Meeting and Trade Show. This year’s recipients will receive their awards during the October 11, 2007 Awards Dinner at the Peabody Hotel in Little Rock.

The 2007 Diamond Awards honor excellence in hospital marketing and public relations, and will be presented in several categories, such as advertising, annual report, Internet Website, publications, special video production, and writing. Diamond Awards (for hospitals with 0-99 beds, 100-249 beds and 250 or more beds) will be presented in each category.

Entries will be judged by a panel of judges not affiliated with any Arkansas hospital. Nominations and entries, accompanied by appropriate documentation, must arrive at AHA headquarters no later than April 6, 2007. A brochure providing details of the awards competition was mailed to hospital CEOs and marketing and public relations directors.

Please call Lyndsey Dumas at (501) 224-7878 with questions about the awards or award process.
A healthy organization feels good when others hit their goals. When I visit an organization, I ask for the names of a couple of the more successful directors. The indicators could be service, quality, finance, people, or any particular indicator.

When I meet with a large group, I make a point to recognize and compliment the successful directors on their specific results. I notice in a healthy organization everybody claps and is excited for the person recognized. If it’s unhealthy, the audience will half-heartedly applaud if the boss is clapping, but they possibly are thinking, "Well, let me tell you what I did better than that person. Or let that person try to run my department." I always point out to the audience that healthy organizations feel good about the success of others.

Once, in Detroit, I had a manager stand up because she really had great outcomes in patient satisfaction. During the break, two other leaders came up to me to let me know that she ran the Mother-Baby Department, and they thought it was easier to achieve high patient satisfaction in that area. It’s not about explaining away success. It’s about how we can learn from those who are succeeding.

Another indicator of an organization’s health is whether the leaders are willing to learn from each other. I was at a large company with several entities spread out across the United States. At a regional meeting I asked the regional manager if any particular location really performed well. Without hesitation, he named the organization and the leader who had the best results in the region. He also noted that this leader had gotten great outcomes consistently for several years.

When I spoke that morning I shared the leader’s results, I asked people from the audience if they were aware of the leader with these outstanding results. Everyone shook their heads, "Yes." Then I asked her, in the last two years, how many people in this room have contacted you to ask how you achieve success or how to benchmark? She said, “none.”

Let me put this in perspective. This was a private company, and most of the leaders had stock in the company. If all leaders in the company get better results, not only would it help the organization, but also personally impact each leader financially.

In the years that I’ve traveled across the country, I’ve noticed that often leaders find it difficult benchmarking internally. They are more comfortable traveling to another organization when the answer may be right around the corner or up one floor.

In healthy organizations, leaders strive to be the best they can be, but they also relish in the success of others. We have to learn to share our successes and be willing to ask others what’s working and why. We don’t want to compare ourselves “out” because we’re all a little bit different. We want to relate ourselves “in,” which means we can all find something that they’re doing that can transfer to our own areas.

Good performers transfer tools, techniques, and teachings to their own area. Poor performers figure out why it won’t work for them. We don’t have to individually reinvent the wheel every day. Instead seek out what’s going right so we can emulate it, copy it, and learn from it and, ultimately, share it with others. After all, we’re all in this together.

Self-Directed Questions:
1. Does your organization share results so it is evident who the more successful leaders are?
   A. If yes, can you share how your organization accomplishes this?
2. Does your organization have a system in place that identifies and standardizes best practices and shares them throughout the organization?

Quint Studer leads The Studer Group, a consulting firm that has helped more than 400 hospitals and health systems improve their service and operational excellence. He is a former hospital COO and the author of Hardwiring Excellence and 101 Answers to Questions Leaders Ask. He serves on the board of the national Healthcare Financial Management Association. He can be reached at www.studergroup.com.
The newly released *Hospital Statistics 2007*, published by the American Hospital Association, shows that utilization for Arkansas community hospitals remained relatively stable between 2003 and 2005, the latest period for which full-year data is available.

Total hospital spending increased at around 3.5% per year for the period. Hospital admissions were off 2.8% from the record levels posted in 2003, while adjusted patient days of care, which translates outpatient visits into patient day equivalents, dropped about 2% in 2004 and again in 2005. However, hospital emergency rooms and outpatient departments continued to get busier, as the state’s hospitals hit a new record with 4.97 million outpatient visits.

The average length of a hospital stay also decreased. In 2003, inpatients averaged 5.38 days in a hospital. For 2005, that went down to 5.27 days, signaling a continued improvement in the clinical management of hospital inpatients and more widespread availability of diagnostic and treatment technology.

The indicator that continues to present the most concern among hospital officials is growth of services provided to under-insured and uninsured patients. The amount of charity care provided through Arkansas community hospitals increased more than 22% from 2003 to 2005 and has been up about 110% since 2000. Total expenses related to deductibles and co-pays not covered by insurance, plus care provided to self-pay patients who can’t afford the out-of-pocket costs, has risen 41% since 2000. The table below compares selected utilization and financial indicators of the state’s community hospitals for 2003, 2004 and 2005.

### Mental Health Parity Act of 1996 Receives One-Year Extension

Before adjourning in December, Congress passed a one-year extension of the Mental Health Parity Act of 1996 as part of the Tax Relief and Health Care Act of 2006. The extension will give supporters of mental health parity legislation another opportunity to pass a parity bill after Congress reconvenes in January.

Proponents tried during the last session of Congress to gain support for the Senator Paul Wellstone Mental Health Equitable Treatment Act, which was intended to prohibit larger group health plans that provide both medical and mental health benefits from imposing greater treatment limits or financial requirements on mental health benefits.

In addition to sponsors Reps. Patrick Kennedy (D-RI) and Jim Ramstad (R-MN), 229 other members of Congress were co-sponsors of the bill and 350 organizations, including the American Hospital Association, supported it.
Those who do not remember the past are condemned to repeat it...

That sounds like a bit of commonsensical counsel that Will Rogers, the cowboy philosopher, might have handed out, but it was another philosopher, George Santayana, who made the observation about a hundred years ago. The gist is that if you don’t learn from your mistakes, you’ll do the same dumb thing again and again. It is good advice that is so practical, so logical...and so frequently overlooked.

Rewind 10 years, to the time when President Bill Clinton signed the Balanced Budget Act (BBA) of 1997. Congress passed the law with the intent of reducing overall federal spending $127 billion between 1998 through 2002. Despite warnings of hospital leaders who knew better, finance wizards at all the federal number-crunching acronym agencies — CBO, OMB and HCFA — projected the Act would cut future Medicare program spending $116 billion.

About $100 billion would be shaved from healthcare provider payments, with hospitals tagged to absorb at least $35 billion of the cuts. Hospitals that operated home health programs, including many small rural hospitals, were in for even greater losses.

By 1999, most government leaders recognized that the BBA’s actual Medicare impact would be far more than projected. Projected hospital losses were tracking at $70 billion, double the original projection, causing service closures and cutbacks as hospitals and other healthcare facilities attempted to wrestle with the BBA’s dramatic reductions.

The “unintended consequences” of the law were so widespread that Congress and the President later agreed to restore about $20 billion of the hospital-related BBA reductions through subsequent laws in 1999 and 2000.

Even so, a study completed later for the American Hospital Association estimated the Act’s final net financial impact on the nation’s hospitals at somewhere in the vicinity of $100 billion. The Medicare Payment Advisory Commission finally acknowledged that the BBA had created great financial stress on many hospitals.

A hidden BBA repercussion was the threat it presented to patient care. A study published in the June 2006 issue of Health Services Research looked into hospitals’ warnings that the draconian Medicare cuts would lead to decreased service provision and lower quality of care.

The conclusion was just what you’d expect: As cuts in reimbursement continue, it will be an ongoing challenge for hospitals to continue to provide high-quality care using fewer resources. Fortunately, the funding restored in 1999 and 2000 helped avoid that situation.

In mid-February of this year, the president released his proposed budget for Fiscal Year 2008. It is supposed to lead to a balanced budget by 2012 and once again tries to do it on the back of the nation’s hospitals. The proposal calls for more than $100 billion in Medicare and Medicaid cuts over the next five years. Seventy-six billion dollars of the total would come from Medicare. Seventy percent of that amount, $53 billion, is targeted to come from hospital payments in one way or another. Based on those estimates, the five-year impact on Arkansas hospitals could climb as high as $260 million.

