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Cooper Chapel at Bella Vista
Ark. Dept. Parks & Tourism
Chuck Haralson
As an old country saying goes, every path has its puddles! And there are puddles galore as the AHA and Arkansas’ hospitals embark upon their 75th year of hiking the trails together, for the challenges we face show no signs of relenting.

The Top Ten list still includes escalating costs of providing care, dwindling rates of payment, a rise in demand for the highest of high-tech services, a shrinkage in ways to fund those expensive services, rising expenses for payroll and pharmaceuticals, a decline in the number of outpatient surgeries performed (due, in part, to a rise in the number of physician-owned surgical hospitals) and the alarming reality that more than a third of hospitals throughout Arkansas and the rest of the nation are operating in the red.

So, what do we do? Well, we begin by looking at these issues from a common sense approach. We continue to work together. And we help Arkansas’ elected officials see exactly what their decisions will mean in the day-to-day operation of our hospitals.

When Band-Aid legislation and governmental regulations handed down from Little Rock and Washington create unintended negative consequences for hospitals, each of us—from the patient to the hospital employee, the trustee to the physician—suffers.

Legislative and regulatory edicts are never enacted with ill intent. They usually result from actions taken by people who thought they had the needed information in hand to make a well-informed decision, but didn’t. CMS’ proposed “75% Rehab Rule,” for example, is so overly restrictive that it would have a devastating effect on the ability of patients to get the rehabilitation they need, particularly those who need joint replacements. Fortunately, Congress listened to us and declared a moratorium on the rule until its impact can be studied more closely.

Another challenge is the continuing rise in the number of uninsured patients and the decided cost burden it puts on Arkansas’ hospitals. Shifting the cost of uninsured patients to others could be reduced if government programs like Medicare and Medicaid paid the full cost of care for the patients participating in those programs. As it is, Medicare payments have fallen to 95 cents for every dollar hospitals spend caring for Medicare patients. Medicaid reimbursement has fallen to 92 cents on the dollar.

Costs could be reduced, and so could the number of hospitals forced to reduce or eliminate patient services due to financial pressures, if legislation and regulations were enacted after a little more communication, with a lot less bickering, and with a considerably larger portion of common sense than we’ve seen in recent months and years.

How can we help ensure this? We start by talking with our elected officials, the governor, our state senators and representatives, and our congressional delegation. We let them know what their actions (or inactions) will mean back home. In other words, we help them think. We keep a dialogue going so they understand the implications of their actions.

As the 85th Arkansas General Assembly and the 109th U.S. Congress enter a new legislative season, let’s resolve to help our elected representatives better understand the healthcare issues at hand. We here at the AHA will, as always, serve as message-bearers on your behalf, but your own individual communication is going to be more important this year than ever before.

With you pitching in, we can help lawmakers understand healthcare’s intricate challenges. We can help them think through the tough issues on which they’ll be voting. Honest dialogue is always important. But the dialogue has got to be strong, and it must be consistent. In 2005, with a state and a nation divided on too many other issues, common sense and good dialogue are imperative for healthcare’s future.

James R. Teeter
President and CEO
Arkansas Hospital Association
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Gary Looper has been named CEO of Northwest Health System in Springdale, succeeding Bill Bradley who accepted a position in Fayetteville. Looper has been CEO of Woodland Heights Medical Center in Lufkin, Texas since 2001. He has more than 25 years of experience in the healthcare industry. Woodland Heights Medical Center is operated by Triad Hospitals Inc. of Plano, Texas, as is the Springdale facility.

Bill Bradley, president and CEO of Washington Regional Medical System in Fayetteville, has announced the appointment of Mark Bever as administrator and Tami Hutchison as senior vice president for planning and business development of Washington Regional Medical Center. Bever is the former administrator/chief operating officer of Northwest Medical Center of Benton County in Bentonville. Hutchison was senior vice president at the Bentonville facility. Both Bever and Hutchison began their new positions at the Fayetteville facility in mid-November.

Leah A. Osbahr has been named president of Lawrence Memorial Hospital of which she was administrator for more than 20 years. Osbahr has more than 100 beds.

Richard Goddard, CEO of Drew Memorial Hospital in Monticello, was named Administrator of the Year for hospitals with less than 100 beds by the Arkansas Hospital Association board in 1972-73 and recipient of the AHA’s highest honor, in 1981. Those who knew Means admired his quiet demeanor, good sense of humor, and keen intellect. “It’s a sad day around here, and for the healthcare community throughout Arkansas, for Hugh’s contributions were so many,” said Donnie Frederic, administrator/COO of Northwest Medical System in Fayetteville, has announced the appointment of Joel Klein as CEO/Managing Director at The BridgeWay Hospital in North Little Rock. Klein joined UHS as the COO at Timberlawn Mental Health System in Dallas and has more than 20 years of healthcare experience.

Stephen L. Mansfield, president and CEO of St. Vincent Health System (SVHS) in Little Rock, has been elected to fill a term as an alternate delegate representing the Section for Metropolitan Hospitals on the American Hospital Association Regional Policy Board 7. Mansfield’s two-year term expires December 31, 2006.

Mansfield also was the recipient of the Maureen Reagan Outstanding Advocate Award at the November 9 Alzheimer’s Association’s “Autumn Lights Gala” in Little Rock. He was recognized for his “pioneering effort to treat memory disorders by establishing the first Memory Center in the state” at SVHS.

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.

Hugh Means of Springdale died November 4 at Northwest Medical Center of Washington County, formerly Springdale Memorial Hospital of which he was administrator for more than 20 years. Means was chairman of the Arkansas Hospital Association board in 1972-73 and recipient of the A. Allen Weintraub Memorial Award, the AHA’s highest honor, in 1981. Those who knew Means admired his quiet demeanor, good sense of humor, and keen intellect. “It’s a sad day around here, and for the healthcare community throughout Arkansas, for Hugh’s contributions were so many,” said Donnie Frederic, administrator/COO of Northwest Medical Center of Washington County. Memorial contributions may be made to Circle of Life Hospice, 610 E. Emma Ave., Springdale, Arkansas 72764.
It’s a new year 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.

