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Edition 50
The Ultimate Gift

Today, tomorrow, and every day, 18 Americans will die before getting a life-saving organ transplant. That’s almost 6,600 people who, in the next twelve months, will breathe their last breath waiting for a lung, liver, kidney, pancreas, or heart that will never come. More than 87,000 are on the transplant waiting list, a list that grows daily. That’s why I’m eager to tell you about a man that meets my definition of a real American hero.

A Hero’s Story

A young Oklahoma physical therapist was riding his motorcycle recently when he had an accident that left him paralyzed from the neck down. He was unable to speak, but could communicate with his family and with his trauma center medical team by blinking, smiling, and moving his eyes to spell out words on a letter board. Using this means, he “discussed” his case with his physicians and came to clearly understand that he had no chance of a full recovery.

An energetic and adventurous health professional, the man found life under these circumstances to be unacceptable. After consulting with his family, he signaled that he wanted to end his active care. Wanting his death to count for something, he requested that his family broach the subject of organ donation with the medical team. Options were explained, including “donation after cardiac death” (DCD), which had never been performed in Oklahoma. The young man smiled and blinked, “Yes, DCD is what I want.” There was absolutely no question that both he and his family understood the consequences of his decision.

With his family, this courageous, generous young health professional planned his own funeral, including a “party” in celebration of his life. After making these preparations, he told his family goodbye and was taken to the operating room accompanied by a chaplain, nurse, and physician who stayed with him from the time life support was withdrawn to the moment death was pronounced. The organ recovery team then entered and salvaged the young man’s organs and tissue. Two kidneys and his liver were soon transplanted, giving new life to three people he had never met.

The Most Personal Decision

What is so different and, in my opinion, heroic, is that this health professional made a conscious decision as to how he would live and die, and in dying, improve and extend the lives of others. In the vast majority of cases, it is the family that grants permission to take organs at death, a decision usually based upon what they think their loved one would have wanted, or upon the patient’s having previously communicated his wishes, perhaps on his driver’s license.

Organ donation after cardiac death, or DCD, as occurred with our Oklahoma hero, is relatively rare, but becoming more common. Before the introduction of brain death laws in the 1960s and 1970s — the early days of transplantation — DCD is considered only after the family has decided to withdraw life support. Like donations after brain death, the DCD option can bring comfort during a time of grief and allow a family to begin the healing process, knowing that their loved one’s organs can live on in as many as four or five people.*

Of the estimated 25,000 Americans who will die this year under circumstances conducive to organ donation, only 5,000 will actually donate. Lack of education about the subject and a hesitancy to approach potential donors and their families too often stand in the way of the program’s growth. That’s why Congress passed the Required Request Act of 1987 which calls for hospital staff to discuss the concepts of organ and tissue donation with the family of any patient that could be considered a potential donor.

Many Arkansas hospitals, physicians, and nurses work closely with the Arkansas Regional Organ Recovery Agency (ARORA), an organization that provides organs and tissues for life-saving and life-enhancing transplantation. Medical teams assist ARORA by identifying potential organ donors and then gently, sensitively approaching their families to make them aware of organ donation options.

Your hospital’s medical team, and you, personally, can help spread the word about the life-giving gift of organ donation. As you do, many more potential heroes like the young physical therapist from Oklahoma may decide to offer life to many after one life has ended. By spreading the word, you are facilitating miracles. You become a partner in offering the ultimate gift.

James R. Teeter
President and CEO
Arkansas Hospital Association

*The first DCD transplant to be performed in Arkansas was at UAMS in December 2004. There are three organ transplant centers in Arkansas – Arkansas Children’s Hospital, Baptist Health Medical Center, and UAMS Medical Center, all located in Little Rock. All three centers perform heart and kidney transplants. UAMS also performs pancreas transplants and has applied for approval to perform liver procedures. Medical centers throughout the state perform tissue transplants, including bone and cornea.
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Education CALENDAR

April 7, Little Rock
Arkansas Association for Medical Staff Services (AAMSS) Spring Conference

April 8, Little Rock
Arkansas Organization for Nurse Executives (AONE) Spring Conference

April 20, Little Rock
Arkansas Association of Hospital Trustees (AAHT) Conference
Holiday Inn Presidential Center, Little Rock

April 27-29, Hot Springs
Healthcare Financial Management Association (HFMA) Workshop

April 29, Little Rock
Arkansas Healthcare Human Resources Association (AHHRA) Spring Conference

May 5-6, Hot Springs
Arkansas Association for Healthcare Engineering (AAHE) Annual Meeting and Trade Show

May 6, Little Rock
Arkansas Health Executives Forum

May 11-13, Hot Springs
Society for Arkansas Healthcare Purchasing and Materials Managers (SAHPMM) Annual Meeting and Trade Show

May 20, North Little Rock
Hospital Emergency Preparedness Vendor Fair

June 3, Little Rock
Fred Lee’s “If Disney Ran Your Hospital—Some Things You’d Do Differently”

June 9, Little Rock
Compliance Forum

June 15-17, Orange Beach, Alabama
Administrators Forum Summer Leadership Conference

July 15, Little Rock
Arkansas Organization for Nurse Executives (AONE) Summer Conference

July 28, Little Rock
Arkansas Society for Directors of Volunteers (ASDVS) Summer Workshop

Program information available at www.arkhospitals.org

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John A. Guest has been named CEO of Sparks Health System in Fort Smith, following the System’s engagement of QHR for hospital advisory services. Guest has more than 20 years of healthcare leadership experience, having served as president/CEO of Harris County Hospital District in Houston, TX and as president/CEO of University Health System in San Antonio. He is a past-chairman of the Texas Hospital Association.

Governor Mike Huckabee has named Angelico Cabantac, administrator of St. Vincent Doctor’s Hospital in Little Rock, to the Advisory Board for Perinatal Health Services. His term will expire November 15, 2006. Cabantac replaces Susan Barrett, president and CEO of St. Mary’s Hospital in Rogers.

Tim Shea has been named Medical Center Director of the Central Arkansas Veterans Healthcare System in Little Rock. He succeeds George “Buzz” Gray who left in August to direct the Veterans Integrated Service Network 8 in Florida and south Georgia. Dr. Nick Lang has been acting director since Gray’s departure. Shea previously was Medical Center Director of the Louisville (Kentucky) VA Medical Center.

David A. Dennis, president of St. John’s Hospital in Berryville, has been elected to the AHA board of directors representing the Northwest Hospital District. Dennis succeeds Donnie Frederic who resigned his position on the board. Frederic has been named CEO of Gulf Coast Medical Center in Wharton, Texas.

Ian Watson has been named CEO of Great River Medical Center (formerly Baptist Memorial Hospital – Blytheville) following the purchase of the hospital by Ameris Health Systems of Tennessee. Watson has more than 11 years of experience in hospital administration, having recently served as COO of Smith Northview Hospital in Valdosta, Georgia.

DeWitt voters overwhelmingly passed a 1.5% sales tax referendum recently that is expected to keep DeWitt Hospital open for at least another decade. The additional 1.5% tax, which brings the local sales tax up to 10.5%, was approved by 80% of voters. Revenue generated by the tax increase will be used to purchase $5.7 million in bonds which will pay off $2.7 million in hospital debt and provide subsidies for daily operations for several years. Darren Caldwell, CEO, told the AHA that the vote “will make a big difference in the solvency of the hospital and the sanity of the CEO.”

Herbert K. “Kirk” Reamey III, administrator/CEO of Magnolia Hospital, was recently elected to fill a term as a Section for Small or Rural Hospitals delegate to the American Hospital Association Regional Policy Board 7. Reamey’s term expires December 31, 2005.

Thomas Kinnebrew has been appointed chief executive officer of Helena Regional Medical Center, after having served in an interim capacity for several months. He succeeded Guy Hazlett. Kinnebrew has more than 25 years of healthcare experience, having previously served as assistant chief executive officer at Fannin Regional Hospital in Blue Ridge, Georgia, and chief operating officer at Delta Regional Medical Center in Greenville, Mississippi.

Jennifer Lang, Ph.D., has been named administrator of Methodist Behavioral Hospital in Maumelle. She is one of the founding directors of the hospital and was previously employed as the clinical operations officer prior to being named administrator. Dr. Lang received her Ph.D. in clinical psychology from the University of Tulsa. Previous positions included Assistant Professor of Psychiatry and Neurology at Tulane University School of Medicine and psychologist for the eating disorder inpatient program at DePaul-Tulane Hospital.

Ronny McMahan, chairman of the board of directors for Saline Memorial Hospital (SMH) in Benton, has announced the resignation of president and CEO Jack C. Mitchell. “Jack has made significant contributions in advancing the mission of SMH, highlighted by the opening of the new $9 million Saline Surgery Center,” said McMahan. Jim Richardson has been named interim administrator while a search is conducted for a new administrator. “Our patients can anticipate the same level of quality and dedication they have come to expect from our physicians and hospital staff as SMH continues to improve the health of our community,” said Dan Cartaya, M.D., SMH chief of staff.

David Chumley, CEO of the American Red Cross Blood Services Greater Ozarks – Arkansas Region, has been named CEO of the American Red Cross Missouri – Illinois Blood Service Region in St. Louis. Glen Baker, M.D., the organization’s medical director, has been named interim CEO of the Arkansas Region until a permanent replacement is found.
It’s a new season and a new approach to thinking about what the Arkansas Hospital Association means to its members. In each issue of *Arkansas Hospitals*, you’ll find CEOs, other administrators and people associated with the hospital field commenting on what their AHA membership benefits have brought to their hospitals and communities. You can add to the discussion by emailing AHA Vice President Beth Ingram at bingram@arkhospitals.org.

**Darren Caldwell, CEO**
DeWitt Hospital, DeWitt

“The AHA gives me, the chief executive of a small hospital with limited resources, the timely information that I need to make decisions on a strategic basis, rather than on a reactive basis. Whether the information deals with changes in the CMS, Medicare, Medicaid, and other regulatory agencies, the advantage I gain from qualified input on difficult topics is fantastic. The AHA staff is always helpful with ideas on issues to address, oftentimes using examples of other member’s experiences. This networking could not be possible without an organization whose sole purpose is to promote an industry whose foundation is taking care of people who cannot take care of themselves.

I have no idea what DeWitt Hospital and Nursing Home would be without the AHA, but I do know it is better because of the AHA.”

**Gary R. Sparks, Administrator**
CrossRidge Community Hospital, Wynne

“The Arkansas Hospital Association is a critical resource to hospitals across the state and is especially beneficial to the small, rural facilities that do not have the staff or resources of the larger, urban facilities. The AHA provides essential education, advocacy, and networking benefits to its members, which is key to the enhancement of healthcare services to the citizens of our state. Both the staff and leadership are always personable, professional, and most importantly, effective. Needless to say, I believe AHA membership is a bargain!”

**John N. Robbins, FACHE, President and CEO**
Conway Regional Medical Center, Conway

“I have had the opportunity to work with several state hospital associations and I believe the Arkansas Hospital Association is the best. In today’s challenging healthcare environment, the importance of having a strong association is even greater. The AHA is a very effective advocate for our hospitals. Additional membership benefits include the educational programs and networking opportunities afforded us. Thank you, AHA, for your great support!”