The BBA and its aftermath are past experiences filled with valuable lessons learned.

Congressional failure to remember those lessons as it prepares its own budget plans would be a costly mistake that could harm hospitals and their patients irreparably.

Worse than not remembering would be to remember the past, but ignore it. It’s up to each hospital to ensure that Arkansas’ members of Congress not only know about the consequences of repeating past mistakes, but also that they do not ignore them.

Decisions made on the budget will affect every Arkansas hospital.

It’s up to Congress to guard against taking a road to a balanced budget that jeopardizes the healthcare safety net. Each hospital has to play a role to ensure that won’t happen and none can afford to be passive about it. If you haven’t already done so, contact your congressman and senators. Urge them to oppose the proposed Medicare/Medicaid cuts and let them know how high the stakes are.

Don’t wait; do it today. It’s that important. •
2006 PAC Contributions Recognized, Appreciated

During 2006, the Arkansas Hospital Association Political Action Committee (AHAPAC) received $49,454.51 in contributions, primarily from hospital executives and employees throughout the state. These donations, which are shared between the Arkansas Hospital Association and the American Hospital Association, make possible the financial support those organizations are able to provide to political candidates seeking state or federal elective offices.

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

Ben Franklin Club membership is awarded for individuals who contributed $1,000 or more to AHAPAC. Capitol Club membership is awarded for individuals who contributed $250 or more to AHAPAC during the year, while the Chairman’s Circle membership is earned with a $500 (or greater) donation.

John Neal, CEO/Administrator of Stuttgart Regional Medical Center is chairman of the AHAPAC. Individuals from Arkansas who qualified for membership in each of these clubs in 2006 are:

**Ben Franklin Club:**
- Phil Matthews, Arkansas Hospital Association

**Chairman’s Circle:**
- Don Adams, Arkansas Hospital Association
- Robert Bash, Bradley County Medical Center
- Roger Busfield, Arkansas Hospital Association, Retired
- David Cicero, Ouachita County Medical Center
- Paul Cunningham, Arkansas Hospital Association
- Dean Davenport, BKD, LLP
- Dan Gathright, Baptist Health Medical Center - Arkadelphia
- Russell D. Harrington, Jr., Baptist Health
- Michael D. Helm, Sparks Health System, Retired
- Tim Hill, North Arkansas Regional Medical Center
- Beth Ingram, Arkansas Hospital Association
- Luther Lewis, Medical Center of South Arkansas
- Ray Montgomery, White County Medical Center
- John Neal, Stuttgart Regional Medical Center
- James E. Newman, St. Edward Mercy Medical Center
- Scott Peek, Chambers Memorial Hospital
- Ron Rooney, Arkansas Methodist Medical Center
- Bo Ryall, Arkansas Hospital Association
- Lee Simpson, The BridgeWay
- Steven Smart, Medical Center of South Arkansas
- Doug Weeks, Baptist Health Medical Center – Little Rock

**Capitol Club:**
- Robert P. Atkinson, Jefferson Regional Medical Center
- Michael Aureli, Arkansas Hospice
- Gary Bebow, White River Health System
- Bill Bradley, Washington Regional Medical Center
- Ben Owens, St. Bernards Healthcare
- Kevin Clement, Summit Medical Center
- Tina Creel, AHA Services, Inc.
- Harrison Dean, Baptist Health Medical Center - NLR
- Vincent DiFranco, Mena Regional Health System
- Bob Gant, Conway Regional Medical Center
- Ray Kordsmeier, Conway Regional Medical Center
- Edward Lacy, Baptist Health Medical Center – Heber Springs
- Jimmy Leopard, Medical Park Hospital
- Mark Lowman, Baptist Health
- C. C. “Mac” McAllister, Ouachita Valley Health System
- Mike McCoy, Saint Mary's Regional Medical Center
- Kurt Meyer, Rebsamen Medical Center
- Larry Morse, Johnson Regional Medical Center
- Barry Pipkin, Universal Health System
- Kirk Reamey, Ozark Health Medical Center
- Nancy Robertson, Robertson Cook Communications, Inc.
- William P. Sennett, St. Edward Mercy Medical Center
- Allen Smith, Baptist Health
- Rosiland Smith, Arkansas Children’s Hospital
- Russ Sword, Ashley County Medical Center
- Elisa White, Kutak Rock
The Medicare prescription drug benefit, officially known as Medicare Part D, was the most salient part of the Medicare Modernization Act (MMA), which was passed in 2003. Part D recently marked the first anniversary of its full implementation.

Hidden Agendas and Flawed Concepts

No one – I hope – would argue that relief from the cost of outpatient prescription drugs wasn’t needed; this was one of the flaws of the original 1965 Medicare legislation, which also excluded coverage of most vision, dental and hearing services. As gerontologist Robert Butler, M.D., later observed, “Medicare is a great program for people under the age of 50.”

So the need was there. Unfortunately, MMA was not exactly a landmark statute in the annals of good health policy-making. It was extremely complex – many senators and members of Congress later confessed that they had not read all (or, in some cases, any) of its more than 700 pages – and it included several peculiar provisions.

Among these were a prohibition on Medicare’s negotiating with pharmaceutical firms for lower prices, thus guaranteeing a very costly program, and government payments to private employers to keep them from dropping retiree health benefits. Beneficiaries would no longer be allowed to purchase Medicare supplemental policies that included prescription drug coverage; the pharmaceutical benefit would have to be separate. In an effort to get beneficiaries to sign up as soon as possible, financial penalties were imposed on those...
who missed the deadline and wished
to sign up later—an odd feature for a
voluntary program.

And although the program would
pay most of the first $2,250 of pre-
scription drug costs, a coverage gap,
colloquially known as the “doughnut
hole,” forces beneficiaries to pay 100
percent of the cost of drugs between
$2,250 and $5,100. Congress found
it necessary to configure the benefit in
this weird way because they were told
by the Bush administration that the
program could not exceed $400 bil-
lion over 10 years; that was what had
been budgeted. Well, as it turns out,
the Centers for Medicare & Medicaid
Services (CMS) officials knew at the
time that it would cost a great deal
more; the CMS chief actuary, who
knew the truth, was ordered not to
inform Congress that the real cost
would be $5.34 billion. A 2005 report
by the Congressional Budget Office
estimated the cost at $849 billion.
The current estimate is around $700
billion, but obviously, no one knows
for sure.

The law also contained many
incentives for Medicare beneficiaries
to join private health insurance plans,
rather than sticking with traditional
Medicare and purchasing separate
“stand-alone” drug coverage. This
was by design; the hidden agenda of
the statute was privatization of
Medicare by herding beneficiaries
into private plans. President Bush had
previously sought to force beneficiar-
ies to join private plans if they want-
ed drug coverage. That flopped, so
Congress contented itself with rigging
the market. The law allows private
plans to negotiate for lower drug
prices, but not Medicare itself, and
allows the plans to cover the “dough-
nut hole.” Private plans can offer
broader coverage and lower premi-
ums than Medicare is allowed. The
bias is not subtle.

**A Rush to Implement**

The program was to begin imple-
mentation in 2005, which gave the
government less than two years to
put into place a very complicated,
multifaceted program. To say that the
launch was less than stellar is an
understatement. Information provid-
ed to beneficiaries by Medicare rep-
resentatives was incorrect more than
half the time, and private insurer rep-
resentatives’ accuracy ranged from
20 percent to 60 percent, according
to the Government Accountability
Office. Booklets mailed to beneficiar-
ies contained glaring errors. The
Medicare Web site was difficult to
use. Information on the prices of
drugs in different plans was largely
unavailable.

And the number of choices was
overwhelming – hundreds of them, from comprehensive HMOs offering lavish coverage to bare-bones “stand-alones." Premiums differed. Information about what was actually covered was inadequate and often misleading. Whether a product was a “stand-alone” or a full private insurance plan was not exactly clear, to put it mildly. The truth about the “doughnut hole” was often conveniently withheld. Many beneficiaries were completely mystified. A USA Today poll in October 2005 found that 61 percent of beneficiaries did not understand the benefit; an Associated Press poll in January 2006 found that true of two-thirds of beneficiaries.