Robert P. Atkinson, *President and CEO*
Jefferson Regional Medical Center, Pine Bluff and AHA Chairman-Elect

“For me, The Arkansas Hospital Association signifies a strong, unified voice which represents hospital interests to legislators, regulatory agencies, special interest groups, and other associations, institutions, and industries. Secondly, the AHA is a catalyst for cooperation and networking among hospitals. Thirdly, the AHA allows us to achieve strength in numbers; more clout than otherwise possible. The good part is the AHA does all these things better and less expensively than any other alternative.”

Ben Frank, *CEO*
Central Arkansas Hospital, Searcy

“The Arkansas Hospital Association has been a tremendous resource to Central Arkansas Hospital in many ways. The leadership of the AHA has the foresight and vision needed to further enhance the delivery of healthcare services to the citizens of Arkansas. The educational programs as well as the annual meeting are a great source of collaboration with fellow CEOs and other key leaders in the state.”

Ross Hooper, *President and CEO*
Crittenden Memorial Hospital, West Memphis

“Membership in the AHA gives me an instant ‘window on the world’ of healthcare. The AHA staff is both gifted and expert in editing important information from the mass of health-related activities...and in providing advice concerning these items. The association is an invaluable source of data for those of us in the field, and is a staunch ally when we need help or advice. AHA membership represents my hospital’s biggest bargain.”

Douglas Weeks, *Senior Vice President/Administrator*
Baptist Health Medical Center—Little Rock

“The benefit of membership in the Arkansas Hospital Association is multifaceted. We depend on the staff to help us prioritize issues of importance on the state and national levels, where they lobby our concerns most effectively. The AHA provides wonderful learning opportunities through summer conferences, the annual meeting and various other events that are tailored to specific subjects. Possibly the most important benefit the AHA offers is the opportunity to network with fellow healthcare workers to solve and resolve issues pertinent to all of us. Keep up the great work AHA!”

Lucinda L. DeBruce, RN, MS, *CEO*
Pinnacle Pointe Hospital, Little Rock

“While being a hospital CEO has never been easy, the current job requires multi-tasking at a whole new level. We always look for ways to be more efficient and to “streamline” the vast amount of information that we need to do our job well. That’s where the Arkansas Hospital Association
comes in—I can always rely on them to be on top of the critical issues hospitals and healthcare are facing, both locally and nationally. They serve as our extension, our advocate, and our collective voice addressing the complex myriad of challenges hospitals face from the reimbursement arena, to quality patient care, to legislative issues, to relationships with other providers, and many other areas. I truly could not imagine our facility without our partnership with the Arkansas Hospital Association.”

Kevin Clement, CEO
Crawford Memorial Hospital, Van Buren

“New to the great state of Arkansas, I have been impressed with the ease of communication I have established with our friends at the Arkansas Hospital Association. Both Jim Teeter and Phil Matthews along with administrative support staff have been there when I was in need of information. Not only new to the state, but as a first time CEO the educational value of AHA membership and political insight has assisted me in localizing to our area of Western Arkansas. I especially value the timeliness of the AHA Hotline that continues to keep me abreast of the issues when interacting with both medical staff and Board members. My family also has benefited from the family environment created at the recent meetings. We have met many nice people and look forward to seeing them at future AHA meetings in 2005. Thank you AHA! Now, if you could help me make budget this year, you will truly be a hero to all…..”

Winter 2005  Arkansas Hospitals
As we all know, healthcare isn’t just about healing, hospitals, issues, and funding. It’s mainly about people—those for whom we care, and those who work in the field.

Addressing the needs and concerns of those who work in the field of healthcare was the idea behind this year’s AHA Annual Meeting October 6-8 in Little Rock. With the theme “Healthy Healthcare—Medicine’s New Horizon,” the three-day meeting addressed the spiritual, ethical, legislative, economic and customer satisfaction concerns with which each of us must wrestle on a daily basis. A very “healthy” group of presenters encouraged us to take a hard look—and sometimes a humorous approach—to our daily lives in healthcare.

Starting us off was the AHA’s own Tina Creel, vice president of AHA Services, Inc., who inspired us with her musical rendition of “Wind Beneath My Wings.” We’d like to thank Tina, and the entire AHA staff for their hard work behind the scenes to keep the conference running smoothly.

Dan Wilford, Advisor, Memorial Hermann Healthcare System, Sugar Land, Texas and mentor to many in the Arkansas healthcare community, helped us look at the role of spiritual leadership. His Spiritual Leadership Institute teaches a principal-based, value-based, spiritual-based system of management. Key to his leadership style are three reminders: 1) Focus on your mission, 2) have clarity of vision, and 3) have clear strategies with specific responsibilities for all.

“AHA Services vice president Tina Creel

As many of you know, I like to go back to my days of officiating in the NFL,” Wilford said. “And what I see today is that too many people forget that it’s all about fundamentals!”

Wilford emphasized the need for each person to maximize his/her own capabilities. “Work with your gifts,” he said. “You must always be developing your spiritual self. And remember to have a positive attitude. Attitude is everything.”

Committing to excellence is also a key of Wilford’s leadership style. He likes to quote the late Coach Vince Lombardi by saying, “The quality of a person’s life is in direct proportion to his commitment to excellence, regardless of his field of endeavor.” And a big part of that commitment to excellence is maintaining personal discipline, and being accountable for your own actions.

“You must own up to your mistakes,” he says. “A big part of it is discipline throughout the organization, and for that to be present, personal accountability must be present throughout the organization.”

People need to see their leaders taking personal accountability for their own mistakes, he says. And they need to see that their leaders sacrifice just as they expect all team members to sacrifice.

“It’s about building a culture, a team, with trust,” he says. “We all have our primary responsibilities, but our secondary responsibility is to back up the other members of our team. We can be ‘right’ together, and we can be ‘wrong’ together, but we need to BE together.”

He sees management as a team sport. “There is a trust dimension to management—trustees, managers, executives all do their thing, and must trust each other to do so,” he says. “If any person falters in holding up their end of their responsibilities, trust can suffer. But if all the team members hold up their end of the bargain you will have a trust worthy organization.”

“Healthcare is a ministry that has to operate like a business,” Wilford says. “If you get hung up on the business end, you are in danger of missing your ministry.” And getting back to those fundamentals? “It’s all about discipline, teamwork and trust,” he says. And he showed us by example that integrity, hard work, truly caring, putting patients first, and investing ourselves in others—all are vital in our roles as healthcare leaders.