**Vince DiFranco, CEO**
Mena Medical Center, Mena

“The Arkansas Hospital Association is an excellent resource for my hospital staff and for me. I feel this is especially true in a rural, remote area of the state. Having access to timely information through the ‘Hotline’ and legislative updates is invaluable to keep abreast of the latest news with which to educate our medical staff and board. The strength of the hospital voice through the strong and persistent advocacy efforts of the AHA has been very apparent over the past few years as hospitals have had an effective influence on statewide legislation. In addition, the AHA is responsive to serving the educational needs of hospitals by organizing meetings and securing speakers to address the hot topics of the day. Finally, after being in the state for less than four years, it is comforting and reassuring to have such an experienced and cohesive staff as we do at the AHA. The teamwork and mission demonstrated by the Arkansas Hospital Association staff is very much appreciated in the field.”
Healthcare accounting consultant Jeff Johnson and former federal law enforcement officer Jim Kopf will be the featured presenters at the Arkansas Association for Hospital Trustees’ (AAHT) spring conference Wednesday, April 20 at the Holiday Inn Presidential Conference Center in downtown Little Rock. The half-day program, which will begin at 9:00 a.m., is aimed at helping trustees better understand hospital financial statements and the need for implementing effective programs to comply with fraud and abuse guidelines.

Johnson will “demystify” hospital financial statements for trustees by explaining the fundamentals of finance and how to interpret financial information. Both have become key elements to successful management and governance of hospital operations at a time when legal and public impacts of the Enron, MCI, and Tyco financial scandals have had a trickle-down effect on hospitals and other nonprofit organizations. Those cases make it even more important that the boards of nonprofit organizations fully understand the financial information of their organizations in order to carry out their fiduciary responsibilities.

Kopf will take a look at federal enforcement initiatives, which require that “the organization’s governing authority must be knowledgeable about the content and operations of the compliance program and exercise reasonable oversight over it.” Attendance will also help to assure the Office of Inspector General when it asks, “Has the hospital’s governing body been provided with appropriate training in fraud and abuse laws?” In addition, Kopf also will discuss pressure by Congress for the Department of Justice to pursue more criminal and civil healthcare cases.

A workshop brochure with registration information was mailed in mid-February. Because the meeting is targeted to both new and veteran trustees, a registration discount will be provided for hospitals bringing three or more individuals. Call Beth Ingram at (501) 224-7878 with any questions about the workshop.
Progress Report: Arkansas Hospital Preparedness

Arkansas hospitals continue to work through the Arkansas Department of Health (ADH) on emergency readiness projects related to federal grant funding from the Health Resources and Services Administration (HRSA) and the Center for Disease Control and Prevention.

Work is progressing on a statewide, secure computer network for hospitals to develop reporting systems, email connectivity, video conferencing, distance learning and telemedicine. The network will benefit disease surveillance among hospitals, help hospitals communicate with others in their regions, and improve overall communications with the ADH.

Hospital employees are beginning to receive email addresses and hospital bioterrorism coordinators are being asked to determine which piece of the Tandberg equipment (videoconferencing or telemedicine) the hospital would like to order. Most of the equipment should be in place by late summer, with the network fully functional by October.

The Arkansas Hospital Association is working with the Arkansas Department of Emergency Management to offer regional “train-the-trainer” workshops on incident command. Expenses for the workshops will be paid through regional training dollars provided through the HRSA grant.

President Bush’s new budget calls for an expected decrease in federal emergency preparedness funds. In the next few years, Arkansas will be in the “fine-tuning” phase of its preparedness efforts which began three years ago. While there remains much work to be done, Arkansas hospitals are much better prepared for emergencies and acts of terrorism than ever before.

Arkansas Bioterrorism Public Awareness Campaign Unveiled

The Arkansas Department of Health has initiated a new public education campaign designed to make Arkansans more aware of the threat of bioterrorism and what to do to prepare for an attack. The campaign, named “Arkansas BioPrepared,” includes a print advertisement, a Web site and a brochure. A video spot will soon be part of the campaign.

The campaign addresses issues such as the importance of making a family response plan and offers instructions about how to put together an emergency response kit. It also directs readers to the agency’s Web site, where they can find fact sheets on the six “bioagents” that the federal Centers for Disease Control and Prevention have identified as having the most potential to do large-scale damage. These bioagents are anthrax, botulism, plague, smallpox, tularemia and viral hemorrhagic fever. The information contained in the “Resources for Families” section of the site comes from the American Red Cross and the Federal Emergency Management Agency.

Funding for the $453,000 campaign came from the state’s federal bioterrorism grants. Arkansas received $9.3 million in bioterrorism preparedness funding from the Centers for Disease Control and Prevention and $5 million from the federal Health Resources and Services Administration for fiscal year 2004. The Arkansas Hospital Association is actively involved with the Health Department on a number of statewide bioterrorism preparedness activities.

Go to http://www.HealthyArkansas.com/services/bioterrorism/preparedness_program.html to view the information posted on the Web site.

<< We’re Ready to Respond

You Can Be Too.

Being prepared is the key to surviving any disaster whether it’s a bioterrorism attack, a tornado, flood or other natural disaster. The Arkansas Department of Health wants you to be prepared. Here’s how:

1. Make a family plan. Everyone should know what to do, who to call and where to go in case of an emergency. Include medical information, phone numbers and email addresses, television stations and radio frequencies for emergency information.

2. Put together an Emergency Response Kit. Make sure every member of your family knows where it is. Look for our brochure in your community or access this information at our website.

A program of the Arkansas Department of Health

For more information on how you can be ready to respond, visit www.HealthyArkansas.com. Being prepared is your family’s best defense against any disaster.
Proposed 2006 Patient Safety Goals

Accredited organizations have recently submitted electronic evaluations of the Joint Commission on the Accreditation of Healthcare Organizations’ (JCAHO) proposed 2006 National Patient Safety Goals (NPSGs) and requirements. The JCAHO posted the proposed goals on its Web site January 27, and plans to review the evaluations before finalizing the goals for release this summer.

The field review for hospitals includes 16 proposed requirements or language updates to existing goals, six proposed new goals with 20 proposed requirements, and “retirement” of several goals. Missing from the list is bar coding, a goal that was proposed last year for implementation in 2007 but didn’t make the cut for the 2005 goals.

Two goals in place for other accreditation programs are proposed for inclusion in the hospital goals. They include: Reduce risk of influenza and pneumococcal disease in older adults and reduce surgical fire risk.

The six proposed new goals are:
• Create and sustain a patient safety culture.
• Empower patients to become involved in their care.
• Avoid patient harm caused by healthcare worker fatigue.
• Avoid healthcare-associated decubitus ulcers.
• Prevent patient harm from anticoagulants, insulin, and narcotic analgesics.
• Reduce risk of harm due to emotional and behavioral crisis.

Go to http://www.jcabo.org/accredited-organizations/field_reviews.htm to view the complete list.

Leapfrog Group’s Latest Patient Safety Survey Results

The Leapfrog Group has released the results of its latest annual survey measuring hospitals’ progress toward reaching the group’s patient safety goals. Of 1,019 hospitals responding to the survey, 80% have implemented procedures to avoid wrong-site surgeries, and 70% require a pharmacist to review all medication orders before medication is given to patients. Roughly 20% of respondents have fully implemented computerized physician order entry (CPOE) or plan to do so by 2006.

The survey measures hospitals’ use of CPOE, referral of patients for certain high-risk procedures based on volume, staffing of intensive care units with specially trained physicians, and implementation of the National Quality Forum’s patient safety practices.

See the survey results at http://www.leapfroggroup.org.

Reviews on Computer Technologies Used for Medication Dispensing Are Mixed

Computer technologies used to order and dispense medications were involved in nearly 20% of the hospital and health system medication errors reported to U.S. Pharmacopeia’s national voluntary database last year.

Computer entry errors, in which incorrect or incomplete information was entered into a computer system, accounted for more than 27,000 errors, with distractions (56.5%), increased workloads (20.4%) and inexperienced staff (17.9%) cited as contributing factors.

Computerized Physician Order Entry (CPOE), one of the initial three hospital patient safety steps (along with Intensive Care Unit Physician Staffing and Evidence-Based Hospital Referral) recommended by The Leapfrog Group for Patient Safety, was associated with more than 7,000 errors.

However, 99% of errors associated with CPOE did not reach or harm patients, suggesting the technology can reduce the risk of harmful errors, USP concluded.

Automated dispensing devices, computer systems used to store and dispense drugs, were implicated in almost 9,000 errors, most of them involving the wrong dose or drug.

Research by The Leapfrog Group shows that implementing CPOE in all urban hospitals in the US could prevent as many as 907,600 serious medication errors each year. Studies have also shown that CPOE reduces length of stay; reduces repeat tests; reduces turnaround times for laboratory, pharmacy and radiology requests; and delivers cost savings.

To read the entire report online, go to http://www.onlinepress-room.net/uspharm/. 
Arkansas hospitals lost a friend March 19 when state Department of Health director Dr. Fay Boozman died as a result of injuries at his farm in Cave Springs. Dr. Boozman was working to remove stalls in a new barn when part of the structure collapsed on him.

Dr. Boozman, who was named director of the Arkansas Department of Health in 1999, was an outspoken advocate for programs aimed at improving the health status of Arkansans statewide. Under his direction, the Health Department became synonymous with the familiar Healthy Arkansas nickname now attached to it.

He dedicated himself and the Health Department to doing whatever possible to change unhealthy behaviors that plague the state’s population, including smoking, bad dietary habits and the lack of exercise. In addition, Dr. Boozman was an early and instrumental supporter of ensuring that monies Arkansas received from the national tobacco settlement fund were used strictly for health-related programs.

During his tenure, Dr. Boozman worked closely with the Arkansas Hospital Association (AHA) and its member hospitals to resolve concerns about numerous licensure and regulatory issues. He was particularly interested in rural hospitals, helping foster the move by 23 Arkansas facilities to seek and achieve designation as Medicare Critical Access Hospitals.

He also strived to make sure Arkansas hospitals are as well equipped and prepared as possible to respond to emergency situations, whether caused by natural events or related to nuclear, biological or chemical terrorist attacks.

Dr. Boozman earned his medical degree from the University of Arkansas for Medical Sciences, graduating first in his class. He completed residencies in both Pediatrics and Ophthalmology, and worked for many years as an ophthalmologist in the Rogers, Arkansas area. In addition, he earned his masters degree in Public Health through Tulane University in 2001.

He served the state as a state senator from 1995-1998, and the nation as a flight surgeon in the Arkansas Air National Guard from 1971-1979.

At the time of his death he served as president-elect of the Association of State and Territorial Health Officials (ASTHO), and served on the faculty of the University of Arkansas for Medical Sciences College of Public Health. He was a member of the Arkansas Tobacco Settlement Commission, the Child Health Advisory Committee and the Pine Bluff Arsenal Citizen’s Advisory Committee.

Since being named director of the state Department of Health, Dr. Boozman received many awards for his dedication to public health. Included in those awards are the National Public Health Leadership Institute’s 2004 Martha Katz Award, the National Governors Association Award for Distinguished Service to State Government, the Arkansas Public Health Association’s Tom T. Ross Award for Outstanding Service to Public Health, the AIDS Foundation Compassion Award and the Southern Health Association’s Charles Jordan Memorial Award for Outstanding Service to Public Health.

Dr. Boozman will be greatly missed by the Arkansas hospital community.

---

Infection Control Efforts Lack Staff, Money, According to Study

About-one third of hospitals surveyed had less than the recommended ratio of one infection-control staffer per 100 patient beds, and the two largest impediments to better performance in infection control were insufficient resources and a lack of physician support, hospital cooperative VHA said recently.