Private insurers pulled out all the stops trying to sign people up. United Healthcare partnered with the AARP to be its “preferred” drug plan, although AARP members were not informed of this “special relationship.” AARP spokesman Mark Carter said of the obvious conflict of interest in an organization purporting to objectively represent seniors making a deal with a private insurer, “We try to be objective and at the same time not turn away business.” Yeah, and it was just a coincidence that when the MMA legislation was in danger of not passing, AARP gave it a ringing endorsement.

Not to be outdone, Humana partnered with Wal-Mart and sent buses all around the country to recruit seniors; PacifiCare ran ads featuring Fred and Ethel from the “I Love Lucy” program. Most health plan advertising did not disclose that the product was full HMO membership, not stand-alone coverage. Private plans made special deals with pharmacy chains to get their offerings promoted. Goodies abounded; plans offered free gym memberships, discounted vision services and acupuncturette coverage. Part D regulations prohibit door-to-door solicitation or use of cash inducements, but health plans engaged in both.

United Healthcare and Humana ended up with the lion’s share of the enrollees. Surprise, surprise. Meanwhile, 6 million low-income, ill beneficiaries known as “dual eligibles” because they had both Medicare and Medicaid coverage became the focus of a tug-of-war between the states and the feds. The states wanted the feds to pay for these beneficiaries’ Part D coverage; the feds wanted the reverse. Eventually this population was automatically enrolled in Part D, but states were required to repay the federal government for much of the cost. That is still a bone of contention.

On the front lines, there were also major problems. Glitches in the Medicare computer system prevented pharmacies from getting timely information on beneficiaries’ status, so prescriptions were not always filled or beneficiaries had to pay out of pocket. At least 19 states had to step in and pay for needed prescription drugs for beneficiaries who had coverage, but could not prove it. Eventually CMS ordered private insurers to provide a 60-day supply of needed medications to beneficiaries who had signed up until things could be sorted out.

In addition, with the coming of Part D, some pharmaceutical firms ended their programs of providing free or subsidized products to low-income people, leaving some of those people with no immediate means of obtaining medications.

In August, CMS mistakenly sent refund checks to 230,000 Medicare beneficiaries to reimburse them for their Part D premiums. When the error was recognized, CMS asked the beneficiaries to send the money back. That provoked a firestorm, and CMS relented and let the beneficiaries keep the money. And despite repeated efforts to address the problem, 50,000 beneficiaries who chose to have their Part D premiums deducted from their Social Security checks are still being billed the wrong amount.

To its credit, the Bush administration admitted that the launch had been rocky and sought to address some of the problems.

Needless to say, critics – Democrats, consumer groups and sometimes conservatives – were relentless. Many people were angry; some were downright furious. Those on the right complained about the cost of the program. Democrats condemned the inept implementation and the “doughnut hole.” Consumer groups carped about almost everything. Law-
suits were filed and largely dismissed. The press was also less than kind. The *Kansas City Star* editorialized, “It is hard to believe that even the federal government could have done such a terrible job in launching the new Medicare drug benefit.” The *Binghamton Press & Sun-Bulletin* noted, “Medicare D might well go down as ‘D for Disaster.’” Even the conservative *Salt Lake Tribune* condemned Part D as “a government-sponsored scheme to direct your business to one of dozens of private insurance plans that are supposed to be available in your area, which probably cover some of the medications you need and which might, if you are both lucky and good, actually save you money over the old system... [The Bush administration] should be expected to take the blame for mixing up the worst possible combination of public and private functions to produce a mess greater than either the government or the business sector could have produced on its own.”

**Who’s on First?**

The deadline for enrollment for 2006 came on May 15. Even before then, CMS was claiming large numbers of people had joined the program; these “progress reports” were required by law. Unfortunately, CMS chose to trumpet the total number of seniors with drug benefits, most of whom already had them, and failed to mention that the 6 million “dual eligibles” had been automatically enrolled. Its January 2006 report announced that 24 million people were already in the program—pretty good, given that most enrollment had begun only two weeks earlier. In the fine print, the report admitted that only 3.6 million people had signed up for Part D.

These misleading reports—which were released monthly—led to more carping by critics and demands from Democrats for hearings.

How do things stand today? Of course, it depends on to whom you talk, but CMS reported in June, after the signup deadline, that 11.5 million people had enrolled. In August, CMS announced that 24.7 million seniors had prescription drug coverage, but at least half did not obtain it through Part D. That left some 11 million without drug coverage, many of whom were thought to be low-income and/or healthy persons not taking prescription medications.

In September of last year, two competing estimates concerning the “doughnut hole” were released: The Democrats said 7 million people had entered it; the Republicans said 3 million.
Despite all the turmoil, the fighting, the problematic launch and ongoing problems, most Medicare beneficiaries who joined Part D seem relatively content. In July, the Kaiser Family Foundation reported that 80 percent of beneficiaries were satisfied with their coverage, although 34 percent had encountered problems. A September survey by the Medicare Rx Education Network found 82 percent of beneficiaries satisfied with their plans, although 25 percent had not saved any money through Part D and 29 percent found it “frustrating.” A Wall Street Journal/Harris Interactive poll in November found that 70 percent of respondents had reduced prescription drug costs and 82 percent did not find their plans difficult to use.

**What Now?**

The bottom line on Part D’s first year is not complicated. Millions of people now have coverage for prescription drugs for which they previously had to pay out of pocket, and most are enjoying cost savings. The attempt to privatize Medicare through enrolling most beneficiaries in private plans has not succeeded so far. And just about everyone has learned valuable lessons about how to implement a complex program in a short time frame – and how not to.

What can we expect now? CMS announced several changes for the next enrollment period, which began on Nov. 15, 2006. In an effort to cut down on the avalanche of competing plans, private insurers will be limited to offering only two products each. Private insurers will still be allowed to partner with other organizations such as pharmacies, but marketing materials must state that “other pharmacies/physicians/providers are available in our network.” In type large enough to read, I hope.

CMS also stated that the average Part D premium will remain at $24 for 2007, a claim immediately disputed by California Congressman Henry Waxman (D), who said premiums would rise by 13.2 percent. In November, the consumer advocacy group Families USA released a report claiming that premiums for plans that cover “doughnut hole” costs will rise by 87 percent. CMS responded that the report was “distorted and incomplete.”

Looking down the road a bit farther, one consequence of Part D could well be a further erosion of retiree health benefits, which are already in virtual free fall. Some employers have told retirees that if they enroll in the program, they will lose all employer-sponsored health benefits. These include Boeing, General Motors, Caterpillar, Verizon and AT&T. Furthermore, should government payments to employers to keep them offering retiree benefits dry up, we can expect that even more companies will simply stop offering those benefits. As it is, only 35 percent of large employers do, and most report that they plan to reduce or eliminate them in the future.

And, as always, there are the politics involved. Most polls indicated that Part D was not a huge issue in the November election. That doesn’t mean it will be flying below anyone’s radar. The Democrats won control of both the House and the Senate. Given that the new House speaker, Nancy Pelosi (D-CA), attended a rally at which AARP members burned their membership cards in protest of AARP’s support of MMA, we can expect more scrutiny of the program and investigation of some of its more interesting features. Furthermore, Pete Stark (D-CA) now chairs the House health subcommittee. He has said he wants to create a government-run prescription drug plan within Medicare, a program he likes a lot. Ted Kennedy chairs the Senate health committee, and he likes traditional Medicare a lot, too.

Democrats are already on the record as wanting to allow Medicare to negotiate lower drug prices for its beneficiaries. They have also criticized CMS for the new 2007 Medicare beneficiary handbook, which they say is heavily biased toward private health plans as opposed to traditional Medicare – a slant that should surprise exactly no one.

But the Bush Administration isn’t going anywhere, and this will hardly be a veto-proof Congress; even Stark admits that much of what might be accomplished will be “tinkering.” We can also expect that House and Senate Republicans will be as vocal in expressing their views about Part D as the Democrats were when they were out of power.