Dr. Lowell Catlett, PhD, Regent’s Professor, Department of Agriculture Economics and Agriculture Business, New Mexico State University, Las Cruces, New Mexico had us all in stitches as we considered the impact of technology on people’s lifestyles—and how that equates to the consumer’s demands of the healthcare field. His background in economics allowed him to take us along the path of progressive affluence in the world; his gifts of teaching and humor made it memorable.

“We are moving from a production economy to a consumer economy,” Catlett said. “An economy where people can afford what they want, where even our ‘poor’ have cars, televisions, riches beyond what many of the ‘affluent’ in other nations own.”

What does that mean for healthcare? “There is more disposable income in Americans’ hands than ever before,” he said. “Healthcare is finding ways to get some of that disposable income, by providing what Americans demand. After all, in hospitals, we don’t just ‘take what they give us’ anymore. We differentiate between hospitals based on the services we feel they will provide.”

The world’s economy is also changing. “Since the beginning of the 20th century we have gone from a world of 51 nations to a world of 206 nations; of seven belief
systems to more than 2000 belief systems.”

Diversity is the key. What this means for healthcare is that the demand for specialized services, providing services that match people’s language and belief systems, will become the norm.

“Think about it. In our nation, we are changing the way we market our healthcare. We market to women, to Hispanics, to other minorities,” he says. “We must address their needs, or they will take their disposable income elsewhere.”

“The presence of animals in the healthcare setting helps heal—let’s address it! We have an aging population—let’s address it! We are a nation of single heads of household, usually where a woman is the head of the household—let’s address it!” he said.

Catlett says we must take the personal technologies available today and apply them to medicine. We must change medicine to address the needs of a changing world.

“Medicine has the potential to put all the pieces together,” he says. “Healthcare can get some of the disposable income, but must be willing to adapt to flow with people’s demands, their needs.

Attorney General Mike Beebe

Luncheon, discussed the November elections and various constitutional amendments being considered by Arkansans. He said he had learned a lot from his years as a hospital trustee, and says he believes hospital trustees have the unique ability to help, influence and set the direction for healthcare as it affects our state.

Julie Hall-Barrow, Director, UAMS Rural Hospital Program, Little Rock, presented a look at telehealth options in Arkansas. Explaining that telemedicine technology gives community physicians the ability to instantly share visual and audio information with specialists, particularly at the University of Arkansas for Medical Sciences (UAMS), Hall-Barrow showed how telephone lines, computers, television cameras, electronic stethoscopes and diagnostic instruments equipped with miniature video cameras all join to help patients receive advanced medical care throughout the state, even in its most rural areas.

Currently, UAMS has 17 sites on campus connected to interactive TV, and more than 180 sites in Arkansas utilizing telehealth technologies.

A demonstration of video training combined with hands-on, real-time interactive practicums showed how new skills can be taught off-site to medical personnel throughout the state.

The objectives of the Telehealth program are to improve access to specialty care through the provision of telemedicine consultations, to improve the quality of emergent care through around-the-clock interactive television connections, and to increase access to health professions education and continuing education for healthcare personnel across the state. The program also strives to improve Arkansas’ system of healthcare delivery through the development of interactive television networks that can be replicated in rural areas.

According to Hall-Barrow, telemedicine works for patients by increasing the subspecialty care they can receive in their hometowns, decreasing the need for patients and their families to travel for care, and thus decreasing their expenses, time investment and inconvenience. It works for hospitals by enabling them to expand patient care services and to increase the number of patients who stay in their own communities for treatment.

“Further,” she says, “it works for communities by helping keep healthcare dollars and resources in the local economy, and it works for physicians by making sub-specialists readily available to work directly with primary care physicians in the care of their patients.”

Fred Lee, Fred Lee & Associates, Altamonte Springs, Florida brought us a thought-provoking session on customer satisfaction, titled “If Disney Ran Your Hospital—You Would Think Differently about Satisfaction and Service.”

“If you try to take satisfaction to the bank, it’s worth nothing,” he says. “Satisfaction does nothing to improve your competition in the marketplace. What matters is LOYALTY. And customers don’t give you their loyalty lightly.”

The commitment of workers at ALL levels of the hospital chain, from janitors to CEOs, is vital, he says. “You want every person all along the line to be committed to making that patient’s stay—and that of his/her family—memorable in a GOOD way.”

Those who sing the praises of hospitals—are not just “satisfied” with their hospital stay, but who found it to be remarkable—become a hospital’s...
Promoters. These people talk positively in the community about the hospital, and can have a positive influence on a hospital’s financial performance.

“If your hospital’s satisfaction survey allows people to rate their experience from 1-5, with 5 being excellent, 4 being good, and 3 being satisfactory, you don’t want to focus on the 3s and 4s,” he explained. “You want to strive for 3s, because those are the people who become your Promoters.”

Lee explains the Disney approach to customer loyalty as 1) doing all you can to make your guests’ experience the best it can be, 2) being aggressively friendly, and 3) doing all you can to keep the place clean. “If every person employed at a hospital takes that attitude, it makes a marked difference,” he says. “You hire people for their competence, you require that they show courtesy, but you inspire when your employees show true compassion. That’s what builds Promoters.”

Helping hospitals take a new attitude toward the patient is another goal of the “Disney way.” Should hospitals be more like service organizations, or experience organizations, he asks? “We must focus on the patient’s experience, not on our service,” he says. “All transactions happen outside of you if you are focused on service. If you are focused on experience—or those of your patients—you become engaged. Something happens inside of you. Your attitude is different. You become ‘people oriented,’ not ‘service oriented.’ And, you create Promoters.”

Lee advocates making certain the whole hospital staff works together as a team, from housekeeping to nursing, kitchen to administration. “People change their attitudes by what you hold them accountable for when you look them in the eye,” he explains. “It is not what’s written on their job description, but the actual role they play in patient’s lives that makes the difference.”

When true teamwork and caring for the patient’s experience happens in a hospital, every employee truly has ownership. What is the value of a committed employee who has become compassionately engaged in each patient’s experience? Priceless.

Commander Scott Waddle, USN (Retired), Cary, North Carolina rounded out the 74th Annual Meeting with a renewed call for ethics in his presentation, “Failure is Not Final.” Waddle commanded the U.S.S. Greeneville when it collided with the Ehime Maru, a 500-ton Japanese fishing vessel, killing nine people on board in February of 2001.