John Hitt, vice president of clinical improvement at VHA, said the cost of a single hospital-acquired infection can range from several thousand dollars to more than $50,000. Hospital-acquired infections add an estimated $7 billion to the national healthcare bill.
The Kaiser Family Foundation and Harvard School of Public Health recently released the results of a poll showing that Americans rank healthcare as the third most pressing priority for Congress and the president in 2005, behind the war in Iraq and the economy, and on a par with terrorism and national security.

Among respondents’ greatest health-related concerns, 63% said lowering the cost of healthcare and insurance should be a top healthcare priority for their national elected officials, while similar numbers cited making Medicare financially sound for the future (58%) and increasing the number of Americans with health insurance (57%) as top priorities.

The survey found that 60% of Americans think the number of malpractice lawsuits is a “very important” factor in rising healthcare costs. Almost a third (32%) say that the most important factor causing rising malpractice insurance rates is too many lawyers filing unwarranted lawsuits, while 15% say it is the high profits of malpractice insurers; 14% say it is too many patients making unwarranted claims against doctors; and 11% say it is too many doctors making mistakes.

While most of the policy debate has focused on putting caps on jury awards, 9% cite “too many juries making excessive awards” as the most important reason malpractice costs are on the rise. Nearly seven in ten say a law to cap pain and suffering awards would help reduce overall healthcare costs. Just over a quarter of the respondents indicated that reducing malpractice jury awards should be a top priority for the president and Congress. That ranks 11th on the list of healthcare concerns, just ahead of increasing federal funding for stem cell research (21%). Thirty-one percent said they want Congress to allow drugs to be imported from Canada as a top priority, ranking eighth on the priority list. The survey of 1,396 adults was conducted from November 4-28, 2004.

Don’t Wait Until It’s An Emergency

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Leavitt is New HHS Secretary

The U.S. Senate on January 26 confirmed former Utah Governor Mike Leavitt as Health and Human Services (HHS) Secretary. Leavitt replaces former HHS Secretary Tommy Thompson, who in December announced that he would resign after spending four years at the helm of the agency. American Hospital Association (AHA) president Dick Davidson said, “Mr. Leavitt’s leadership, management skills and record of public service make him an excellent choice to lead an agency that touches the lives of nearly all Americans.” Davidson added that the AHA stands ready to work with Leavitt on the many critical issues facing our healthcare system, such as approving professional liability reforms, ensuring adequate funding for Medicare and Medicaid, and adopting information technologies to further enhance quality of care for all patients. Leavitt, who until recently served as Environmental Protection Agency administrator, said his priorities at HHS will include Medicaid reform, healthcare information technology and medical liability reform.

Nursing Enrollments Improve; Shortage Continues

Despite a recent report from the American Association of Colleges of Nursing (AACN) that enrollment in U.S. baccalaureate nursing programs increased for the fourth consecutive year in 2004, the nursing shortage in the U.S. is likely to get worse before it gets better. One reason: schools had to turn away more than 26,000 qualified applicants, primarily due to a shortage of faculty.

Enrollment in nursing schools increased by 10.6% in 2004, down from a 16.6% increase for the previous year, suggesting some nursing schools may have reached the limit in how far they can expand, according to the AACN. The organization expressed concern that growing competition for limited courses could encourage nursing students to change majors as they near graduation.

The situation is further complicated by a recent action of the State Department. As of January 1, the federal government stopped issuing employment-based visas for workers in countries that have exceeded their annual quota for green cards, such as the Philippines, India and China. The new policy will hurt the nurse supply in Arkansas hospitals where there is a 12% vacancy rate in hospital-based nursing positions, according to a report by the Arkansas Legislative Commission on Nursing. That report says that Arkansas needs 1,925 new nurse graduates each year to keep up with demand. In 2004, there were 793 nurse graduates who were licensed.

In a recent letter to members of Congress, American Hospital Association executive vice president Rick Pollack said the move will dramatically curtail the recruitment of foreign nurses and aggravate the serious shortage of caregivers. Pollack encouraged the congressmen and senators to act swiftly to address this imminent change in immigration processing. He wrote, “We urge you to take action now to address an emergency situation that will limit hospitals’ ability to address their workforce challenges and respond to the needs of their patients and communities, and that only legislation can correct.”

CMS Expands Patient Discount Guidance

The Centers for Medicare & Medicaid Services (CMS) has issued additional guidance confirming that hospitals can offer discounts to any uninsured patients, without putting the hospital’s Medicare payments at risk. The agency issued its first set of guidance in February, 2004 and responses from administration officials during a June CMS open door forum led hospitals to believe that offering discounts to any uninsured patient would be permitted and would not imperil Medicare payments.

The new guidance, released in the form of a “Frequently Asked Question,” appears to confirm the information provided to hospitals last June that “individualized determinations of need” are not required to offer discounts to uninsured patients. Go to http://www.cms.hhs.gov/providers/FAQ_Uninsured_Additional.pdf.
FCC Decision Reflects AHA Concerns

The Federal Communications Commission (FCC) announced January 26 that it will delay plans to lift power restrictions on Airport Terminal Use (ATU) frequencies operating in the 460-470 MHz band of Private Land Mobile Radio Services. The decision is based on American Hospital Association (AHA) concerns that relaxing current power limits could lead to harmful interference with wireless medical telemetry equipment. The agency said that it will continue to take steps to protect medical telemetry from interference because the equipment is used to protect safety of life. The FCC in October 2002 proposed lifting the restrictions to improve communications at large airports.

In its report, the agency said it agreed with the AHA Task Force on Medical Telemetry’s contention that allowing higher-powered ATU frequencies into the 460-470 MHz band would have a “negative impact” on wireless medical equipment operating in the band. It said it will delay lifting the restrictions until January 30, 2006, 30 days after an FCC freeze on high-powered users in the 460-470 MHz band expires. The FCC last year extended the freeze on high-powered users in the 460-470 MHz band, as requested by AHA and its American Society for Healthcare Engineering, to allow hospitals sufficient time to migrate into the Wireless Medical Telemetry Service bands set aside for medical telemetry equipment.
HIPAA Security Rule Guidance Paper Issued

The Centers for Medicare & Medicaid Services (CMS) has released one of seven guidance papers on the Health Insurance Portability and Accountability Act (HIPAA) security rule. This paper, “Security 101 for Covered Entities,” offers a basic overview of the security rule, covering topics such as what administrative simplification means, who the rule covers, and who must comply.

The papers are meant to assist providers in understanding the HIPAA security rule — not provide sure-fire compliance methods. “While there is no one approach that will guarantee successful implementation of all the security standards, this series aims to explain specific requirements, the thought process behind those requirements, and possible ways to approach the provisions,” according to the first paper.

Topics for future guidance include:
• Administrative, physical and technical safeguards
• Policies and procedures, and documentation requirements
• Basics of risk analysis and risk management
• Implementation for the small provider

Go to http://www.cms.hhs.gov/hipaa/hipaa2/education/default.asp#securityed to download the first paper and for more information.
Uninsured Policy Manual Available

One of the hottest issues today is how hospitals bill and collect from low-income, uninsured patients. Intense public and legislative scrutiny has brought the issue to a boiling point. It is critical that all hospitals have written charity care policies and clearly communicate them to low-income patients. Equally important, hospitals must report their charity care accurately and consistently.

The California Healthcare Association has published Assisting Low-Income, Uninsured Patients, a guidebook that details a step-by-step process for developing and implementing a charity care policy. It includes relevant state and federal guidance, details charity-care policy components and outlines collection processes, record keeping and documentation requirements for assisting low-income, uninsured patients. Sample policies and a process checklist are also included.

The Arkansas Hospital Association has purchased two copies of the guidebook and is making them available for loan to member institutions. If you would like to borrow a copy for a one-week period, please call Sandra Minor at (501) 224-7878 or email her at sminor@arkhospitals.org. To purchase a copy of Assisting Low-Income, Uninsured Patients for $190, call the California Healthcare Association at (800) 494-2001 or obtain the order form at http://www.calhealth.org/public/pubs/gms/assisting.html.

Medicare Contractor Survey Will Assess Satisfaction

The Centers for Medicare & Medicaid Services (CMS) has initiated a pilot test of a new survey to assess providers’ satisfaction with the services provided by fiscal intermediaries and other Medicare fee-for-service contractors. CMS plans to send the draft survey to roughly 7,400 Medicare providers, including hospitals, in multiple states. The 76-question survey, which CMS estimates will take 22 minutes to complete, asks providers to rate contractors on administrative functions such as provider inquiries, claims processing, appeals, medical review, reimbursement and other areas. The findings will be used to fine-tune the survey instrument before a planned roll out to all Medicare providers in 2006. CMS intends to use the final survey instrument to help contractors improve the quality of their services, and create a performance-measurement standard for contracting purposes.

Hospital Staff Privileging Requirements Should Be Regular, Complete

A recent memo to state survey agency directors from the Centers for Medicare & Medicaid Services (CMS) clarifies that a hospital’s governing body is responsible for ensuring that all practitioners who provide care in the hospital are individually evaluated by the hospital’s medical staff and that they have the appropriate qualifications and competencies. The memo says that a hospital’s governing body must determine which categories of practitioners are eligible to be on its medical staff or to have hospital privileges, and to clearly delineate the scope of privileges for each category of practitioners.

The memo further specifies that hospital medical staff must conduct individual reviews of practitioners at least once every two years to ensure they have the necessary qualifications and demonstrated competencies for the privileges granted — including education, licensure, and current work practice and patient outcomes. Based on medical staff recommendations, the governing body must decide whether to grant, deny, continue, limit or revoke a practitioner’s privileges, and must notify the appropriate state and federal authorities and registries if it has revoked or constrained a practitioner’s privileges.

The memo, effective immediately, instructs state survey agency surveyors to assess whether a hospital’s privileging process complies with CMS requirements. The memo is available at http://www.cms.hhs.gov/medicaid/survey-cert/sc0504.pdf.
HHS Proposes Medicare E-Prescribing Rules

Health and Human Services (HHS) Secretary Mike Leavitt announced January 27 new proposed regulations that will support electronic prescriptions for Medicare when the prescription drug benefit takes effect in January 2006. In his announcement, Leavitt said that the proposed e-prescription rules would set standards to help Medicare, physicians and pharmacies take advantage of new technology that can improve the healthcare of seniors and persons with disabilities.

The proposed e-prescribing regulations would adopt standards for:

- Transactions between prescribers and dispensers for new prescriptions, prescription refill requests and responses, prescription change requests and responses, prescription cancellation requests and responses, and related messaging and administrative transactions.
- Eligibility and benefits inquiries and responses between drug prescribers and prescription drug plans.
- Eligibility and benefits inquiries and responses between dispensers and Part D sponsors.
- Formulary and benefit coverage information, including information on the availability of lower-cost, therapeutically appropriate alternative drugs, if certain characteristics are met.

Electronic prescribing, or “e-prescribing,” enables a physician to transmit a prescription electronically to the patient’s choice of pharmacy. It also enables physicians and pharmacies to obtain from drug plans information about the patient’s eligibility and medication history. It offers a way to improve patient safety and reduce avoidable healthcare costs by decreasing prescription errors due to hard-to-read physician handwriting and by automating the process of checking for drug interactions and allergies.

Participation by physicians in e-prescribing will be optional, but the establishment of standards and steps to encourage the adoption of effective e-prescribing programs will make e-prescribing more attractive.

The proposed rule was published in the February 4 Federal Register. For more information, visit the Centers for Medicare & Medicaid Services Web site at: http://www.cms.hhs.gov.

HHS Signals “Go” on Several New Gainsharing Ventures

The inspector general’s office of the U.S. Department of Health and Human Services (HHS) released advisory opinions in early February that open the door to the possibility of hospitals and physician groups sharing in financial gains resulting from cost-saving measures.