**What Have We Learned?**

We have learned a great deal from Part D’s first year. I will mention only six key lessons:

- The policy process is messy and loaded with hidden agendas; more honesty and public disclosure would help.
- Implementing large, complex, expensive programs takes time and should not be rushed, no matter the political situation.
- Oversight of new programs should be competent, sincere, timely and free of political bias.
- When things go wrong, problems should be recognized and addressed; denial only causes more harm.
- Accurate data collection and reporting, and honest analysis thereof, are essential for improvement.
- The oldest lesson of all: The devil is in the details.

The question is: Can we keep the political rhetoric down to a dull roar and do what is necessary to improve this program, or will we just be treated to more squabbling, accusations, misinformation and stonewalling, at least until the 2008 election is over? I dunno. Stay tuned. ●

Emily Friedman is an independent health policy and ethics analyst based in Chicago. She is also a regular contributor to H&HN OnLine. This article is copyrighted, and is used with permission.
Quality Conference

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CMS Letter Addresses DRA Obligations

The federal Centers for Medicare & Medicaid Services (CMS) sent a December 13 letter to all state Medicaid directors containing guidance on their obligations under the Deficit Reduction Act of 2005 (DRA) to implement certain education requirements for providers and others who receive at least $5 million a year in Medicaid payments. The law took effect January 1, 2007, with states given until March 31 to bring their plans into compliance, unless the Secretary grants an extension. The states also are expected to incorporate the requirements into provider enrollment agreements.

The guidance specifies that providers need to establish and disseminate written policies for all employees and certain contractors or agents. The policies are to include detailed information on federal false claims laws and similar state laws, and detailed information about the provider’s policies and procedures for detecting and preventing fraud and abuse. If the provider has an employee handbook, it should include a discussion of the laws detailed in the written policies, the fraud prevention policies of the provider, and the rights of employees to be protected as whistleblowers. CMS did not create model language for provider policies or handbooks, though it says the states may do so.

Read CMS’ letter at http://www.aha.org/aha/content/2006/pdf/061214-6032.pdf. Further information on the DRA requirements and compliance resources to assist hospitals in developing these policies is available at http://www.aha.org/aha/issues/Medicaid/resources.html. If you have questions, please contact Maureen Mudron, Washington counsel for the American Hospital Association, at mmudron@aha.org or (202) 626-2301.

American Hospital Association Opposes Proposed Medicaid Rule

The American Hospital Association (AHA) has strongly urged Congress to stop the Centers for Medicare & Medicaid Services (CMS) from implementing a rule proposed on January 12 that would reduce Medicaid funding by $3.8 billion over five years and significantly disrupt care delivered through Medicaid programs around the nation.

In a January 16 statement, the association called on the Bush Administration to work with Congress and hospitals to properly protect and improve Medicaid rather than bypass needed input and propose drastic changes through a regulatory process.

Last year, the Administration proposed cutting $12.2 billion from Medicaid in its fiscal year (FY) 2007 budget, of which $5.8 billion would have affected hospital payments directly – $2 billion in cuts from lowering the allowable provider tax rate from 6% to 3% and $3.8 billion in cuts from limiting payments to government safety-net hospitals through capping payments, redefining eligible public hospitals and restricting intergovernmental transfers (IGTs).

Congress put the brakes on efforts to reduce the provider tax by codifying in the Tax Relief and Health Care Act of 2006 the maximum tax rate at 5.5% for five years. The new proposed rule includes the remainder of those budget-cutting steps.

Specifically, the proposed rule would:
• Cap payments to government providers at no more than the cost of providing health services to Medicaid beneficiaries, undermining hospitals’ ability to subsidize care for uninsured people.
• Limit federal matching dollars for legitimate Medicaid expenditures by public safety-net providers by redefining “public hospitals,” limiting the type of government hospitals that are eligible to certify public expenditures and restricting many states’ use of certified public expenditures to offset Medicaid losses incurred by hospitals.
• Further curb state Medicaid “financing practices,” making the legal, appropriate use of IGTs as a Medicaid financing tool more difficult.

The AHA believes that the Medicaid program deserves a thoughtful, deliberative reform process that ensures the nation meets its obligation to care for the neediest of our society and that it should not be changed expeditiously through the regulatory process. The AHA is developing a legislative strategy to stop CMS from moving forward with the cuts and will continue to work with Congress, the National Governors Association, member hospitals, and national and state association partners to oppose CMS’ proposed rule.
According to an American Hospital Association analysis, Arkansas hospitals could lose up to $260 million over a five-year period, if Congress eventually approves President Bush’s proposed federal budget for fiscal year 2008. The proposal, released February 5, calls for total nationwide Medicare and Medicaid cuts of more than $100 billion between FYs 2008 and 2012.

About $76 billion of the proposed entitlement cuts would come from Medicare. Total hospital losses could exceed $53 billion nationwide.

Payments to hospitals and health systems would be cut through a combination of reductions or eliminations in market basket updates and phasing out of bad-debt reimbursement to hospitals, hospital-based skilled nursing facilities, home health agencies, and hospices. The president also proposes the elimination of duplicate Indirect Medicaid Education payments to hospitals for Medicare Advantage patients, yet does not propose reducing funding to private Medicare Advantage plans despite the Medicare Payment Advisory Commission and other experts indicating these plans are paid at least 10% above what fee-for-service Medicare reimburses.

More than $25.7 billion in proposed Medicaid cuts would result from cutting federal funding for certain children already covered by the State Children’s Health Insurance Program (SCHIP). That would eliminate federal funding for children in families with income over 200% of the federal poverty level. Plus, the budget proposal would eliminate Medicaid funding for Graduate Medical Education.

In keeping with plans expressed in the State of the Union Address, the president also proposes stripping federal Medicare and Medicaid Disproportionate Share Hospital (DSH) funding from safety net hospitals.

Click on http://www.aha.org/aha/content/2007/pdf/CMS-medicare-FY08.pdf for more details on the budget proposal.
CMS Launches Year-Long Home Health Quality Improvement Campaign

The Centers for Medicare & Medicaid Services has launched a yearlong campaign to reduce acute-care hospitalizations for home health patients, improve clinical outcomes, and raise patient satisfaction. Hospital-based and other home health agencies are encouraged to participate in the Home Health Quality Improvement National Campaign by registering online.

Best practices on reducing avoidable acute care hospitalizations will be shared monthly, and each participating home health agency can select the strategies that best support their organization. Participants also will receive CMS reports comparing their actual and risk-adjusted acute care hospitalization rates to national and statewide benchmarks.

Go to http://www.home-healthquality.org/bbh/ for more information, including online registration.

LTCH Rule for 2008 is Proposed

The Centers for Medicare & Medicaid Services (CMS) on January 25 released its proposed rule governing the long-term care hospital (LTCH) prospective payment system for the 2008 rate year. The net impact of the proposed rule, which was published in the February 1 Federal Register, is negative 2.9%, or a reduction of $117 million. That includes increasing the LTCH standard payment by 0.71% to $38,356.45, a 3.2% market basket increase and a coding reduction of -2.49%.

The rule would expand the “25% Rule” to all LTCHs, regardless of type, applying a payment reduction to referrals from a host hospital to co-located LTCHs for referrals that exceed a specific threshold (25% of admissions upon full transition for most affected LTCHs). CMS also proposes re-weighting the LTCH payment categories in a budget-neutral manner to align the LTCH payment system with others under Medicare, beginning October 1, 2007.

In addition, CMS wants to expand the short-stay outlier policy by adding a new payment alternative. Patients with a length of stay less than or equal to the comparable length of stay for general acute hospitals, plus one standard deviation, would be paid the inpatient rate; other short-stay cases would fall under the current policy.

Go to http://www.cms.hhs.gov/LongTermCareHospitalPPS/downloads/cms-1529-p.pdf to find the proposed rule.
Medicare Conditions of Participation Announced

The Centers for Medicare & Medicaid Services (CMS) published a final rule in the November 27, 2006 Federal Register revising requirements in the hospital conditions of participation (CoPs) for completion of history and physical examinations, authentication of verbal orders, securing medications and completion of post-anesthesia evaluations.