Against the advice of his attorney and the Navy’s direction, he took responsibility for the accident. Commander Waddle’s compelling story about the ordeal and the choices that followed are a lesson in integrity, faith and resilience. Waddle also gives his top list of important elements of leadership:

1) Lead by example
2) Invoke exacting standards
3) Listen
4) Communicate effectively with a sense of purpose and meaning
5) Foster a climate of trust
6) Build your people up
7) Improve their quality of life

“There are people out there who feel that they’re adrift,” he says. “Help them find where they fit, then work on their weak areas to help build them up.”

Other “Waddle Rules” include:

1) Never say, “It’s not my job.” Have the humility to do in your heart what you know is right. Remember that ethics and integrity are what you do when people aren’t watching.
2) “We need to learn to embrace and learn from failure,” he says. “In the case of our accident, each and every seaman told the truth, no matter the consequences to self or career. It was hard, so hard to live with the truth of those nine lives lost. But we learned that if you can get through these moments, your building blocks (values) will get you through.”

His unbending ethics serve as a beacon to leaders in all fields of endeavor.

Fred Lee

Fred Lee returns to help hospitals work on service excellence, patient loyalty, and employee satisfaction. Don’t miss it!

February 15, 2005
Holiday Inn Select
Little Rock

The second thing he learned, he said, is that “if the boss isn’t having fun, you can bet those working for him/her aren’t, either!” He urges bosses to look at morale. Stop all yelling and profanity, belittling behaviors, etc. Help people learn to be efficient in all that they do, and help them learn how to back each other up. “If your organization is not doing well, look internally for answers,” he says. “Our problem was morale, but we became known for helping people find their gifts, and became ‘the boat of second chances.’”

Don’t miss it!
Luther J. Lewis, CEO of the Medical Center of South Arkansas (MCSA) in El Dorado, is the recipient of the 2004 A. Allen Weintraub Memorial Award. The award, named for the late administrator of St. Vincent Infirmary Medical Center in Little Rock, was decided by the Arkansas Hospital Association board of directors and presented during the Arkansas Hospital Association’s 74th Annual Meeting October 6-8 in Little Rock. It is the highest honor bestowed upon a hospital executive by the AHA.

Lewis has served as the CEO of the El Dorado medical center for the past 13 years. For the balance of his almost 30-year career in healthcare, he worked in administrative positions with hospitals in Louisiana and Texas.

During his tenure at the MCSA, Lewis has overseen $26 million in construction and service expansion projects, including laboratory services, the addition of an open MRI, a cardiac cath lab, a physical medicine and rehabilitation unit, one-day surgery unit, and the expansion of the hospital’s surgical capabilities; capital acquisitions totaling $40 million; and new or upgraded services throughout the hospital. He is also responsible for the development of the South Arkansas Center on Aging —Senior Health Center, a joint venture of the UAMS Area Health Education Center—South Arkansas, the City of El Dorado, and the MCSA.

Lewis is a former chairman and member of the AHA board of directors, an officer of the Southwest Hospital District, and a Fellow in the American College of Healthcare Executives.

Active in civic and community affairs, Lewis is a board member of the Junction City Industrial Development Corporation and the South Arkansas Community College Foundation, and a former board member of Main Street of El Dorado and the El Dorado Chamber of Commerce.
Mansfield, Craft Receive ACHE Awards

Steve Mansfield, president and CEO of St. Vincent Health System (SVHS) in Little Rock, and Karen Craft, administrator of Stone County Medical Center (SCMC) in Mountain View, were recipients of awards presented by the Arkansas Chapter of the American College of Healthcare Executives (ACHE) during the Arkansas Hospital Association’s 74th Annual Meeting at The Peabody Little Rock October 6-8. The awards were presented in recognition of their accomplishments as healthcare executives.

Mansfield, who joined SVHS in May 2000, received the 2004 ACHE Regent’s Award for Senior Career Healthcare Executive. The award honors his four years of service to the organization, during which time he has achieved a successful turnaround in hospital operations, from community perception and patient satisfaction to employee morale and the bottom line.

Before joining SVHS, Mansfield was administrator and CEO of Baptist Memorial Hospital–East in Memphis, Tennessee. Baptist Memorial is a division of Baptist Memorial Health Care Corporation, which he joined in 1977. A Fellow in the American College of Healthcare Executives, Mansfield is a member of the Little Rock Rotary Club, a board member of the Greater Little Rock Chamber of Commerce, and past corporate chairman for the National Conference for Community and Justice–Arkansas Region’s “Walk as One” campaign.

Craft was presented the Regent’s Award for Early Career Healthcare Executive. Since being named to lead SCMC in November 2002, she has succeeded in gaining many significant improvements at the facility, particularly in the areas of employee and physician satisfaction. Also under her guidance, the hospital broke ground in June 2004 for a $6 million construction project, which includes new surgical suites and an outpatient area, expansion and renovation of the hospital emergency department, and a lobby area that is designed specifically to be customer friendly.

Prior to being named SCMC administrator, Craft served as the laboratory director at White River Medical Center in Batesville, which purchased the Mountain View hospital in 1999. While there, she was successful in implementing the WRMC Reference Lab program and led that laboratory through the implementation of a lab information system.

Craft is also involved with community activities in Mountain View, where she organized the community’s first Kiwanis Club and now serves as its chairman. She is active with hospital members of the Arkansas Hospital Association’s North Central District, is a member of the Arkansas Health Executives Forum and is preparing to advance to Diplomate status with the ACHE.

John Heard Receives 2004 Melville Award

John E. Heard, chief executive officer of McGehee Desha County Hospital, is the recipient of the 2004 C.E. Melville Young Administrator of the Year award presented by the Arkansas Health Executives Forum. The award is named for the late C.E. Melville, former administrator of Jefferson Regional Medical Center in Pine Bluff. The recipient is selected by a committee formed by the Regent of the American College of Healthcare Executives (ACHE) and ACHE members currently holding administrative positions in Arkansas.

The award was presented during the Arkansas Hospital Association’s Annual Meeting October 6-8 in Little Rock.