In the opinions, hospitals in Georgia, Pennsylvania and South Carolina were given permission to share with their cardiology groups savings accrued from a new program to use specific supplies during specified cardiac surgery and heart catheterization procedures.

Cost savings projected through use of the specific supplies are $600,000 to $4 million a year, and physicians agreeing to use of the specified supplies will share in up to half of the savings.

In each of the cases examined by HHS, the inspector general’s office said the proposed arrangement would constitute an improper payment to physicians under federal antikickback law, but the office said it would not impose sanctions because of safeguards – such as the transparency of the arrangement and credible medical support – in place for each proposal, according to a February 16 Modern Healthcare Alert.
AHA Meets With Governor Huckabee

Members of the Arkansas Hospital Association (AHA) executive team met in December with Arkansas Governor Mike Huckabee to discuss hospitals’ need for more Medicaid funding. The AHA reviewed with the governor its study conducted by the accounting firm BKD showing that hospitals lost $33 million in 2002 providing inpatient and outpatient services to Medicaid patients.

Based on those findings, the AHA has been seeking support of lawmakers and the administration to add $6.5 million per year to the Medicaid budget. That would generate around $26 million annually, when coupled with federal matching funds, enough to increase the current Medicaid hospital per diem cap from $675 per day to $850 per day. The money is not a part of the current Medicaid budget request, which is now under review.

Huckabee said that he understood the need for the additional funds, noting that local hospitals provide not only vital healthcare services, but also that they are necessary for future economic development across the state. He indicated that competition for state dollars is intense, in light of continuing issues about the funding for public education and school facilities.

While the governor was supportive of the AHA's request, he said his first priority for Medicaid would be to get the additional $200 million the program had requested to keep services at current levels. However, if the dollars can be found, he said that he would do what he could to support the added funding.

Any Willing Provider Law Now Act 490

Arkansas Governor Mike Huckabee signed the state’s second Any Willing Provider legislation (the first being enacted in 1995) on March 2. The governor actually signed two bills that would open up health plan networks to more providers, assuming they will accept the plan’s payment rates.

Act 490 of 2005, which allows healthcare providers’ participation in insurance companies’ networks, is the latest round in the state’s decade old fight over “any willing provider” laws. The Act will go into effect only if the 8th Circuit Court of Appeals in St. Louis overturns a current decision upholding the previous 1995 Arkansas AWP law.

The legislature first passed an any willing provider law in 1995. A state court later overturned that law, saying the federal Employee Retirement Income Security Act (ERISA), made it unenforceable. A federal district court judge and the 8th Circuit agreed with the ruling.

Then, in April 2003, the U.S. Supreme Court upheld a similar law in Kentucky, saying it was not contrary to ERISA. That decision led supporters of Arkansas’ 1995 law to reopen their case. A federal judge lifted the injunction against the law last year. The case is now again before the 8th Circuit, which has yet to rule.

"Making life easier for seniors, recovering patients, new moms"
Even the fastest sprint runner would need to stop for a breather trying to keep up with Jim Maddox. Being regional administrator of not one, but three St. Edward Mercy Health satellite hospitals keeps him running between the three small western Arkansas towns of Paris, Ozark and Waldron.

Maddox is familiar with the many complexities of these St. Edward satellites, having been with the hospital system for 25 years. In 1999, he was named regional administrator of Mercy Hospital of Scott County in Waldron, North Logan Mercy Hospital in Paris, and Mercy Hospital/Turner Memorial in Ozark. “On an average day, I start at Paris in the morning, then go to Ozark, then back to Paris in the afternoon. I spend one day each week at Waldron,” says Maddox.

The three hospitals are each a part of the rural satellite healthcare network of St. Edward Mercy Medical Center, located in Fort Smith. “When I became regional administrator in 1999, we did a reorganization of the facilities, and the Directors of Nursing took on the role of assistant administrators,” said Maddox. “They are the operational component.”

Also, the hospitals became licensed as Critical Access Hospitals, a new designation. “This changed reimbursement from the prospective payment system to a cost-based reimbursement which offered opportunities for better survivability for the rural facilities,” he said. “We were also fortunate to pass sales tax initiatives in Paris and Ozark to help fund operational costs to maintain the facilities.”

Maddox’s degree in medical technology first led him to St. Edward as a staff medical technologist in Fort Smith. “At that time, I was trying to decide between management and equipment sales. Hospital administration just seemed like a better fit,” he said. After two years of lab and another two years serving as managerial director of Nursing Services, Maddox was named Chief Administrative Officer for North Logan Mercy Hospital in Paris. “I was born and raised in Paris, so working in my hometown was a real joy for me,” he says.

North Logan Mercy Hospital is a 16-bed acute care rural facility employing 35 professional staff members. It was the first satellite facility to be established in the St. Edward system. “It was like starting up a new business, and I was proud to be a part of that unique situation,” he says. North Logan Mercy was also the first hospital in the state to be designated as a Critical Access facility; Maddox was on the steering committee that helped establish the Critical Access Hospital licensure designations.

Several criteria must be met before a facility can achieve Critical Access status. “To begin with, the hospital must be a nonprofit or public hospital located in a rural area, must be at least 35 miles from another hospital, must provide 24-hour emergency care and must have a maximum of 25 total beds,” Maddox explains. “The rural area must also be located in a county with an unemployment rate that exceeds the state’s overall unemployment rate and contains a percentage of population age 65 or older exceeding the state’s average.” In order to be named a Critical Access Hospital, the hospital must pass a survey by the state’s Department of Health and Human Services. All three hospitals have passed the survey and have been designated as Critical Access Facilities.

Several years later, Maddox had the opportunity to return to Paris and take the position of Chief Administrative Officer for North Logan Mercy. “I was born and raised in Paris, so working in my hometown was a real joy for me,” he says. North Logan Mercy was also the first hospital in the state to be designated as a Critical Access facility; Maddox was on the steering committee that helped establish the Critical Access Hospital licensure designations.

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Health satellite hospitals keep him “running”

Access facility, a hospital must meet two out of five criteria, go through a comprehensive application process and perform several studies regarding economic and community involvement with the hospital, he explains.

Maddox says small rural facilities do have obstacles to overcome. “Over the years, many changes have hurt rural healthcare. Medicine has become so specialized and technology has become so expensive that it is difficult to keep up with the changes,” he explains.

“Also, there has been a shift from inpatient to outpatient services. In the past, most of a hospital’s revenue came from inpatient services, but since new technology has come along, most of the procedures can be done in a day, so inpatient stays are reduced. And, of course, to provide the new technologies the hospital must have money to buy the equipment that the medical staff needs.”

That’s where the satellite network’s benefits really shine. “Though a rural hospital will never be a (fully outfitted) medical center, we can provide quality services in certain niches,” he says. “The goal is to provide excellent care, personalizing it for our patients.”

St. Edward Mercy Health provides each facility with necessary services including accounting, dietary services and laundry, to name a few. “Because we’re a part of St. Edward, we have all the backing we need,” says Maddox. “Three times each week, a shuttle comes from Fort Smith bringing supplies, medicine and food that we have ordered. It will drop off new inventory, collect dirty laundry and other items that need to go back to our main facility, and then travel to the next hospital. This shuttle approach has quite a positive effect on the economics of each hospital. It’s a very sophisticated system that has been worked out over the years.”

Upon establishment of the satellites by St. Edward, a regional board of hospital and community leaders from each town was created. “They meet quarterly, and this is where we start to see the whole picture come together,” says Maddox. “Within the board, there are committees overseeing different areas. They compare best practices between the members. This allows for the best practices to be implemented at other facilities.”

He is a past president of the Arkansas Hospital Association’s Arkansas Valley District and is a true believer in the AHA’s benefits. “The AHA is very supportive of rural healthcare,” he says. “AHA representatives have attended all of our quarterly Critical Access meetings.”

He is also a charter member and former chairman of the board for the Arkansas River Valley Health Cooperative, a non-profit organization formed in 1999 to help improve health-care access to residents in Franklin, Logan and Scott counties. Maddox, along with executive director Bob Redford, developed Community Healthlink with the Office of Rural Health. Local and regional health-care providers, who were giving a large volume of uncompensated care in the network area, also voiced interest in this program.

With the help of the Arkansas legislature, the Health Care Access Program, or HCAP, encompasses three areas: a low-cost insurance plan to help those who cannot afford coverage on their own but do not qualify for Medicare or Medicaid; health education and chronic disease education; and an information and assistance program that helps individuals gain access to programs such as the Prescription Drug Assistance Program.

Maddox has served on the Paris School Board and is a member and past president of the Paris Chamber of Commerce. Other professional memberships include the American Society of Clinical Pathologists, American College of Healthcare Executives, Paris Kiwanis Club and the Paris Knights of Columbus.

Maddox assures us that he does find time for a little rest and relaxation. “Whatever one administrator at one hospital does, I do that job times three, so I always take advantage of my down time,” said Maddox. An avid photographer, Maddox will capture on film subjects ranging from old barns to insects. Friends say he also loves losing golf balls on the local golf course.

His wife, Elizabeth, has been a nurse with St. Edward Mercy Health in Fort Smith for 33 years, and together they have three children, Austin, 30; Leslie, 25; and Sabra, 23.

Keeping up with the intricacies of three hospitals definitely isn’t an easy task, but Jim Maddox has stepped up and keeps the system running smoothly. “Without our dedicated staffs and communities, we wouldn’t be able to operate as well as we do,” he says. Because of his expertise, the people in and around Paris, Ozark and Waldron are provided with quality healthcare services and will have those opportunities for many years to come.
The Health of Arkansas’ Hospitals and the Year Ahead:

What’s The Story?

Every week we get calls from hospital executives, the news media, and others who ask basically two questions: (1) How are Arkansas’ hospitals doing, financially? and (2) What’s the story with Medicare and Medicaid, and what should we expect from Congress this year with regard to these programs? They’re good questions, and it occurs to us that it might serve a purpose to share our answers with you, our treasured readers of Arkansas Hospitals.

How are Arkansas’ hospitals doing financially? The year 2003 is the most recent year for which we have complete statistics. That year, we had 33 fewer acute-care beds than the year before, yet admissions were up by 4,500. Even so, there were almost 22,000 fewer inpatient days in 2003 than the year before. Although “the business” seems to have shifted more to the outpatient side in recent years, there were 256,000 fewer outpatient visits in 2003 than the year before. While inpatient surgical procedures were down by 2,300, there were more than 7,600 fewer hospital outpatient surgical procedures performed. We suspect the troubling growth of physician-owned and other freestanding surgical centers are responsible for some of the decline in hospital-based surgical procedures.

Of great concern to us is the fact that Arkansas hospital write-offs to bad debts and charity soared by 9.3% in 2003, reaching $738 million. Total write-offs, including billed charges not paid by Medicare, Medicaid and third-party payers reached $5.8 billion (yes, billion with a “B”) meaning that Arkansas’ hospitals were unable to collect any more than 59% of billings.

Across the state, total hospital operating costs, in the aggregate, exceeded net patient revenue by $29 million for the year, knocking the aggregate patient revenue margin in Arkansas down to minus 0.73% as opposed to 2.47% in 2002.

Twice a year, Arkansas Business reports hospital profits and losses. While we might dispute some of their numbers, we do pay attention to the AB reports, the most recent of which was published in October 2004. According to that report, 42 of our acute-care hospitals posted a net income while 36 had net losses ranging from $40,000 to $15 million. We can only imagine how dire the circumstances of those hospitals would be had the AHA not been able to get the Medicaid supplemental UPL payments established in Arkansas. While severe restrictions have been imposed on these payments recently, they have yielded $150 million in badly needed additional revenue for our hospitals.