The new rule addresses concerns of the healthcare community that the old regulations were outdated and unduly burdensome.

This final rule will ensure that CMS requirements are consistent with current standards of practice to provide hospitals and practitioners greater flexibility in meeting the needs of patients, and to reduce unnecessary regulatory burden for hospitals. The rule became effective January 26, 2007.

Medicare Advantage Information Available on Web Sites

In 2003, the Medicare Modernization Act, which also created Medicare’s Part D prescription drug coverage, changed Medicare Part C plans from Medicare+Choice to Medicare Advantage (MA). At the same time, the Centers for Medicare & Medicaid Services changed certain rules by allowing private insurance companies to offer three basic types of MA plans: health maintenance organizations (HMOs), preferred provider organizations (PPOs) and private fee-for-service (PFFS) plans.

The PFFS plans have proved to be the most popular enrollment choice, especially in rural states.

PFFS plans cover Medicare benefits, much like Medicare HMOs and PPOs, except PFFS plans do not have a formal or required network of providers, PFFS plans do not require referrals, and PFFS may charge higher cost sharing for certain healthcare services than the original Medicare program. Plans may let providers charge the beneficiary up to 15% above the plan’s payment for service. Since there is no formal network of providers, it is the responsibility of the beneficiary to verify that the provider will accept the PFFS payment for services.

As more MA plans offer PFFS plans and as more beneficiaries enroll in them, healthcare providers have a growing number of questions. For information that may help to answer some of those concerns, click on: http://www.cms.hhs.gov/PrivateFeeforServicePlans/Downloads/benqa.pdf, http://www.cms.hhs.gov/PrivateFeeforServicePlans/Downloads/provqa.pdf or http://www.medicare.gov/Publications/Pubs/pdf/10144.pdf.
Healthcare Coalition for the Uninsured
Asking for Congressional Action

At last count, nearly 47 million Americans are uninsured. Most of them rely on their local hospital as the healthcare safety net for themselves and their families. Nationwide, hospitals spent almost $30 billion in 2005 on services to uninsured and underinsured patients who can afford to pay nothing or a very small part of the cost of the care they receive.

That total grew around 30% between 2000 and 2005. In Arkansas, those costs exceeded $300 million, with a 25% growth rate for the same period.

More importantly, the absence of coverage is a significant barrier to getting people the right care, at the right time, in the right setting and it is also an underlying reason why healthcare premium costs to employers and individuals are continually rising. Those are just a few reasons behind a January 18 announcement by a coalition made up of the American Hospital Association (AHA) and 15 other national organizations that they plan to work together to significantly expand insurance coverage to the nation’s uninsured population.

The groups, collectively known as the Health Coverage Coalition for the Uninsured (HCCU), pledged to jointly push for Congress to act on a two-phased consensus proposal.

The first phase will be on a “Kids First Initiative” to make it easier for parents to enroll their children in public programs like Medicaid or the State Children’s Health Insurance Program, to give states additional funds to cover new beneficiaries, and provide tax credits to families to purchase private coverage. The second phase focuses on uninsured adults and would give states the flexibility and funds to expand Medicaid to all adults with incomes below the federal poverty level. To see a list of coalition members and to learn more about the HCCU, visit www.coalitionfortheuninsured.org.

Innovative Program for Small Businesses Will Allow More Employee Coverage

Last March, the Arkansas Department of Health and Human Services (DHHS) obtained federal approval for a new program to allow the state to offer an innovative health insurance program for uninsured employees of small businesses. The approval made possible a unique partnership between the state and federal governments, employers and families for a safety net health plan designed to provide needed coverage for low-income employees at an affordable price.

The plan, ARHealthNet, is now being marketed across the state. ARHealthNet is available to businesses with 2 to 500 employees who have not offered a group health plan in the past 12 months or longer. The plan is only available to working Arkansans through qualified employers and is not available as an individual plan. All employees enrolled in the plan will receive immediate benefits with no waiting period upon initial enrollment of the group. Benefits will be available to everyone in the group regardless of any pre-existing medical conditions.

DHHS, the sponsor for ARHealthNet, selected NovaSys Health as the plan administrator and payment rates are the same as NovaSys rates.

For more information on ARHealthNet, including eligibility requirements, benefits, brokers, a provider directory and a downloadable brochure, visit http://www.ARHealthNet.com.
Continuous governance knowledge building can be the difference between a high-performance, high-impact board of trustees and a board that does not fully tap into its leadership potential. In an effort to offer education to Arkansas hospital trustees in a variety of ways, the Arkansas Hospital Association (AHA) is sponsoring a series of one-hour online education programs that will deliver the governance knowledge hospital trustees need right into their boardrooms.

The innovative distance-learning package features a Microsoft PowerPoint NetConferenceTM program presented over the Internet and using a simple speaker phone. Subscribers call a toll-free 800 number and simultaneously log onto a Web page that displays the presentation.

Trustees and hospital administrators then listen as they watch the presentation on a screen in the boardroom just as they would in a live presentation.

All programs are presented by governance expert Larry Walker, president of The Walker Company, a Lake Oswego, Oregon-based health-care management consulting firm.

Programs are being presented monthly, and are economically priced at $169 per program. In addition, CDs of the program, complete with both the PowerPoint presentation and audio, are also available (one week following the program date) for $169 each. Or, you may purchase online participation and a CD of the program for only $219.

By purchasing the CD, programs may be shown at the convenience of the board and administration or viewed individually by trustees at a later date. Arkansas hospital CEOs have received via email an announcement of the series and registration details for the series.

Sessions remaining include:
- April 24: Raising the Bar: Using Board Self-Assessment to Increase Leadership Effectiveness
- May 29: Governance Accountabilities and Opportunities in the Quest for Quality
- June 26: The Community-Centered Board: Building Connections, Strengthening Value
- July 24: Best Practices in Medical Staff Alignment
- August 28: Practical Prescriptions for Improving Governance Health and Wellness
- September 25: Under the Microscope: Governance Leadership Strategies in the New Era of Transparency
- October 23: Supercharging Your Hospital Governance Committees
- November 20: Governing Leadership Essentials for a Complex Health Care World
- December 18: Tough Leadership for Tough Times: Governing Through the Storms of Change

Subjects covered in earlier sessions were “Building Trustful Governance in Turbulent Times,” and “The Board’s Role in Strategic Planning,” and “Building Bonds: Pathways to Better Board/CEO Relationships.”

For additional information or questions about the online governance education series, please contact Beth Ingram at (501) 224-7878 or email at bingram@arkhospitals.org.
The connection between satisfied, productive and committed employees and the leadership of qualified and capable managers is well established in practice and in research. Studies of employee turnover show that the direct relationship with the supervisor is the No. 1 reason staff members leave their current positions. Additional studies confirm the influence of managers, underscoring the supervisor's ability to create an environment of mutual trust, respect and open communication as a key driver of employee commitment.

In line with these findings, the Arkansas Hospital Association's Mid-Management Certificate Series builds on the premise that managers represent the hospital and are the primary factor for determining an employee's desire to work for that hospital. At the same time, AHA understands that individuals who move into management positions want to succeed and do well, yet often have had little assistance in developing leadership skills and competencies. In response, the Mid-Management Series exists to improve management skills and abilities of managers with the overarching objective of increasing retention of managers and front-line staff.

**Series dates and topics include:**

**April 25**
Leaping from Staff to Management: You're a Manager...Now What?
The success of any organization depends in large measure upon a cadre of management leaders whose perspective, knowledge and skills are continually updated. Whether new to the role of manager/leader or a seasoned veteran, this session has been designed to help participants keep pace with management and leadership practices consistent with today's ever-changing work environment.

**April 26**
Leaping from Staff to Management: You're a Manager...the Next Steps
Continuing the theme of the April 25 program, and whether new to the role of manager or a seasoned veteran, it is important to periodically step back to review realistic and workable techniques for managing and leading people. In doing so, we can more confidently go about our business, knowing that we are keeping pace with management and leadership practices consistent with today's complicated healthcare environment.