Heard, who obtained his Masters Degree in Health Services Administration at the University of Arkansas at Little Rock after earning a Bachelor of Science in Cardio-Respiratory Care at the University of Arkansas for Medical Sciences, has been CEO of the hospital for two years. Prior to joining the facility, he served an administrative residency in Malvern, an administrative fellowship in West Monroe, Louisiana, and worked in the Arkansas Department of Health’s Office of Rural Health.
AHA 2004 Diamond Awards Announced

Winners of the Arkansas Hospital Association’s 2004 Diamond Awards received their trophies at the AHA Annual Meeting October 7. The competition, co-sponsored by the Arkansas Society for Healthcare Marketing and Public Relations, recognizes excellence in hospital public relations and marketing. Diamond, Excellence, and Judges Merit Awards were possible in three divisions (hospitals with 0-99 beds, hospitals with 100-249 beds, and hospitals with 250 or more beds) in twelve categories. The competition drew 142 entries.

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

Congratulations to all 2004 award winners:
Arkansas Children’s Hospital, Little Rock
Arkansas Heart Hospital, Little Rock
Arkansas Methodist Medical Center, Paragould
Baptist Health, Little Rock
Baptist Memorial Hospital, Forrest City
The BridgeWay, North Little Rock
CARTI, Little Rock
Conway Regional Health System, Conway
HSC Medical Center, Malvern
Jefferson Regional Medical Center, Pine Bluff
Medical Center of South Arkansas, El Dorado
Methodist Behavioral Hospital, Maumelle
National Park Medical Center, Hot Springs
North Arkansas Regional Medical Center, Harrison
Ozark Health Medical Center, Clinton
Saint Mary’s Regional Medical Center, Russellville
St. Vincent Health System, Little Rock
Stuttgart Regional Medical Center, Stuttgart
UAMS Medical Center, Little Rock
White County Medical Center, Searcy
White River Medical Center, Batesville
OIG Releases New Work Plan for 2005

The Office of Inspector General (OIG) will continue to focus on long-running audits and evaluations in its Work Plan for 2005. Released October 12, the work plan lists projects that the OIG expects to study in 2005, many of which are potential causes of fraud, waste, and abuse. “In the 2005 Work Plan, there is a tremendous amount of continuation of audit and evaluation work from prior OIG Work Plans,” says Howard Young, Esq., a partner with Sonnenschein, Nath & Rosenthal LLP in Washington, D.C. The Work Plan shows how much time the OIG must now devote to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) implementation, including drug-pricing and other issues. However, the OIG won’t be taking its eye off hospitals, labs, and physician practices, according to Young. He said the agency will continue to focus on medical necessity and perform medical reviews. Hospital-related projects slated for 2005 include:

- **Post-acute care transfers**—The OIG will assess contractors’ ability to limit payments to hospitals for patients who are discharged from a prospective payment system inpatient hospital and admitted to one of several post-acute care settings.

- **Rebates paid to hospitals**—The OIG will determine whether hospitals are properly identifying purchase credits as a separate line item in their Medicare cost reports. This study is an outgrowth of the audit work the OIG is doing with group purchasing organizations.

- **Inpatient rehabilitation payments for late assessments**—The OIG will determine the accuracy of Medicare payments for inpatient rehabilitation stays when patient assessments are entered late.

To read the complete work plan for 2005, go online and click on [http://www.oig.hhs.gov/publications/work-plan.html#1](http://www.oig.hhs.gov/publications/work-plan.html#1).
Arkansas Emergency Preparedness Grants Update

The Arkansas Department of Health (ADH) is working with hospitals, community health centers, emergency services and other entities on several Health Resources and Services Administration (HRSA) emergency readiness grants. Arkansas hospitals are receiving thousands of grant dollars to add or upgrade emergency readiness equipment and supplies, and, in some cases, to fund construction projects. The following is an update on those grants:

• Year 2 agreements between the ADH and Arkansas hospitals have been extended to allow hospitals additional time to spend the money offered through the second year HRSA grant period. The Health Department has mailed all qualified hospitals an amendment extending the date of the original contract to June 30, 2005. However, in order for the hospital to be reimbursed for those expenses, the contract amendment must have been signed by the end of November 2004. After that date, all remaining funds were to be reallocated. Arkansas hospitals that have not spent any of their funds are urged to begin doing so immediately.

• Tandberg audio/visual equipment is being distributed in four phases to hospitals throughout the state. The first phase was included in the Year 2 grants to selected hospitals, under which hospitals placed their own orders for the equipment. Thirty-six additional hospitals will receive the equipment under the Year 3 grants. Also under the new grant cycle, hospitals in the second and third phases of the program will be contacted by ADH representative Bruce Thomasson to determine which model of Tandberg equipment (the 880 or Intern II) they prefer. Thomasson will place the orders. The fourth phase will be announced later.

• Seventy Arkansas hospitals have received “standard” Year 3 (October 2004—August 2005) grants. The standard grant includes $4,000 for hospital bioterrorism coordinators, $2,000 for training, and receipt of a 700/800 mhz radio. Agreements for other hospitals, such as Tier One facilities, are being processed.

• Additional funds from the Year 3 grant will be awarded regionally in order to “fill the cracks” and strengthen the regional plans. Each region will receive funding for training, drills and exercises, decontamination improvements, and personal protective equipment.

The T-1 computer lines are being installed to link all acute care hospitals that will make up the Arkansas Hospital Network. That work is near completion. In addition, equipment has been installed in all but six hospitals that lie in the CenturyTel area; minor adjustments are being made in another five hospitals.

The Health Department is offering hospitals $100 per “drop” to connect each of five work areas to the network. Those include the hospital emergency operations center, lab, infection control, hospital bioterrorism coordinator, and emergency department. A private contractor will be used for hospitals that do not wish to make these connections themselves.

The Cost of Uncompensated Care in America

The cost of uncompensated care in America rose from $22.3 billion in 2002 to 24.9 billion in 2003, according to the American Hospital Association Annual Survey and a Health Forum fact sheet released in November. In addition, the number of hospitals in America continues to drop—from 4,927 in 2002 to 2,895 in 2003—while the cost of uncompensated care as a percentage of total expenses continued to rise, from 5.4% in 2002 to 5.5% in 2003.

Uncompensated care, in this report, is defined as the estimated cost of bad debt and charity care to the hospital. This figure is calculated for each hospital by multiplying uncompensated care charge data by the ratio of total expenses to gross patient and other operating revenues. The total uncompensated care cost is arrived at by summing all individual hospital values.