What is the status of Medicare and Medicaid, and what will the Congress do this year? Medicare, of course, is a big, big problem — much bigger than Social Security on which President Bush seems to be...
There are many new faces in Congress this year. Committees with jurisdiction over Medicare have changed in membership composition and many of the members’ records on healthcare are unclear. Even HHS has a new director, Michael Leavitt, former Governor of Utah.

C. We’re told by Arkansas congressional staffers in Washington that the 2005 congressional agenda seems to be less certain this year than in any year they can remember.

D. Congress learned in the BBA ’97 fiasco that there are many unintended consequences of legislation of that kind and that cutting Medicare hospital payments is not good public policy. Twice since the passage of BBA ’97, Congress has had to pass legislation to help mitigate the damage it caused.

E. The Medicare outpatient Rx bill, which included a $25 billion infusion for hospitals, kicks in next year. We think the Congress might be loathe to further Medicare “reform” right now.

F. And finally, MedPAC has told Congress that Medicare margins dipped to minus 1.9% in 2003, a signal that now is not a good time to impose more cuts.

But again, if not this year then surely the one following, something will simply have to be done about Medicare. While we cannot imagine it ever happening, there is talk of cutting Medicare beneficiaries’ hospitalization benefits by 50%. There’s also talk of increasing the wage tax that funds Medicare Part A from the current 2.9% to 6%.

While we think Medicare might escape scrutiny this year, Medicaid could be another story. Medicaid costs are escalating wildly, shooting up 63% since 2000. With more than 50,000,000 beneficiaries and more than $300 billion in federal and state outlays, Medicaid is bigger than Medicare.

With this in mind, President Bush has asked for significant reductions in Medicaid spending and may try the block grant approach he first proposed in 2003. There would be much opposition to this — beginning with the governors who have told the White House not to reduce federal Medicaid spending since the states simply don’t have the money to pick up the slack. But remember that new HHS Director Leavitt reformed Medicaid when he was Governor of Utah. He got a controversial waiver that allowed the state to expand its Medicaid program. However, it cut benefits and forced some beneficiaries to pay for inpatient hospital services in order to pay for the expansion. What other “reform ideas” might Leavitt have?

No matter what, it promises to be an interesting and, as always, a suspenseful year in Washington. Medicare and Medicaid accounts for a large portion of your hospital’s revenue, and that’s why it’s incumbent upon you and other advocates of your hospital to work closely with us as we try to meet the Medicare and Medicaid challenges that surely will surface in the future.

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**On the Home Front**

As we went to press, the Arkansas Hospital Association had asked the 85th Arkansas General Assembly for an additional $6.5 million a year in state dollars, earmarked for hospital services to Medicaid patients. Hospitals are now being paid $33 million a year less than what it costs them to care for these patients.

Should the legislature appropriate the requested $6.5 million for each year of the current biennium, about $26 million would be gained, including federal Medicaid matching funds.
American Hospital Association Advocacy Agenda—2005

Protecting the healthcare safety net, increasing affordability and improving care are the three major areas of focus in the American Hospital Association’s 2005 advocacy plan.

In early February the American Hospital Association (AHA) distributed its final 2005 Advocacy Agenda, which will serve to guide the organization’s advocacy activities throughout 2005. In brief, the AHA’s 2005 advocacy plan includes:

- Legislative and regulatory strategies to ensure adequate Medicare and Medicaid funding for hospitals and the people and communities they serve.
- An effort to permanently extend the moratorium on physician self-referral to new limited-service hospitals, and to examine new models for working with physicians in a more constructive manner.
- Work with other national organizations to develop solutions to the uninsured crisis and to make care more affordable.
- Strategies for improving coordination of care for all Americans (especially the chronically ill).
- Ongoing advocacy to pass federal legislation that solves the crisis being caused by skyrocketing medical liability insurance costs.
- Ongoing strategies to strengthen the delivery of care, while also strengthening the bond between hospitals and those we serve.

At the same time, the AHA will also work to achieve several long-term goals in partnership with government by the end of the decade, with the intent of moving America to a unified health policy. These long-term goals focus on:

- Quality: Public quality reporting by every hospital, to promote trust, choice, competition and affordability.
- Information Technology (IT): National IT standards should be developed to achieve interoperability among hospitals and other healthcare settings, and every hospital should be on the road to meeting them to promote safety, quality, choice and affordability.
- Workforce: 300,000 new healthcare professionals on the job in America’s hospitals.
- Emergency Readiness: Every hospital with staff, equipment and training should be self-sufficient for 48 hours following a mass casualty incident.
- Affordability: Maintain affordable coverage for all Americans who have it today. Increase by 25 million the number of Americans with access to affordable coverage. No public policy changes that will cause any citizen to lose coverage.
- Care Management: Every hospital should be a key partner in managing services in their community to improve the quality, coordination and efficiency of care to the 20% of our patients who are chronically ill and on whom 80% of resources are spent today.

Join Us for the AHA Annual Meeting in Washington, D.C.

“America’s Hospitals: Cornerstones of Community Care” is the theme for the American Hospital Association’s annual membership meeting May 1-4 in Washington, DC. During the event, Arkansas hospital executives and trustees will visit with the state’s congressional delegation on Wednesday, May 4, and honor the congressional aides with an appreciation/get-acquainted dinner Monday, May 2.

The annual meeting format has much to offer. Attendees will hear keynote speaker Karen Hughes, former advisor to President Bush, in one of her last speaking engagements before she returns to the Administration as under secretary for public diplomacy at the Department of State. Other keynote speakers include HHS Secretary Mike Leavitt and National Coordinator for Health Information Technology David Brailer.

Participants have the opportunity to attend American College of Healthcare Executives Category I credit through a workshop on Sunday, May 1. “The Challenge of Managing Physician-Hospital Relations” features an interactive session led by Ken Mack, FACHE, president of DMI Transitions.

Hospital trustees will have several educational opportunities to discuss issues such as financial fitness, the trustee’s role in quality and patient safety, and future trends in healthcare and governance. Several executive briefings will be held on topics such as the rising cost of healthcare, positioning the hospital as a community resource, retaining tax-exempt status, the Baldrige Award process, healthcare information technology, and patient safety improvement strategies.

Meeting and registration information has been mailed to American Hospital Association members or you may register online at http://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.
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This material was prepared by Arkansas Foundation for Medical Care (AFMC)
under contracts with the Arkansas Department of Human Services, Division of
Medical Services. The contents presented do not necessarily reflect their policies.
The Arkansas Department of Human Services is in compliance with Titles VI and
VII of the Civil Rights Act.
Hospital campuses across Arkansas will become smoke-free environments as of October 1, 2005 under provisions of new legislation passed by the Arkansas Legislature. Act 134 of 2005 prohibits smoking in and on the grounds of all medical facilities in Arkansas, including hospitals as well as hospital-owned and operated ambulatory surgery centers and hospital-owned and operated free-standing medical clinics.

The law exempts psychiatric facilities as defined by Department of Health rules for hospitals and related institutions, and does not cover the use of smokeless tobacco products. It also provides that physicians may write orders for patients who need to use tobacco, as long as the orders are consistent with the hospital’s bylaws, state hospital regulations and local ordinances.

The Arkansas Hospital Association (AHA) backed the bill as a way to improve overall community health for smokers and non-smokers alike. Several hospitals in the state that had previously made their own decision to move to smoke-free campuses have weathered the transition with few complaints.

The October 1 effective date was included to give ample time for all other hospitals to educate their medical staff members, employees and the public about the new law and to move toward full implementation.

What happens if some individuals choose not to comply? The Act says the first step would be for a representative of the facility to request the person to stop smoking. If that fails, then the medical facility may report the violation to the appropriate law enforcement agency.

The AHA has encouraged all its member hospitals to review Act 134 and to begin making preparations for the October 1 implementation date.
Arkansas PAC Contributions Recognized

During 2004, the Arkansas Hospital Association Political Action Committee (AHAPAC) received $30,553 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 Capitol Club or its Chairman’s Circle.

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 donation. Individuals from Arkansas who qualified for membership in each of these clubs in 2004 are shown below.

Arkansans who contributed at least $500, becoming members of the AHAPAC’s 2004 Chairman’s Circle are:
Don Adams, Arkansas Hospital Association (AHA)
Robert Bash, Bradley County Medical Center
Roger Busfield, AHA, Retired
Paul Cunningham, AHA
Dean Davenport, BKD, LLP
Stephen Erixon, Baxter Regional Medical Center
Dan Gathright, Baptist Health Medical Center-Arkadelphia
Russell Harrington, Baptist Health
Michael Helm, Sparks Health System
Tim Hill, North Arkansas Regional Medical Center
Beth Ingram, AHA
Luther Lewis, Medical Center of South Arkansas
Phil Matthews, AHA
C.C. “Mac” McAllister, Ouachita County Medical Center
Ray Montgomery, White County Medical Center
John Neal, Stuttgart Regional Medical Center
Scott Peek, Chambers Memorial Hospital
Barry Pipkin, Universal Health Services
Ron Rooney, Arkansas Methodist Medical Center
Jim Teeter, AHA
John Tompkins, Baptist Memorial Hospital-Blytheville
Doug Weeks, Baptist Health Medical Center-Little Rock

Members with minimum contributions of $250 who qualify for membership in the 2004 Capitol Club are:
Robert P. Atkinson, Jefferson Regional Medical Center
Gary Bebow, White River Health System
JoAnn Butler, AHA
David Cicero, Ouachita County Medical Center
Kevin Clement, Crawford Memorial Hospital
Tina Creel, AHA
David Dennis, St. John’s Hospital
Randall Fale, St. Joseph’s Mercy Health Center
Nancy Fodi, Southwest Regional Medical Center
Donnie Frederic, NW Med. Ctr. of Washington County
John Hoffman, M.D., St. Edward Mercy Med. Center
Ross Hooper, Crittenden Memorial Hospital
Edward Lacy, Baptist Health Medical Center-Heber Springs
Peter Leer, UAMS
Jimmy Leopard, Medical Park Hospital
Mark Lowman, Baptist Health
Mike McCoy, Saint Mary’s Regional Medical Center
Larry Morse, Johnson Regional Medical Center
David Morton, American Hospital Association
James Newman, St. Edward Mercy Medical Center
Kristy Noble, St. John’s Hospital
Craig Ortego, Dallas County Medical Center
Ben Owens, St. Bernards Healthcare
Kirk Reamey, Magnolia City Hospital
John Robbins, Conway Regional Medical Center
Allen Smith, Baptist Health
Jason Spring, HealthPark Hospital
Sandy Sullins, Lawrence Memorial Hospital
Russ Sword, Ashley County Medical Center
Your Leadership Contributions Count

The meetings of the American Hospital Association’s (AHA) Committee on Governance (COG) frequently include an open forum in which members discuss a timely and provocative topic or question – usually one posed by AHA staff. At its fall meeting, the COG was asked to identify the key areas where they thought board members could make the greatest leadership contributions – both within the organization and in the community or political arena.

Within the hospital, committee members felt that internal leadership could be implemented through trustees working with senior executives to improve and communicate a desirable organizational culture, working to make the organization an attractive one for patients, staff and stakeholders. Trustees are also highly effective liaisons between the administration and the medical staff, helping to build and clarify their relationship.