**May 15**
Behavior-Based Interviewing: Getting the Right Person for the Right Job
Healthcare managers are increasingly more responsible for the hiring decisions within their departments and services. These decisions are extremely important since, once hired, the individual will not only be depended upon for their technical skills, but also as a personal asset to the team and a citizen of the hospital community. In their urgency to fill staffing gaps, too many managers are quick to hire based upon a review of the technical qualifications and their “gut” feeling about the person. Behavioral interviewing operates on the premise that the most accurate predictor of future performance is past performance in similar situations. This program will focus on the nature and dynamics of behavioral interviewing and allow participants to practice new skills in using this effective technique.

**August 8**
Creating a Retention Climate and Preventing Union Organizing
Healthcare organizations today face four key realities regarding registered nurses: Demand for RNs is increasing as the population ages; availability of RNs is decreasing as fewer nurses are available to replace those reaching retirement or leaving the profession; current nursing educational programs do not have enough capacity to handle the demand for professional nurses; and RNs are becoming more militant, often unionizing to fight the effects of stressful working conditions and cost containment efforts. This session offers a contemporary look at these key realities and suggests strategies to create a retention culture where union representation is not desired. Current trends in union organizing and strategies to prepare for and respond to unionization attempts also will be addressed.

**September 21**
Financial Skills for Healthcare Managers
Like it or not, healthcare has become a business. Resources are scarce and stretched to the breaking point. Doing more with less is routine. The need for sound business/financial management tools – survival skills – is paramount. This session will provide participants with those tools, including planning and budgeting, financial analysis and resource maximization, all of which are essential if managers are to achieve the institution’s mission and contribute to “bottom line” results.

**October 25**
Dealing with Conflict
Conflict is inherent in any environment. Leaders must be able to deal...
Q. Did you know that Private Fee-for-Service (PFFS) health plans pay you rates based on Original Medicare?
A. You just submit the bills to Humana, and we will pay for the services.

Q. Did you know that no contract is necessary with Humana to treat our PFFS members?
A. You see your patients as you do today. Nothing changes but whom you bill.

Q. Did you realize the billing process is similar to what you experience today with Original Medicare?
A. Humana’s PFFS plan follows all Original Medicare medical policies and reimbursement methodologies.

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GH 18901 1/06
FEMA Providing NIMS Implementation Help

The Federal Emergency Management Agency (FEMA) has announced two courses to help hospital personnel with implementation of the National Incident Management System (NIMS), which was developed so responders from different jurisdictions and disciplines can better collaborate to respond to natural disasters and other emergencies.

According to FEMA information, IS-100.HC, “Introduction to the Incident Command System (ICS) for Healthcare/Hospitals,” describes the history, features, principles and organizational structure of ICS and should be completed by hospital personnel who would have a direct role in emergency preparedness, incident management and/or emergency preparedness.

IS-200.HC, “Applying ICS to Healthcare Organizations,” is designed to enable healthcare personnel to operate efficiently during an incident or event within the ICS and should be completed by personnel whose primary responsibility is emergency management.

Completion of these or equivalent courses is among the activities required for hospitals that wish to become NIMS compliant.

A more detailed description of NIMS implementation activities for hospitals can be found at http://www.fema.gov/emergency/nims/compliance/assist_non_govt.shtml.

While all hospitals are encouraged to take steps toward becoming NIMS compliant, hospitals that receive federal preparedness funding through the Health Resources and Services Administration’s National Hospital Bioterrorism Preparedness Program must implement certain of these compliance elements in FY 2006, including the completion of IS-100 and IS-200.

OSHA Issues Pandemic Flu Guidance

The Department of Labor’s Occupational Safety and Health Administration (OSHA) issued a February 9 workplace safety and health guidance that will help employers prepare for an influenza pandemic. Developed in coordination with the Department of Health and Human Services (HHS), Guidance on Preparing Workplaces for an Influenza Pandemic provides general guidance for all types of workplaces, describes the differences between seasonal, avian and pandemic influenza, and presents information on the nature of a potential pandemic, how the virus is likely to spread and how exposure is likely to occur.

Under the president’s National Strategy for Pandemic Influenza Implementation Plan, the Labor Department is responsible for promoting the health, safety and welfare of employees and providing guidance to assist employers in protecting the health and safety of employees during a pandemic.

The guidance gives recommendations for employee protection for each of the four levels of anticipated risk and includes engineering controls, work practices and use of personal protective equipment such as respirators and surgical masks and their relative value in protecting employees. It also encourages employers to prepare a plan to deal with a depleted workforce during a pandemic.

To read the guidance, go to www.osha.gov/Publications/OSHA3327pandemic.pdf.

Guidance Recommends Actions During Pandemic Flu Outbreak

The Department of Health and Human Services (DHHS) and its Centers for Disease Control and Prevention has released new guidance to help states, local leaders and individuals take appropriate measures in the event of a flu pandemic. Because a vaccine is unlikely to be available for the first six months of a pandemic, the guidance offers various strategies to slow its spread.

The strategies include asking sick people and those who live with them to stay home, dismissing students from school and closing daycare centers for up to three months during severe pandemics. They also recommend closing large public gatherings, changing workplace environments and shifting work schedules without disrupting essential services.

The guidelines incorporate a Pandemic Severity Index modeled after the hurricane-rating system that ranges from 1 (moderate severity) to 5 (most severe). The agencies also released new radio and television public service announcements encouraging people to learn more about a potential flu pandemic by going to http://www.pandemicflu.gov. See http://www.pandemicflu.gov/plan/community/community_mitigation.pdf.
Upgraded National Incident Management System Under Review

The Department of Homeland Security (DHS) is coordinating a comprehensive review of the National Response Plan (NRP) and National Incident Management System (NIMS) to assess their effectiveness and identify improvements. The review process, which includes participation from all levels of stakeholders, commenced in October 2006 and is scheduled to conclude by June 1, 2007.

The NIMS is a key element in the national framework for domestic incident management. It provides a nationwide template that enables federal, state, local and tribal governments, the private-sector and non-governmental organizations to work together efficiently and effectively to manage the consequences of domestic incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property.

As part of the review process, stakeholder groups have been asked to participate in two formal comment periods on both documents to ensure their effectiveness as national doctrine for incident management. Work groups representing all levels of stakeholders have been working diligently, under a very compressed timeframe, to develop a first draft of the NIMS document, which was to be released for national comment February 1 – 19, 2007. Due to the tight time constraints, the work groups focused on resolving key concepts, rather than technical edits.

For a copy of the draft document under review go to the link below. (This is a large download.)
http://www.dhs.gov/xprepresp/programs/gc_1170278871831.shtm

Arkansas Flu Pandemic Plan Template Available

Anyone choosing to disregard continued warnings about a coming flu pandemic is making a potentially fatal mistake. Flu pandemics don’t occur like clockwork, but they do pop up about every 40 years and it’s been 39 years since the last outbreak in 1968. While there may be no immediate or clear and present danger, the experts agree that the odds of pandemic flu are extremely high. There is no question that one will occur. The mysteries are when and where it will happen. Because of the likelihood of such a disastrous event, Arkansas hospitals should begin preparations now. A good first step is available in a new Arkansas hospital pandemic planning template.

The Arkansas Hospital Association and four Tier 1 hospitals in Little Rock (Arkansas Children’s Hospital, Baptist Health Medical Center–Little Rock, Central Arkansas Veterans Healthcare System and UAMS Medical Center) worked with the state Division of Health to begin preparations for a template to be used by all hospitals in the state. The draft template was finalized in December by representatives from those hospitals along with hospital representatives from each region of the state who made up the Arkansas Hospital Pandemic Task Force. The template, which gained Division of Health approval February 20, is consistent with federal and state guidelines and incorporates use of the Hospital Incident Command System.

Every Arkansas hospital CEO has received both a hard copy of the template and an electronic version to distribute to appropriate individuals in the hospital. The overall goal of this template is to provide a standardized plan that would be consistent across the state and that would be effective in responding to avian flu or any other novel strain of influenza or other comparable communicable disease.
Checking Arkansas Hospital Quality Online: The New Hospital Consumer Assist Web Site

On December 21, 2006 the Arkansas Hospital Association (AHA) officially rolled out its new hospital transparency Web site, Hospital Consumer Assist (http://www.hospitalconsumerassist.com). The site was created to provide basic demographic, quality and pricing information on Arkansas hospitals and to serve as a factual starting point that promotes discussions among consumers, providers and insurers.