The uncompensated care figure does not include Medicaid or Medicare underpayment costs, or other contractual allowances. Moreover, the figure does not take into account the small number of hospitals that derive the majority of their income from tax appropriations, grants and contributions.

For more information on accessing the annual survey findings, go to www.aha.org.
AHA Honors Three With Distinguished Service Awards

Wayne Hartsfield of Searcy, Dr. Carl Chambers and Dr. John Wilson of Little Rock were selected by the Arkansas Hospital Association board of directors to receive the association’s Distinguished Service Award. The awards were presented during the AHA’s 74th Annual Meeting in Little Rock.

Hartsfield has played a key role in White County Medical Center’s growth and accomplishments since its inception in 1967. As chairman of the hospital’s board of directors, he was instrumental in the hospital’s successful conversion to a county-owned 501(c)3 facility. He has also worked to secure widespread support in Searcy and its surrounding areas for a broad expansion of the hospital’s facilities and services during his service on the board.

Dr. Chambers, a retired otolaryngologist, is a professor and associate director of residency training in the Department of Otolaryngology at UAMS. He is past president of the Arkansas Medical Society. He was in private practice in Harrison and instructed surgical and nursing staff at North Arkansas Regional Medical Center for many years. He was also instrumental in initializing several innovative changes that benefited the continuing medical education department at the hospital.

Dr. Wilson is an orthopedic surgeon in Little Rock and immediate past president of the Arkansas Medical Society. An active volunteer, he is a lifetime member of the Arkansas Nature Conservancy; a volunteer physician for Project Dawn, an international professional outreach program that provides medical and surgical services in Guyana, South America; and a former board member of the UALR Foundation. He is a member of the Arkansas State Medical Society Council, former chairman and board member of the Pulaski County Medical Society, and founding partner of OrthoArkansas.

Drs. Chambers and Wilson were leaders in getting the Arkansas Civil Justice Reform Act passed during the 2003 Arkansas Legislative session. In promoting the need for a tort reform law, they toured the state gathering political and monetary support for the coalition of Arkansas healthcare providers and business organizations that backed and eventually won the changes which are found in Act 649 of 2003.

JCAHO Increasing Triennial Survey Fees

The governing board of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has voted to increase triennial survey fees for hospitals by $2,700 in 2005, an 11.7% rise compared with the average $23,000 fee for surveys in 2004. In addition, the JCAHO will tack on a separate fee of $3,500 for hospitals of 200 beds or more to defray the cost of adding a certified healthcare engineer to the survey team. The engineer will enhance the commission’s ability to evaluate hospital compliance with life-safety code and physical plant requirements. With that added fee, the total increase in costs for larger hospitals in 2005 stands at 27%. The JCAHO last increased survey fees in 1999 for the 2000 accreditation year. That fee increase was 3.25%. The commission also increased fees in its other accreditation programs, ranging from $300 for critical-access hospitals to $3,000 for healthcare networks.

QIO Work Plan Proposed

The Centers for Medicare & Medicaid Services (CMS) has released for public comment a summary of its proposed “Scope of Work” for Quality Improvement Organizations (QIOs) for the three years beginning in August 2005. The QIOs are Medicare contractors whose role is to lead CMS efforts to improve the quality of care throughout the nation’s healthcare system.

Under the agency’s proposal, QIOs would work to form and expand partnerships with other organizations, such as provider and consumer groups. The review agencies would also push to improve the adoption and effective use of healthcare information technology, including broader use of electronic medical records in doctors’ offices.

The Arkansas Foundation for Medical Care, Arkansas’ Medicare QIO, is currently educating physicians on the use of an electronic health records system through the Doctors’ Office Quality Information Technology (DOQ-IT) Project. Comments on the Scope-of-Work summary were received this fall, and will be used to develop the full Scope of Work and determine the level of funding for the program. The so-called “8th Scope of Work” summary can be found at http://www.cms.hhs.gov/qio2.asp.
JCAHO, CMS Aligning Core Measures

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) announced September 16 the signing of an agreement to work together to completely align current and future common Hospital Quality Measures in their condition-specific performance measure sets. The current Hospital Quality Measures are included in the Joint Commission’s ORYX® Core Measures and CMS’ 7th Scope of Work Quality of Care Measures on heart attack, heart failure, pneumonia and surgical infection prevention.

CMS and the Joint Commission released and made available on their Web sites a common measures specification manual, which includes a data dictionary, measure information forms, algorithms and other technical support information. The specification manual can be found at http://www.jcaho.org/pms/core+measures/aligned_manual.htm on the JCAHO Web site.

Aligning measures for both groups should make it easier and less costly for hospitals to comply with existing CMS and Joint Commission requirements for data collection and reporting. The measures in the four Joint Commission and CMS hospital measure sets presently in use calculate the same way, but there are differences in the format of the specifications for data elements, types of cases excluded, calculation algorithms, and other measure dimensions.

Core measures are an integral component of efforts by CMS and the Joint Commission to improve the quality of care provided to hospital patients and bring value to stakeholders by focusing on the actual results of care. All of the hospital measure sets currently being used by the Joint Commission and CMS have been reviewed and endorsed by the National Quality Forum. The public availability of core measure data also permits user comparisons of hospital performance at the state and national levels.

J-1 Visa Waiver Gets Two-Year Extension

The House Judiciary Committee approved American Hospital Association (AHA)-backed legislation September 30 (H.R. 4453) that will reauthorize and extend by two years a visa program that helps staff medically underserved rural and urban communities with foreign physicians.

The Conrad State 30/J-1 Visa Waiver program, which was originally enacted in 1994 and expired May 31, authorizes state departments of health to annually hire up to 30 foreign physicians to practice in medically underserved rural or inner-city communities. The physicians, who have completed U.S. medical residency programs, are granted J-1 visa waivers enabling them to remain in the country after completing their residencies, provided they commit to practice medicine for three years in underserved areas.

H.R. 4453 reauthorizes the program for two years and clarifies that foreign physicians selected for J-1 waivers are exempted from caps on H1-B visas, temporary work visas used by highly skilled foreign workers.

An amendment sponsored by Reps. Hostettler (R-IN) and Jackson-Lee (D-TX) further clarifies that foreign physicians who are granted J-1 waivers may practice in primary care or specialty medicine. Both the House and the Senate (S. 2302) approved the measure in October.