Outside the boardroom, trustees can be ambassadors for the hospital when we speak with our friends, neighbors and colleagues. As hospital trustees, we are respected members of our communities and when we talk about our hospital’s community benefits, our words have the integrity of volunteers committed to our organization – we do not speak as paid lobbyists or employees dependent on a salary or bonus. And, board members are invaluable for educating the community on billing practices by explaining, in layman’s terms, how money is spent by the hospital.

Finally, trustees can provide leadership by participating in the political advocacy process. This can be done both when legislators visit the community and when trustees take the hospital’s message to their state and federal legislators. As we have often noted, legislators need to have issues brought before them often in order to appreciate hospitals’ problems and needs. And then, when a relationship does develop, your message cannot be passed over as easily as one from a professional lobbyist.

I hope you are already making a leadership contribution both inside and outside your hospital. If not, please use the post-election period as a time to establish some new patterns of leadership as a member of the board.

—

Robert J. Parsons, Ph.D., is COG chair and chair of Intermountain Health Care-Urban South Region, Provo, Utah. He can be reached at robert_parsons@byu.edu. This article originally appeared in the November 2004 edition of Trustee Magazine.

AHA Protests President’s Proposed Medicaid Cuts

This letter was sent to Arkansas Senator Blanche Lincoln February 9 by Jim Teeter, Arkansas Hospital Association president and CEO, on behalf of the association. Similar letters were sent to Senator Mark Pryor and Representatives Marion Berry, John Boozman, Vic Snyder and Mike Ross.

February 9, 2005
The Honorable Blanche Lincoln
The United States Senate
Washington, D.C. 20510

Dear Sen. Lincoln:

With both state and federal Medicaid costs escalating wildly, we were not surprised when President Bush proposed in his FY 2006 budget to reduce federal Medicaid spending. However, we were astounded by the magnitude of his proposed reductions — $60 billion over the next 10 years!

Undoubtedly there are ways to reform and improve Medicaid — the only healthcare safety net for the most vulnerable Americans — but this is not the way to do it. The true test of any reform is not how many dollars can be saved but whether it improves the lives of those who depend upon the program — children, the blind and disabled, and others who simply don’t have the means to pay for health services.

The president’s proposed cuts are staggering and would shift enormous costs to Arkansas and other states, an ill-conceived move that would add to the financial burden the states are already experiencing. Arkansas would lose at least $561 million in Medicaid funding under the president’s proposal, according to projections issued by Families USA. We fear the actual losses could easily exceed those projections.

The president’s draconian Medicaid spending reductions are proposed at a time when the Arkansas Department of Human Services is already struggling to meet the needs of 664,000 Arkansans who receive Medicaid services (27% of the state’s entire population). These beneficiaries include at least 280,000 children and 90,000 persons who are blind and disabled. The president’s proposed cuts in Medicaid also come at a time when Governor Huckabee and members of the Arkansas Legislature are trying to find $200 million in state funds just to preserve our state’s Medicaid status quo.

Not only would President Bush’s slashes in Medicaid spending jeopardize services to beneficiaries, but they would also further harm the healthcare providers who serve those beneficiaries, including Arkansas hospitals that are already being paid $33 million a year less than the cost of providing services to the beneficiaries.

This payment deficit would be exacerbated by another $30 million a year were it not for Medicaid supplementary UPL payments that the governor, you, and other members of the Arkansas delegation helped us achieve four years ago. Unfortunately, even these payments will soon be severely reduced due to a recent amendment to the State Medicaid Plan forced upon us by the Centers for Medicare & Medicaid Services.

Given these facts, we urge you to vigorously oppose cuts in federal Medicaid spending to the degree the president has proposed.

Sincerely,

James R. Teeter
JCAHO Joins Those Calling for Medical Liability Reform

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued a call to action to reform the nation’s medical liability system, urging that the current proposal for caps on non-economic damages be expanded to pursue intermediate and long-term system changes that truly facilitate improvements in patient safety.

According to the Joint Commission, by its basic design, the current medical liability system chills the identification and reporting of adverse events in healthcare and thus undermines opportunities for learning that could provide the basis for significant safety improvements.

The call to action is set forth in the Joint Commission’s newest public policy white paper, “Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury.” The Joint Commission’s report urges intensified attention to patient safety and medical injury prevention by healthcare providers and practitioners; emphasizes the critical importance of open communication between patients and practitioners; and urges the creation of an injury compensation system that is patient-centered and serves the common good.

Any redesign of the medical liability system, the report suggests, should assure appropriate compensation for all injured patients, while also encouraging healthcare providers and practitioners to surface errors, learn from mistakes in the design and performance of care processes, and take action to ensure that adverse events do not recur.

The Joint Commission’s white paper was developed in collaboration with an Expert Roundtable whose 29 members represent a wide diversity of interests relevant to medical liability.

The report contains 19 specific recommendations and identifies accountabilities for each of those. As with its other public policy initiatives, the Joint Commission intends to work in collaboration with other parties at interest to see that each of those recommendations is eventually met.

The current medical liability system, the Joint Commission suggests, fails patients because it does not effectively deter negligence, truly offer corrective justice, or provide fair compensation to those who have been injured through the care process. The Joint Commission also says it’s accurate to say that too little progress has been made in improving patient safety since the release of the Institute of Medicine’s groundbreaking report on medical error five years ago. The Joint Commission notes that a very small proportion – two to three percent – of injured patients receive compensation through the medical liability system, and those who do receive highly variable compensation for similar injuries.

The Expert Roundtable identified three strategies for achieving its overall goal:

- **Actively pursue patient safety initiatives that prevent medical injury.** Specific recommendations address the need to encourage the creation of cultures of safety in healthcare organizations; to strengthen oversight and accountability mechanisms for ensuring the competency of doctors and nurses; and to provide healthcare researchers access to open liability claims to permit timely identification of problematic trends in care. “Pay-for-performance” programs that provide incentives for improving patient safety and healthcare quality must also be part of the solution.

- **Promote open communication between patients and practitioners.** Emphasize that patients must become members of the healthcare team. Ineffective communication and lack of disclosure are the most prominent complaints of patients, and their families, who are victims of medical error or negligence. As one of its recommendations, the report urges pursuit of legislation that would protect disclosure of mistakes and the associated apologies from being used against practitioners in litigation. Other recommendations encourage the non-punitive reporting of errors to third parties to support the development of patient safety solutions, and enactment of pending federal patient safety legislation that would provide legal protection for medical errors and adverse events reported to designated patient safety organizations, such as the Joint Commission.

- **Create a patient-centered injury compensation system.** Specific recommendations emphasize the need to conduct demonstration projects of alternatives to the current medical liability system that promote patient safety and provide swift compensation to injured patients. While these efforts are underway, the report also advocates for prohibition of confidential settlements known as “gag clauses” that prevent learning from events that lead to litigation; use of court-appointed, independent expert witnesses; and the redesign or replacement of the National Practitioner Data Bank which has never fulfilled its promise to be the premier resource for meaningful, valid and reliable information about physician performance.

A complete copy of the Joint Commission white paper, “Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury” is available on the Joint Commission Web site, at

Could Arkansas land six super projects a year?

Could Arkansas land six super projects a year? Yes. (If you like the premise of this column title, then read on.)

Last July, I had the “fortunate” and “unfortunate” experience of a lengthy stay in the hospital, followed by an even longer homebound recovery. The experience was “unfortunate” in that a major health setback forced the hospital stay. However, it was “fortunate” in that I received excellent in-hospital and home healthcare during my surgery and recovery. I praise my doctor for saving my life, but I praise my nurses for saving my sanity.

For ten days following surgery (and several weeks after my hospital discharge at home), nurses helped me find comfort in my most painful and pride-less moments. When you are sick, injured, and compromised by pain or grueling discomfort, you just want to feel better. You are miserable. You are restless. You are scared. My nurses came to my aid daily and nightly and I can honestly say that I would have never made it through my hardship without their skills, their attention, and most importantly, their caring.

I’m lucky. They were there for me. But will they be there next time and will they be there for you?

A legislative commission has been studying a crisis in our state’s nursing profession for four years. A lot of good people deserve credit for plowing through this tough issue. The commission presented its findings recently and here are some incredible facts:

- Arkansas needs 1,925 new registered nurses (RNs) and 959 new licensed practical nurses (LPNs) each year to meet current workforce needs. That’s 2,884 new nurses per year.
- On average, Arkansas graduates fewer than 700 new RNs and around 500 LPNs each year.
- By 2010, the state must have at a minimum 27,000 RNs and 16,000 LPNs compared to the 18,750 RNs and 10,975 LPNs we had in 2000.
- If this number of new nurses were added to the state each year, it would yield on a per year basis: $69,744,500 in new salaries; $3,398,360 in new state tax revenues; and produce a $174,361,250 economic benefit to Arkansas communities.

There are nearly 2,900 nursing jobs in this state waiting to be filled. These jobs already exist. We don’t have to create them. We don’t have to recruit them to Arkansas. We don’t have to wait for “market forces” to produce them. We don’t have to come up with an incentive package that would “give away the state” to get those jobs to come here.

We have the potential to create nearly six super projects in Arkansas per year without turning a spade of dirt, without making a phone call to Japan, without seeking the help of an out-of-state recruiter, and without commissioning another study.

A super project has typically been defined as any business enterprise that would create 500 new jobs or result in $500 million in new infrastructure investment. Doesn’t solving our nursing crisis qualify?

In talking to a two-year college president at the Capitol recently, I was told that a nursing program can be a money loser for the college. So why doesn’t the state chip in like we would if Toyota wanted to come to Arkansas? Why not commit a fraction of the money necessary to fund our education institutions adequately to address this need? Why not find a way to make nursing school available to the thousands of Arkansas high school graduates not attending college?

Some private institutions are already stepping up. Private hospitals are paying for nursing school for students on the promise that they will work for their hospitals for two years. Wait! We’ll pay for your schooling and provide you with a job upon graduation! That’s a bargain. But it’s not enough and we can do more.

If the political will is there to do what it takes to land one super project in Arkansas, then surely the political will is there to create six super projects a year.

I am optimistic that the Legislature will look at this potential and do something about it this session. I think private industry, i.e. the healthcare industry in Arkansas, would step up to the plate and do whatever is asked to meet this critical challenge. More so than a car maker, which can locate anywhere and expect red carpet treatment.

Bluntly put, people will continue to age and be sick. With a larger, aging population, the need for these jobs is never going away.

Nursing also allows great flexibility in terms of career changes. A nurse can utilize technology in a high-tech ER setting. A nurse can work with the youngest and most fragile children with health needs. A nurse can work with our aged seniors whose health needs know no boundaries. Nurses are facilitating breakthrough research at UAMS. Career options and new needs are endless in this profession, much more so than working at an auto plant.

I think we are missing a major opportunity by continuing to just analyze and discuss this problem. While there are public and private institutions out there doing what they can, frankly more can be done.

And it should be. Your life could depend on it.

Roby Brock is the host of “Talk Business,” a weekly television program that focuses on business and politics in Arkansas. His email address is roby@aristotle.net.

by Roby Brock
Study Recommends Improved Communication Among Healthcare Workers

Poor communication and collaboration among healthcare professionals leads to continued medical errors and staff turnover, according to Silence Kills: The Seven Crucial Conversations for Healthcare, a study of more than 1,700 nurses, physicians, clinical care staff, and administrators.

Released January 26, the study was co-sponsored by the American Association of Critical-Care Nurses (AACN) and VitalSmarts, a Utah-based company that specializes in leadership training and organizational performance, according to a U.S. Newswire article.