It reflects the commitment by AHA’s member hospitals to openness in the reporting of both prices and quality indicators to provide Arkansas health-care consumers with an additional decision-making tool specific to hospitals throughout the state. Prior to going public, the AHA previewed Hospital Consumer Assist December 20 before members of the Joint Legislative Committee on Public Health.

Reports contained on the Web site reflect the average prices that individual hospitals charge Medicare for 25 different kinds of inpatient hospital stays, which capture about 75% of all such cases that Medicare covers. The prices are based on claims data from the federal government’s Medicare Provider Analysis and Review (MedPAR) tapes. The quality reports show how the hospitals compare nationally and statewide on each of 20 quality measures developed by the Hospital Quality Alliance and posted on the Centers for Medicare & Medicaid Services’ Hospital Compare Web site. All information will be updated as new data resources become publicly available.

EDUCATION

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effectively with conflict and learn how to shape and mold people’s differences for team productivity. This program embraces the often prickly topic of conflict and disagreements and how best to achieve personal and organizational goals when conflicts arise.

October 26
Leadership Essentials: Building Influence and Credibility
Understanding the driving forces impacting change in one’s organization causes increased importance on understanding the role of the manager and leader. Leaders must employ building blocks of credibility and the means/techniques needed to build and sustain that credibility. Management is about dealing with the complexity of work whereas leadership is about dealing with change and influencing others toward goal accomplishment. This session provides an overview of best practices in management, leadership and organization development thought and practice.

November 16
Getting Results: Be an Inspirational Facilitator, Trainer and Coach
Inspiring employees is a difficult job. Encouraging them to take risks and unleash their individual potential to increase productivity is even more difficult. In this session, managers will learn how to understand what motivates coworkers and how to enhance their performance as well as how the manager’s role actually creates and sustains an organization’s environment. Participants will learn appropriate methods of improving managerial skills to get desired results while supporting and ensuring positive change within an organization.

Series and workshop information has been mailed to AHA members. It is also available on the AHA Web site at www.arkhospitals.org/calendar. Please contact Beth Ingram at 501-224-7878 for additional information.
IHI Expands the 100,000 Lives Campaign; Arkansas Hospitals Participating

The Institute for Healthcare Improvement (IHI), the American Hospital Association and other healthcare groups have embarked on Phase 2 of the 100,000 Lives Campaign with the announcement of an initiative to prevent five million incidents of medical harm nationwide over a 24-month period ending December 9, 2008.

The Arkansas Hospital Association (AHA) Board of Directors enrolled the association as a participant in the expanded 100,000 lives campaign. As a participating organization, the AHA works with the Arkansas Foundation for Medical Care (AFMC), the primary organization in Arkansas providing implementation and communication support for Campaign hospitals in the state.

The groups’ 5 Million Lives Campaign asks U.S. hospitals to adopt up to 12 interventions to prevent harm, including the six that were adopted by hospitals participating in the IHI’s 100,000 Lives Campaign.

The six new interventions are focused on preventing methicillin-resistant staphylococcus aureus (MRSA) infections, reducing harm from high-alert medications, adopting Surgical Care Improvement Project interventions, preventing pressure ulcers, improving care for congestive heart failure and getting hospital boards of directors more involved in quality improvements.

As the campaign continues, the IHI is offering a series of national calls to provide additional information on the initiative, education on new interventions and opportunities to keep improving work on the six interventions that were at the heart of the original 100,000 Lives Campaign.

Go to http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=7 for detailed information.

Arkansas 5 Million Lives Campaign Kick-Off

The formal kick-off for the 5 Million Lives Campaign in Arkansas took place March 14 in Little Rock. The Arkansas Hospital Association is working in conjunction with the Arkansas Foundation for Medical Care (AFMC), the state’s Medicare-designated Quality Improvement Organization, to enlist hospitals that choose to be a part of this national initiative which works to improve medical care by significantly reducing current levels of morbidity and mortality in U.S. hospitals. Twenty-seven Arkansas hospitals are already fully committed to the project.

The kick-off program featured IHI officials Joe McCannon, vice president and campaign manager; Jonah Borrelli, central region field coordinator; Kathy Duncan, RN, faculty lead for rapid response teams and pressure ulcers; and Pam Brown with AFMC. The agenda included an overview, preview of new interventions, question and answer session, and the opportunity to network with colleagues. Hospital leaders and quality professionals from across the state attended the event.

In addition, two town hall sessions in Searcy and Hot Springs took place where hospital staff learned about campaign updates and status reports, intervention success stories, barriers to implementation, and tips and tactics for success. The town halls were held at White County Medical Center in Searcy and St. Joseph’s Mercy Health Center in Hot Springs. Approximately 15 hospitals participated in the sessions to gain more information about the program and to share their experiences.

St. Joseph’s Mercy Health Center and Arkansas Children’s Hospital in Little Rock have achieved mentor status with the IHI’s 5 Million Lives Campaign. Both hospitals provide excellent resource opportunities for other hospitals just beginning in the campaign initiative.

For more information about the program, contact Pam Brown, hospital team leader at the Arkansas Foundation for Medical Care, at 501-212-8710.
By now, most Arkansas health care professionals have become familiar with quality measurement using national performance standards derived from clinical practice guidelines. For several years, Medicare has been using such “quality measures” to help determine the rates of provision of critical and widely recognized steps in the care of acute myocardial infarction, congestive heart failure and several other conditions. Now, to emphasize the importance of comprehensive high-quality care for each patient, Medicare is going one step further, bundling measures for specific conditions to create a new reporting framework known as “appropriate care measurement.”

**Focus on a bigger picture**

Health care quality improvement has seen many advances in recent years. We have gone from educating ourselves about the clinical science behind performance measurement to creating systems change, ensuring that critical steps in the care of patients with specific clinical problems are delivered consistently and reliably.

Most clinicians now recognize the existence of specific interventions that nearly all patients with a given condition should receive upon presentation. For example, patients with acute myocardial infarction should receive beta-blockers and aspirin on admission unless there are contraindications. Because of the importance of these fundamental steps, we have been measuring our performance in reliably delivering these specific elements of care to the patients who need them. The resulting data are reported as component measures.

Researchers at Duke University have found that institutions frequently providing all or nearly all of the recommended steps of care on presentation with a specific illness, most notably myocardial infarction, have lower mortality rates than facilities with less consistent delivery of all the recommended components. Thus, emphasis is now shifting toward composite measurement, based on provision of all the recommended components of care to each patient.

Medicare’s composite measures, termed “appropriate care measures,” or ACMs, bundle the components of care for a particular service and examine how many patients received all the recognized components of care. The component measures have been used for national measurement for years and are familiar to Arkansas health care providers. The new appropriate care measures will reflect the percentage of patients who received all the recognized components of care for that condition. (Patients with contraindications are not included in the measure.) High performance on several components of care, combined with a low performance on a single element, can result in a low score on that ACM.

As clinical performance measurements continue to evolve, reimbursement incentives for top-performing institutions are likely to emerge. ACMs will likely become the basis for...
many pay-for-performance activities in the hospital sector. Focused activity now could result in increased clinical revenue in the near feature.

**Arkansas performance: ACMs present new challenges**

In Arkansas, our statewide performance on component measurement sets has gradually improved. However, when component measures are bundled into ACMs, performance ratings can drop considerably. (See Figure 1.) For instance, on the majority of pneumonia component measures that make up the pneumonia composite measure, Arkansas is above the national average. However, under the new reporting framework, our performance for pneumonia care is not much higher than our performance for cardiac care, a category that has historically been problematic for our state.

AFMC analytic staff members have examined the performance of Arkansas hospitals to estimate current ACMs for pneumonia, acute myocardial infarction, and congestive heart failure both statewide and by individual institution. Performance varies widely by region. Table 1 shows the ACM ratings for AMI, heart failure and pneumonia care by region. The hospitals in the southeastern quadrant of the state have lower ACM scores than those in other parts of Arkansas, especially in the care of patients with heart failure.