Healthcare Benefits: Workers Losing Ground

Workers at all but the smallest firms were less likely to have health insurance provided by their employers in 2002 than in 1987, according to a new analysis from the Employee Benefit Research Institute (EBRI). EBRI reports that there has been a decline in the probability that a worker had employment-based health benefits between 1987 and 2002 in businesses of almost all sizes. Only in firms with fewer than 25 employees did the percentage of workers with employment-based health benefits not decline. For that group, the percentage increased slightly from 30% to 30.8% over the period.

Employment-based health coverage dropped to 69.1% from 75.9% at firms with 500 or more workers, to 64.9% from 68.8% at firms with 100-499 workers and to 54.4% from 57.4% at firms with 25-99 employees. Despite the lower probability that employees can look for employer-sponsored health benefits, health premium costs continue to be a drag on overall employment. Newly collected government data indicate that employers are delaying the hiring of new workers primarily due to the cost of health coverage, which averages about $3,000 annually per employee. Health benefit costs rose at an annual 8.1% clip for the second quarter of 2004, three times the rate of wage and salary growth.
St. Bernards Medical Center in Jonesboro has always been “home” to Chris Barber. It was in this hospital that he began his life, and it’s in this hospital that he continues to carry out the tradition of bringing quality healthcare to the region. As administrator for the 375-bed facility, Barber is continuing the mission established by the Olivetan Benedictine Sisters more than 100 years ago by “seeking to provide Christ-like healing to the community through education, treatment and health services.”

Born and raised in Jonesboro, Barber completed his bachelor’s degree in business administration at the University of Arkansas in 1989. A few years later, he earned his master’s degree in public administration from Arkansas State University. It was during his graduate program when he chose hospital administration as a career.

“I completed my semester-long internship at St. Bernards under Ben Owens, to whom I am deeply grateful for taking the risk of selecting me as an administrative intern,” said Barber. “Throughout the years, he has provided me with many opportunities to grow and develop while providing wise counsel. Most importantly, he has taken his time and energy to truly serve as a mentor.”

From quality coordinator to work in Information Services to serving as chief operating officer, Barber has worked in different areas of the hospital giving him the skills needed to run the facility. He became administrator in March 2003 and continues to use his 13 years of St. Bernards experience for the betterment of the hospital.

Overseeing expansions to the hospital has become one of Barber’s major priorities over the past few years. In the summer of 2004, the Wound Healing Center opened for patients with non-healing chronic wounds. This facility came about because of a need in the community. “Patients were having to drive several hours for treatment, but with the Wound Healing Center, people’s lives are literally being changed. I am pleased we are able to offer this important service to our community with an expert staff totally focused on healing wounds,” said Barber.

One of the newest projects currently under construction is the Outpatient Imaging Center. The $13.9 million, free-standing facility located in Matthews Medical Park will feature the latest diagnostic equipment, as well as an area designated for women’s health.
in St. Bernards Medical Center

“We will have several new services for women’s health, including a resource library, counseling offices and a breast care navigator that provides guidance and plan of action for women just diagnosed with breast cancer,” Barber said. The center is scheduled for completion around April 2005.

Barber sees an important aspect of the role of administrator as propelling the hospital further into the 21st century with the use of new medical technologies. As Barber explains, electronic patient folders and PACs, or picture archiving communication systems, allow physicians to pull up information regarding a patient from any computer at the hospital. “This technology is of great value because of its accessibility and instant access for timely decision making,” said Barber. “Physicians can consult each other regarding patients while looking at the same files.”

St. Bernards has also implemented the use of wireless technology in the hospital. “Doctors can sync information from different access points around the hospital and have all the information stored in their Palm Pilots. We have a progressive medical staff in the area of technology; currently we have close to 100 physicians utilizing the electronic medical record system within the clinic setting,” said Barber.

For Barber, St. Bernards is a very special place that provides a vital role within the community. Last year alone, the staff and volunteers served 502,960 individuals in search of healing, education and preventive care. “Over the past five years, we’ve provided more than $60 million in community benefit services above and beyond our normal pay-for-service obligations. Those services include traditional charity care, community outreach and health screenings, cash and in-kind contributions, education classes and volunteer efforts,” said Barber.

Other civic activities for Barber include being involved with the Jonesboro Regional Chamber of Commerce Board of Directors. “St Bernards is the largest employer in the area having around 2,000 employees and providing comprehensive services for 23 counties in Northeast Arkansas and Southeast Missouri,” he said. “It is important to keep a healthy relationship between the hospital and the community.”

“With sophisticated systems and advanced technology, the heart of St. Bernards is our people,” said Barber. We have individuals who are performing in amazing ways to create a thriving environment of growth. We are extremely proud of our recent designation as an Employer of Choice. St. Bernards is the only Arkansas recipient and only the second hospital in the nation to receive this prestigious designation. “This is truly a reflection of the healthy organizational culture that our employees have created over the years,” he said.

If running the hospital isn’t enough for Barber, raising three small boys under the age of six with his wife, Michelle, also keeps him on his toes. “Family is extremely important to me,” he said. Barber is also involved with First Baptist Church of Jonesboro, serving as a deacon. “There are many benefits to working and living in the town where I was raised. It has been exciting to experience the progress and growth of Jonesboro over the past several years.”

Another community important to Barber is the Arkansas Hospital Association. “The AHA provides a respected resource for timely and accurate information that assists in day to day operations. Communication and advocacy in the legislature and quality educational programs prove beneficial,” he said. “They also provide an excellent conduit for networking and professional development within the state.”

For St. Bernards Medical Center and Chris Barber, the future has never looked brighter. As they continue to move forward in the areas of technology and community services, Barber is a firm believer in the Golden Rule for both patients and employees. “‘Treat others how you would like to be treated’ should be your first responsibility, and then everything else will fall into place,” he said.

This is the eighth in a series profiling Arkansas hospital executives.
The Agency for Healthcare Research and Quality (AHRQ), part of the U.S. Department of Health and Human Services, has released a new evidence-based toolkit to help hospitals evaluate their disaster training drills. The kit, “Evaluation of Hospital Disaster Drills: A Module-Based Approach,” is designed to help hospitals identify strengths and weaknesses in their responses during a disaster drill so that they can improve their ability to fulfill required emergency management plans. It is available as a notebook with accompanying CD-ROM.