The findings include:
- 84% of physicians and 62% of nurses and other clinical care providers have seen coworkers take shortcuts that could endanger patients
- 88% of physicians and 48% of nurses and other providers work with people who display poor clinical judgment
- Fewer than 10% of physicians, nurses, and other clinical staff directly confront their colleagues about concerns, and one in five physicians said they have seen harm come to patients as a result
- Those healthcare workers who raise these concerns observe better patient outcomes, work harder, are more satisfied, and more committed to staying in their jobs

“Too often, improving workplace communication is seen as a ‘soft’ issue. The truth is we must build environments that support and demand greater candor among staff if we are to make a demonstrable impact on patient safety,” said Kathy McCauley, RN, PhD, BC, FAAN, FAHA, president of the AACN.

Hospital leaders must make improving crucial conversations a priority, according to the study. As a solution to the communication problems, the AACN developed a set of recommendations to promote communication and collaboration among caregivers.

The four recommended steps to this end are:
- Establish a baseline and target for improvement
- Conduct focus-group interviews
- Focus on problem areas
- Implement training

Dennis O’Leary, MD, president of the Joint Commission on Accreditation of Healthcare Organizations, said that communication is a major contributor to medical errors. “The standards and recommendations put forth today make an important contribution to beginning to solve the identified communication problems,” he said.

To read the study, visit www.rxforbettercare.org.

Disruptive Acts Common Among Hospital Staff, Study Shows

About 86% of nurses and 49% of physicians recently surveyed said they had witnessed disruptive behavior among healthcare professionals, according to a VHA study.

Most respondents said they believed such behavior had an impact on adverse events, medical errors, patient safety, patient mortality, quality of care and patient satisfaction.

VHA defined “disruptive behavior” as any inappropriate behavior, confrontation or conflict, ranging from verbal abuse to physical and sexual harassment. It drew responses from a total of 1,500 nurses and physicians in 12 states. About 60% of respondents said they were aware of potential adverse events that may have occurred as a result of disruptive behavior.

Disruptive behavior among nurses was commonplace. Some 68% of nurses and 47% of physicians said they had witnessed disruptive behavior among nurses and by nurses directed at other hospital staff.

The report did not provide data specific to disruptive behavior by physicians.

“The survey suggests a serious problem within and across disciplines,” said Alan Rosenstein, co-author of the study. “Disruptive behavior needs to be addressed at the organizational level. Hospitals need to invest time and resources into performing self-assessments, increasing staff awareness of the issue, opening lines of communication and creating great collaboration among peers. If hospitals don’t do this, the problem will continue to grow and patients will continue to needlessly suffer.”

The full survey results can be found in the January American Journal of Nursing.
Arkansas Medical Imaging

Empowering Radiology in Rural Arkansas

Arkansas Medical Imaging was founded with a vision... that radiology departments in small, rural facilities could become clinical centers of excellence. Through a unique blend of technology, professional, and marketing service, AMI is bringing that vision to reality every day—to the benefit of rural Arkansas Hospitals, to their communities, and to rural Arkansans across the state.

Fueled by rapid advances in digital technology, Radiology is changing more rapidly than any medical specialty. Every day, technology-driven advances lead to new imaging strategies, protocols and algorithms that dramatically improve the ability to diagnose, stage and evaluate disease. While radiology throughout much of the country moves forward, it has historically lagged behind in many rural community hospitals.

AMI empowers small, rural facilities to provide the same quality of care that is available in tertiary care radiology facilities. Even in cases where definitive care cannot be provided locally, complex imaging evaluations can be performed locally. Capture of these imaging evaluations strengthens the local hospital, and builds a resource vital to the residents of the community both economically and practically. AMI accomplishes its mission through a blend of the following services:

eRadiology: The first step in achieving local excellence is to convert inefficient film-based operations to filmless, even paperless radiology departments. The benefits are myriad:
• No lost films
• No lost reports
• No waiting for images or reports
• Report-image integration for you clinical staff
• Improved workflow and efficiency
• Higher patient throughput
• Improved patient, clinician, and radiologist satisfaction

Access to subspecialty trained radiology: In addition to the practical efficiencies of filmless/paperless imaging, eRadiology provides much needed support to the hometown radiologist. Often in solo practice, or covering a “circuit” of hospitals, rural radiologists are often overworked. That’s where AMI’s network of fellowship trained specialists can help by providing night-time coverage, weekend coverage, and access to over-read and consultative services. Never in competition with local resources, AMI stands ready to help build volumes by supporting, and backing local radiologists and making sure that local hospital always has the coverage it deserves.

MARKETING: A unique, but highly effective marketing campaign constitutes the third leg of the AMI solution. As quickly as the state of the art changes, it can be challenging for the most highly trained radiologist to keep up with the latest imaging protocols. AMI marketing teaches referring physicians how to use technology to work-up and effectively diagnose their patients. Evidence-based imaging protocols coupled with local hospital branding ensure that rural Arkansas physicians what is available at home...and that they order the appropriate examinations from their local hospital.

These turnkey programs, offered within the institution’s operational budget allow the smallest rural hospitals to compete on even footing with the centers that have been drawing their patients away for years.

According to AMI founder and President Michael V Beheshti MD, a practicing radiologist in Little Rock, “Too many Arkansans are driving too many hours to obtain imaging examinations. In today’s world, local patients can be imaged locally. It is better for them, better for their hospital and better for their community.” “We have been deeply gratified by the success of this model in the state,” continued Dr. Beheshti. “We have seen one institution’s CT volume increase over 40% in one year—a testament to the quality and value of the AMI solution.”

Backed by a team with hundreds of man-years of experience in radiology and in information technology, AMI is quickly becoming known to rural Arkansas hospital executives. “Every day our vision is becoming reality”, commented Dr. Beheshti. “Our solution works. It improves quality of care, it builds local excellence in radiology, and it strengthens the facilities with whom we work.”

Anyone seeking additional information regarding AMI services may call Mr. Charles Socia at (501) 223-3392, or may email Arkansas Medical Imaging at info@arkansasmedicalimaging.com. Further information is available on the web at www.arkansasmedicalimaging.com.
How To Handle The Media

Editor's Note: Steve Rivkin will be the keynote speaker at this year's Summer Leadership Conference. His topic will be "How to Overcome Negative Publicity." For more information, see related article on page 34.

“What we have here is a failure to communicate.”

How often have you heard that old saying? A “failure to communicate” is an underlying aspect of every hospital crisis, adverse development or challenging situation.

Dealing with the media is an opportunity for you to get across the points you want to help achieve the objectives of your organization. Standing in your way is a journalist, whose only job is to extract from you the most interesting story he or she can.

Contrary to what you may think, most journalists are neither overly hostile nor overly friendly. In fact, they don’t care much what you say, as long as it’s interesting to their readers, listeners or viewers.

Your job is to be available, to be candid, and to be interesting—while always keeping your organization’s goals in mind.

STICK TO THE SCRIPT

To succeed with the media, you have to know your M.A.P.s—your Must Air Points.

These are the three or four — no more — messages that you must get across on the air or in print.

These are the key messages that will help your organization respond to a crisis or deal with a difficult situation.

Good M.A.P.s have these characteristics:
• They go right to the heart of the matter.
• They are direct and truthful.
• They are strong, positive, committed.
• They cite evidence, facts, proof.

10 INTERVIEW DO’S

1. Do prepare. Before an interview or meeting with the media, you should know how the interviewer reports, for whom he reports, and what his point of view is. Know the main points you want to make before the interview begins.

2. Do relax. Most reporters are people just like you, trying to do a job. Sure, some reporters are jerks. Even so, building rapport will help.

3. Do be open and honest. TV, in particular, magnifies phoniness. A half-truth can quickly become a half-lie.

4. Do speak in personal terms. Most people distrust large organizations. Too many references to “the institution” and “we believe” are ominous. Don’t hesitate to use “I.”

5. Do welcome a naive question. The question may sound simple, but answer it anyway—with enthusiasm. It may be helpful to someone who doesn’t know much about you.


7. Do play it straight. Be careful with humor. If humor doesn’t come naturally, play it straight. Reaching for a joke or an irreverent comment may be interpreted as being foolish or frivolous.

8. Do state facts and back up generalities. Examples bolster an interview. Be armed with specific data to support general statements.

9. Do radiate some energy. You should be enthusiastic about your topic. True, you may have been asked the same question many times before. But it’s fresh for this audience.

10. Do tell the truth. It’s the cardinal rule. Journalists are generally perceptive; they can sniff out a fraud. So don’t be evasive, don’t cover up, and don’t lie. If you have to decline to answer a specific question, explain why you’re doing so.

10 INTERVIEW DON’TS

1. Don’t let the interviewer dominate. You can control the interview by varying the length and content of responses. If a question requires a complicated answer, say so before you get trapped in an incomplete and misleading response. If you make a mistake, correct it and go on. If you don’t understand a question, ask for clarification.

2. Don’t assume everything you say will be used. Print interviewees pick and choose what they need to fill the space they are given. TV is a quick, imperfect and heavily-edited medium. To make a point on TV, you need to be brief and direct.

3. Don’t say, “no comment.” It sounds evasive. If you can’t answer a question, explain why. Begging off for competitive or proprietary reasons is perfectly acceptable as long as you offer some explanation.

4. Don’t take the skepticism personally. A journalist’s job is to be skeptical of everything.

5. Don’t patronize. Journalists aren’t terribly impressed by titles. Many hold
the heretical view that there are a lot of dumb politicians and business executives running around. (For shame!)

6. Don’t take offense. Some reporters aren’t mannerly, polite or deferential. As long as they’re honest, who cares?

7. Don’t get confrontational. Most reporters know very little about healthcare issues. Sure, it would be better if they were better briefed. Just be patient and keep cool.

8. Don’t tell them how to do their jobs. No, you can’t see the story in advance. No, they won’t agree with your definition of “news.”

9. Don’t get chummy. Reporters are never off-duty. So keep your guard up — all the time.


**SOME IMPORTANT DEFINITIONS**

**On the Record.** Means the comment is for quotation by a source whose name will be used.

**Background.** Implies that while the material can be quoted, it will not be applied directly to you. A term such as “an industry observer” is often used to muddle the identity of a background source.

**Deep Background.** A synonym for “not for attribution,” which means the reporter should not attach the comment to anyone. (Instead, the journalist paraphrases you and attributes the ideas to his or her own intuition.)

**Off The Record.** Strictly defined, means not for publication or use on the air. (In other words: “Don’t use this!”) Over the years, this term has frayed at the edges and may instead mean “just between us” or “use with discretion.”

Your best bet is to proceed by assuming that there is no such thing as “off the record.” If you don’t want to see something in print, or on the air, don’t say it.

**PRINT VS. BROADCAST—A QUIZ**

1. Who gives you more time to express yourself?

   Print. You’ll normally spend more time talking with the writer of an article than you would with a broadcast host or newscaster. Often, you’ll meet the broadcaster right before they turn the camera on. So be prepared to hit the air running!

2. Where are you most likely to be caught off guard?

   Print. The extended time spent with print journalists tends to lull some into a relaxed, informal state. Dangerous. Keep alert at all times, or you’ll be quoted saying things you won’t be proud to see in the cold light of print.

3. Where can you make the greatest impact?

   TV. The viewer sees you and hears your words. The impact is immediate, emotional and lasting.

4. Where are you at most risk to be perceived inaccurately?

   Print. Readers can neither see nor hear you. They absorb the writer’s impressions. This “filter” can alter markedly how you and your organization come across.

5. Where are you safest?

   Radio. You can use as many notes and references as you like. Listeners won’t know and hosts won’t care. So your facts (and your cleverest comments) are literally at your fingertips for easy reference.