Over the past two years, AFMC staff have prepared radar graphs (Figure 1) showing the individual hospital performance on the components of a composite measure and on the ACM as a whole. This format can help increase performance on ACMs by promoting activity to bring all components closer to 100% compliance rates.

**Help is available**

Appropriate care measures have become one focus of the Arkansas Foundation for Medical Care’s regional collaborative area learning sessions (CALS). AFMC is also providing information about the new surgical care improvement measures, which include greater use of DVT prophylaxis, and improvements in postoperative care such as tight glucose control after cardiac surgery and maintenance of normothermia after colorectal procedures. Help is available, free of charge, with Medicare’s other new areas of emphasis, such as adoption of health information technology, facility culture change to improve workforce retention, and strategies to effectively treat ethnically diverse clinical populations.

In addition to statewide efforts, AFMC is working with 33 hospitals for more focused activities on specific aspects of care, including treatment for heart attack, heart failure, pneumonia, and prevention of surgical infection. Recent data show that participation in AFMC’s intensive work groups can result in increased improvement. (Golden WE, Heft M, Brown P, Dyer P. Intensive participation accelerates clinical improvement. *Journal of the Arkansas Medical Society*. June 2005, 101:12; 360-361.)

Institutions desiring closer clinical support in their efforts to raise their performance on the ACMs should consider joining forces and sharing strategies and successes with AFMC to improve the care of hospitalized patients in Arkansas.

To find out more about appropriate care measures, Medicare’s new priorities for quality improvement and the Arkansas Foundation for Medical Care’s free guidance and support, call 1-877-375-5700, visit [www.afmc.org/acms](http://www.afmc.org/acms) or e-mail hospital@afmc.org.

*This article was submitted by the Arkansas Foundation for Medical Care. An earlier version originally appeared in the *Journal of the Arkansas Medical Society*. Spring 2007*.

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**Table 1: 2nd quarter 2006 ACM rates by region**

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<tr>
<th></th>
<th>Central Region</th>
<th>Northeast Region</th>
<th>Northwest Region</th>
<th>Southeast Region</th>
<th>Southwest Region</th>
<th>Statewide</th>
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<tr>
<td>AMI</td>
<td>78.22</td>
<td>84.21</td>
<td>85.25</td>
<td>81.69</td>
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<td>Heart Failure</td>
<td>81.59</td>
<td>88.69</td>
<td>83.45</td>
<td>73.38</td>
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<td>Pneumonia</td>
<td>63.87</td>
<td>76.84</td>
<td>76.81</td>
<td>67.68</td>
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<td>All Three Topics</td>
<td>75.21</td>
<td>83.11</td>
<td>81.32</td>
<td>72.42</td>
<td>75.96</td>
<td>78.44</td>
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**Figure 1: 2nd quarter 2006 pneumonia ACM radar graph**
Joint Commission on Accreditation of Healthcare Organizations Announces Name Change

The Joint Commission on Accreditation of Healthcare Organizations in January announced the launch of its new brand identity in a “Dear Colleague” letter to all accredited organizations.

The new identity includes a new name (The Joint Commission), redesigned Web site and new tagline (“Helping Health Care Organizations Help Patients”). The “Jayco” extranet also has a new name (The Joint Commission Connect) and can be accessed by clicking on the Joint Commission Connect logo.

Questions about the new brand or suggestions for improving the organization’s accreditation activities should be emailed to Brand@jointcommission.org.

CMS Launches Physician Quality Reporting Web Site

The Centers for Medicare & Medicaid Services’ 2007 Physician Quality Reporting Initiative (PQRI) Web page is now available. The quality initiative was authorized under the Tax Relief and Health Care Act of 2006, which the president signed last December. PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare physician fee schedule services. Visit [http://www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri) on the CMS Web site for more information on the 2007 PQRI.

Nursing Performance Measures to be Tested

The Joint Commission will use a grant from the Robert Wood Johnson Foundation to test whether nursing performance measures endorsed by the National Quality Forum are reliable and feasible for hospital use and improve the quality of patient care. The measures address patient outcomes, nursing-centered interventions and system factors related to quality and safety. They will be tested during the next two years at hospitals that have volunteered to participate in the project. The accrediting organization expects the testing will yield a set of refined technical specifications that can be used by hospitals nationwide and by quality initiatives such as the Hospital Quality Alliance.
NATIONAL HOSPITAL WEEK
May 6-12

National Hospital Week (NHW) will be celebrated this year during the week of May 6-12. This annual celebration, which began in 1921 to alleviate public fears about hospitals of the day, has expanded to include activities sponsored by hospital facilities across the nation. Today, through promotion and participation, National Hospital Week is the nation’s largest healthcare recognition program.

Activities during the week are aimed at emphasizing and recognizing the thousands of healthcare workers and other employees who keep the nation’s hospitals going from day to day and who make a difference in their communities. The theme for 2007 is “Care You Can Count On. People You Can Trust.”

Hospitals throughout Arkansas are encouraged to support these efforts by sharing information with local media outlets and community members and by planning activities to recognize the week and acknowledge staff members. The American Hospital Association has distributed to its member hospitals a guide that includes information to assist them in planning, posters promoting National Hospital Week and a listing of other products available for purchase.

Hospitals interested in additional materials should call 1-800-822-1923. To access the NHW planning guide, or to order promotional products, visit the online store at http://www.imprintmall.com/hospitalweek/. ●
**Number and Age of U.S. Registered Nurses Growing**

The number of licensed registered nurses in the U.S. grew 7.9% between 2000 and 2004 to an estimated 2.9 million, according to final survey results released by the Health Resources and Services Administration. That’s up from 5.4% growth between 1996 and 2000, according to the quadrennial survey.

More than 41% of RNs were 50 or older in 2004, up from one third in 2000. “While we are encouraged by the growth in the number of RNs, we are concerned about the aging of the nursing workforce and how this will impact the future supply of nurses,” said HRSA Administrator Betty Duke.

More than 83% of licensed RNs were employed in nursing in 2004, the highest rate since 1980. Average annual earnings for RNs were $57,785, a 14% increase since 2000 after adjusting for inflation. The findings are posted at www.bhpr.hrsa.gov.

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**Coalition Sponsors Public Education Campaign**

The Coalition to Protect America’s Health Care is sponsoring a public education campaign of television and radio ads urging Congress to reject President Bush’s proposed cuts to Medicare and Medicaid. The proposed cuts would take away about $75 billion in future spending on hospital care, including approximately $260 million from Arkansas hospitals, threatening access to healthcare services for everyone, especially children, seniors and the disabled.

A copy of the ads and placement schedule, which includes Washington, D.C., national cable and several local radio markets, are available at http://www.protecthealthcare.org. All of the ads provide a toll-free telephone number through which the public can contact their member of Congress. The coalition of hospitals, businesses and hospital associations funds public education advertising to put issues affecting America’s hospitals and health systems at the top of the nation’s healthcare agenda.

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**ABN Revision**

A notice was published in the February 23 Federal Register on a revised version of the general Advance Beneficiary Notice (ABN). Public comments are requested during the 60-day comment period and will be considered as part of finalizing the revised ABN.

As required by Section 1879 of the Social Security Act, the ABN is used to inform beneficiaries of potential financial liability, except in home health care and inpatient hospital settings. Formerly, the Centers for Medicare & Medicaid Services (CMS) maintained two versions of the ABN, a general and lab-test specific version. But with this revision, CMS proposes to combine these two versions of the ABN into a single notice meeting both needs.

Other proposed changes are described in the Web site posting. Physicians, practitioners, providers and suppliers already required to use ABNs will continue to use the currently approved ABN until the revised notice is finalized and approved.

To view the announcement and requirements for submitting comments in the Federal Register, go to http://frwebgate4.access.gpo.gov/cgibin/waisgate.cgi?WAISdocID=12213020595+0+2+0&WAISaction=retrieve.

To obtain copies of the ABN and supporting documents, go to: http://www.cms.hhs.gov/PaperworkReductionActof1995.

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