6. Where will your radiant personality most readily be revealed?

   TV. Live television is the best medium to convey to viewers who you are and what you stand for. There is no intermediating device between you and the viewer to filter your words and deeds.

7. Which is the most difficult challenge?

   TV. Particularly live television. Your words, actions and appearance must all “click” at once, or else the viewer will “click” you off, that is. You get no second chance.

8. Where will you be most pressed for time?

   Broadcast news interviews. These depend on brevity and immediacy. So your answers must be short and pithy. Remember your M.A.P.s.

9. Where is rapport with the interviewer most important?

   Print. In broadcast, you speak directly to the listener or viewer. But in print, you must depend on the interviewer to interpret your views accurately. This, in turn, is often dependent on what the interviewer thinks of you. So be gentle and don’t alienate.

10. Which is most likely to convey your message accurately?

    Radio. TV conveys more of you and your personality than your message. Print depends on a reporter’s interpretation to convey your message. But radio carries only your message. Unless, of course, it’s edited severely.

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**AHA Summer Leadership Conference, June 15-17**

The Arkansas Hospital Administrators Forum/Arkansas Health Executives Forum summer leadership conference will be held June 15-17 at the Perdido Beach Resort in Orange Beach, Alabama. As expected, the area is re-building and renovating after hurricanes repeatedly slammed the Gulf Coast late last year.

Educational topics and speakers for the two-day conference include healthcare strategist Nate Kaufman and his ideas to improve hospital performance, and marketing and communications consultant Steve Rivkin, who will discuss ways to change negative public perception and how to cope in a crisis situation. Diane Mackey, AHA legal counsel, will present a healthcare update.

Along with the planned educational activities, Perdido Beach Resort and the Gulf Coast area offer many opportunities for family entertainment—beautiful beaches, golfing, shopping, fishing, boating, swimming, tennis, a full range of activities for children, and much, much more — which make the trip to the coast memorable.

Because the Gulf Coast area remains a popular summer vacation spot, we encourage you to make reservations now. You may call the hotel direct at 1-800-634-8001, mentioning the Arkansas Hospital Administrators Forum (or the Arkansas Hospital Association) to obtain the special convention rate. Or, you may make reservations online at www.perdobeachresort.com, clicking on “reservations,” and entering the Group Code AHA605. Contact Beth Ingram at (501) 224-7878 for additional information.
In early April, helpful consumer information on hospital quality became available to the general public for the first time through the new consumer Web site www.hospitalcompare.hhs.gov. This site marks a milestone in public accountability and is the outcome of a landmark public-private partnership between hospitals, government and other healthcare organizations, known as the Hospital Quality Alliance.

Patients, families and communities will, through the Hospital Compare Web information, be able to examine quality statistics and make an apples-to-apples comparison of hospitals. By using a common set of measures, the public will be able to access relevant data, presented in laymen’s terms, to help make important healthcare decisions. (In the past, comparative information was available, but because no standard set of measurements existed, there was no accurate way to evaluate the comparative data.)

The launch of the Hospital Compare Web site is an important first step in hospitals’ efforts to publicly report quality information, and the site will continue to evolve as new conditions and measures are added.

Consumers will first be able to research and compare hospital quality data for three common medical conditions – heart attack, heart failure and pneumonia. More quality-related information will be added over time, with new information on surgical infection prevention scheduled to be added as early as this summer, and patient satisfaction comparisons scheduled in 2006.

It is very difficult to measure the quality of healthcare, but one method is to measure how often healthcare providers make use of treatments that have been shown to be most effective. The 17 measures being reported through Hospital Compare help patients understand the effectiveness of the care they receive compared with care that research indicates will lead to the best outcome. The new quality measures are one important source of information about a facility, but they should not be the only source.

Most Arkansas hospitals, working in conjunction with the Arkansas Foundation for Medical Care (AFMC), Arkansas’ medical quality improvement organization, have submitted data as part of this voluntary initiative to better equip their communities with credible quality information. The
Arkansas Hospital Association (AHA), which endorses the national Hospital Quality Alliance, notes that Hospital Compare is an important tool for improving patient safety and quality of care. The AHA agrees that it should be viewed as just one of the many sources that patients and families can use to choose a hospital.

Paul Cunningham, AHA senior vice president, said, “Hospital Compare is a starting point in a process of collecting and sharing information on quality of care that will continually expand and evolve. This initial report provides consumers a brief snapshot of current practices that individual hospitals use in caring for patients admitted to those facilities for three specific conditions.”

Cunningham added, “Future reports will not only include additional quality measures and patient satisfaction information but also will allow consumers to track hospital progress over longer periods of time toward improving their quality measures through adopting proven ‘best practices’ of care.”

The initial three “starter” measures are further broken into sub-areas representing the best standard of care for treatment of the conditions. To begin, consumers will be able to compare hospitals based on:

**Treatment of Heart Attack**
- Aspirin given at arrival
- Aspirin given at discharge
- Beta-blocker at arrival
- Beta-blocker at discharge
- ACE inhibitor for left ventricular systolic dysfunction (LVSD)
- Percutaneous coronary intervention within 120 minutes of arrival
- Thrombolytic agent received within 30 minutes of arrival
- Smoking cessation counseling

**Treatment of Congestive Heart Failure**
- Left ventricular function (LVF) assessment
- ACE inhibitor for left ventricular systolic dysfunction (LVSD)
- Smoking cessation counseling
- Discharge instructions

**Treatment of Pneumonia**
- Mean time to first antibiotic dose
- Pneumococcal screening and/or vaccination
- Oxygen assessment
- Smoking cessation counseling
- Blood culture before antibiotic

AFMC plays a pivotal role in improving Arkansas hospital quality by offering hands-on resources, one-on-one training and staff education. “As the Medicare contractor in Arkansas charged with working with hospitals to improve their quality of care, we have seen first hand how hospitals are making changes and improving,” said Pam Brown, AFMC’s inpatient project manager. “We commend our state’s hospitals for making quality a top priority every day.”

Hospitals across the country chose to participate in this voluntary partnership as a part of their ongoing effort to improve patient safety and quality of care within their facilities. The hospital field has taken the lead in making more and better information available to patients and consumers about the quality of hospital care. The Web site is one important tool for improving the quality of care and empowering patients with credible quality information.

In 2002, the American Hospital Association, Federation of American Hospitals (FAH) and Association of American Medical Colleges (AAMC) worked together to develop a national strategy to provide relevant information on hospital performance to the public. The goal was to share hospital quality information with patients, families and communities in a unified, consistent manner. Joining the hospitals and hospital organizations in this ambitious effort were the Centers for Medicare & Medicaid Services (CMS), consumer and employer groups, national healthcare accreditors (including JCAHO, the Joint Commission on Accreditation of Hospital Organizations), and others. Hospital Compare is truly a team effort, and is one important tool in improving patient safety and quality of care.

For more information, visit www.hospitalcompare.hhs.gov or www.medicare.gov and select “Compare Hospitals in Your Area,” or call 1-800-MEDICARE (1-800-633-4227).
Arkansas Foundation for Medical Care (AFMC) in late February announced progress in surgical infection prevention after the Archives of Surgery published a study highlighting the need for better, more consistent practices to address infection risk factors.

The precise timing of administering antibiotics to prevent surgical infections is critical, but often not strictly regulated. AFMC says it plans to intensify its work with local hospitals to redesign procedures and protocols so that surgical patients are given antibiotics within sixty minutes before surgery begins, the timeframe most effective for preventing infections.

In the Archives of Surgery study, titled “Use of Antimicrobial Prophylaxis for Major Surgery: Baseline Results From the National Surgical Infection Prevention Project,” researchers found that only a little more than half of Medicare beneficiaries undergoing major surgeries during 2001, including open cardiac, vascular, colorectal, total hip, total knee, and hysterectomy. Data was collected in conjunction with the 2002 launch of a surgical infection prevention project jointly sponsored by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).

In the article, researchers report the results of their analysis of medical records from 2,965 acute care hospitals throughout the United States, involving a random sample of 34,133 Medicare inpatients undergoing major surgeries during 2001, including open cardiac, vascular, colorectal, total hip, total knee, and hysterectomy. Data was collected in conjunction with the 2002 launch of a surgical infection prevention project jointly sponsored by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC).

“AFMC recognizes the importance of this research and, seeing the opportunity for significant improvement, already has efforts underway to address the problem of surgical infection prevention,” said Pamela Brown, inpatient project manager for AFMC’s Health Care Quality Improvement Program.

As AFMC works with local hospitals to improve delivery and administration of preventative antibiotics, it is reporting widespread successes across the state as well as plans for an expanded focus on surgical infection prevention in the near future.

As part of Medicare’s Hospital Quality Initiative, Quality Improvement Organizations (QIOs) like AFMC promote rapid resolution of hospital quality issues and sharing of “best practices” to assist hospitals in improving their quality of care in several areas. In addition to surgical infection prevention, focus areas include heart attack, heart failure and pneumonia.
Medical Center, Ouachita County Reach Settlement

A long-lingering $326,000 lawsuit filed against Ouachita County by the Medical Center of South Arkansas in El Dorado has been settled to the satisfaction of the medical center.

The suit was filed after Ouachita County officials refused to pay for medical services provided in 2001 to a Ouachita County woman who, while incarcerated in the Union County Jail on a murder charge, became gravely ill.

The woman was being housed in the Union County Jail because Ouachita County does not have facilities for female inmates. She received 76 days of care at the El Dorado medical center, including six or seven surgeries. She has since died.

Under terms of the settlement, Ouachita County has agreed to pay the medical center $675 for each day the inmate received care there. This amount equates to the medical center’s Medicaid per diem rate.

In action related to the case, the Medical Center of South Arkansas had also sued Union County. However, Union County was released from the suit after it agreed to pay the medical center $675 a day for the care of its own inmates in the future.

In 1989, the Arkansas Supreme Court ruled in yet another El Dorado case that law enforcement agencies are responsible for payment for hospital services provided to inmates.

Yet the Arkansas Hospital Association is still getting calls from hospitals reporting cases in which cities and counties have “dumped” inmates at hospital doors with absolutely no intention of paying for services provided to the inmates.

Acting on a series of unsolicited “advisories” from a Little Rock lawyer—“advisories” that have been widely circulated in recent years—there are prosecutors, sheriffs, and others in the law enforcement community who believe they can “out-smart the system” by taking prisoners to the hospital, releasing them from custody, thereby being released from liability for medical bills, then taking these people back into custody after they have been treated.

The Arkansas Hospital Association has, on a number of occasions, pointed out—both to hospital executives and law enforcement officials—the potential pitfalls of this practice, including the tragedies and public relations nightmares that could ensue.
You wouldn’t trust just anyone with these little details.

When it comes to quality of care, you want the best for your facility. That means well trained, proven physicians and allied health professionals who have both the clinical skills and the interpersonal skills to provide the highest level of care.

The MHA Group can help you meet this standard.

We are the industry leader in healthcare staffing and consulting, specializing in the placement of both permanent and temporary physicians and allied healthcare professionals. With over 17 years of experience and over 700 staffing professionals we offer the expertise and resources to be successful in today’s highly competitive staffing market.

The MHA Group is the Endorsed Staffing Provider of AHA Services

For complete information about our services and track record in Arkansas please contact us at:
Nabholz Construction is the recognized leader for hospital construction in Arkansas, and the preferred contractor of healthcare clients who demand the highest quality and performance. Our management team and project delivery record is why more than 75% of our work performed in this crucial field is for clients we have served in the past.