The toolkit guides hospitals through key steps for their disaster planning, including the need to plan drill objectives, train observers, document drill activities and debrief all participants. Evaluation modules are designed to capture all phases of drill activities, such as pre-drill planning and recording activities in each area of the hospital, including incident command, decontamination, triage and treatment. It also includes four supplemental forms to help facilities customize their drills so that they can practice responding to specific health threats, such as bioterrorism.

The kit is available at http://www.ahrq.gov/research/hosp-drills/hospdrill.htm. Copies also may be ordered by calling (800) 358-9295 or sending an e-mail to ahrqpubs@ahrq.gov.

The newly proposed revisions to the Rules and Regulations for Hospitals and Related Institutions in Arkansas include changes in twelve major areas including hospital emergency services. Under that section, the proposed rule contains language that would allow “qualified medical personnel” (QMP) to perform hospital Emergency Department medical screenings in the absence of a physician. Federal rules governing the Emergency Medical Treatment and Active Labor Act allow that flexibility.

The Health Department held a public hearing on the proposed rule changes September 10 and members of the Legislative Joint Committee on Public Health, Welfare and Labor reviewed it September 16. The revised rule is expected to take effect in January, 2005.

Specifically, the proposed changes state under Section 36(F)(1): “Each patient presenting to the Emergency Department shall have a medical screening examination by a qualified medical personnel. The examination shall be completely documented. If a physician is not present, the qualified medical personnel shall contact the physician requested by the patient or the physician on call to discuss the assessment findings and determine the patient’s condition.” That changes previous language which specified that an RN or physician shall assess the patient.

The rule also removes Section F(5), which previously stated, “Physicians’ Assistants (PAs) shall not see patients, in lieu of a physician, in the emergency department.” According to the Health Department, QMPs who have been formally designated by the hospital’s medical staff and governing authority may provide those screenings. However, if there is no physician present, the QMP must contact a physician to discuss the assessment findings. Health Department officials have previously clarified that a QMP, who assesses only in the absence of a physician, may be a Physician Assistant, Registered Nurse, Advanced Practice Nurse, or Nurse Practitioner.

Regulations establishing certain procedures for the imposition of civil money penalties for violations of the privacy, electronic transactions and security rules of the Health Insurance Portability and Accountability Act (HIPAA) will remain in place for another year, according to an interim final rule issued September 15 by the Department of Health and Human Services (HHS).

The procedural rule was slated to expire September 16, but HHS opted to extend it until September 16, 2005, to “avoid disruption of ongoing enforcement actions” while the agency continues to develop a “more comprehensive enforcement rule.” The interim final rule did not address the 19 comments submitted to HHS in response to the original procedural rule, including those of the American Hospital Association (AHA).

In its June 2003 written comments, the AHA called for closer alignment with HHS Office of Inspector General’s civil money penalty procedures, a less punitive enforcement approach to HIPAA transactions, and better guidance on how to handle violations of the privacy law.

Go to http://www.access.gpo.gov/su_docs/fedreg/a040915c.html and look under “Health and Human Services Department” to view the rule.
Arkansas Hospitals Meet Reporting Requirements

The Centers for Medicare and Medicaid Services (CMS) announced September 2 that 100% of the hospitals in Arkansas have taken their first step toward a commitment to improving their quality of care by voluntarily registering to submit quality data for public disclosure. Under provisions of the Medicare Modernization Act of 2003 (MMA), hospitals that submit quality information to CMS will be eligible to receive the full Medicare payment update in 2005. Hospitals that do not submit data will receive a 0.4 percentage point reduction in their annual update factor.

The CMS announcement stated that all of the 64 Arkansas hospitals participating in the Medicare inpatient prospective payment system have met each of CMS’s requirements. Nationwide, 98.3% of eligible hospitals met the reporting requirements. The data on quality of care that participating hospitals report will give consumers information about performance in three medical conditions—heart attack, heart failure and pneumonia. These conditions can result in hospital stays and are common among people with Medicare.

Currently, CMS publishes quality information for Medicare- and Medicaid-certified nursing homes and Medicare-certified home health agencies. Dallas CMS Regional Administrator James Randolph Farris, M.D., noted in the announcement that, “Soon, patients in Arkansas will be able to use this quality information to help them make decisions about hospital care, and hospitals can compare their performances, ultimately improving the quality of care for everyone.”

Beginning in early 2005, the hospital quality data will be publicly available on a consumer Web site, Hospital Compare, at http://www.medicare.gov, or by calling 1-800-MEDICARE (800-633-4227).

Strategies for Leadership: Don’t Overlook This!

Helping your hospital become more patient- and family-focused in its care practices is the idea behind a new toolkit from the American Medical Association. Strategies for Leadership: Patient- and Family-Centered Care is now in your hands, and is a valuable resource for focusing on safety, effectiveness, efficiency, timeliness and equity in care. Use of this toolkit in conjunction with other resources will allow hospitals to make the strides needed to improve patient care and address the challenges that patients have said we need to face.

The kit includes a video, video discussion guide, resource guide and hospital self-assessment tool for use by the hospital’s leadership team.

Questions or requests for more toolkits may be directed to Robyn Cooke, director of the State Issues Forum, 202-626-2672 or you may email Robyn at rcooke@aha.org.

Number of Uninsured Americans is Up—Again!

The U.S. Census Bureau reported August 26 that the number of Americans without health insurance for at least part of the year 2003 increased by 1.4 million, to a total 45 million people. That’s 15.6% of the population, up from 15.2% in 2002. About 1.3 million fewer Americans reported having coverage through their employer in 2003. That is 60.4% of the population compared with 61.3% in 2002. The percentage and number of people covered by government health insurance programs increased, to 76.8 million from 73.6 million in 2002. The percentage of children without health insurance remained unchanged at 11.4%, or 8.4 million. Children in poverty were more likely to be uninsured (19.2%).

For Arkansas, the report shows that an average 16.9% of the population lacked healthcare coverage during the two-year span 2002-2003. That was up from a 16.2% average for the 2001-2002 period. Arkansas has the 12th highest three-year percentage of uninsured people of the 50 states and Washington, D.C. from 2001 through 2003. Texas, New Mexico, Louisiana, California and Oklahoma are the five states with the highest three-year average uninsured rate.
Medicare is taking another step to improve the quality of healthcare by requesting public comment on how well physicians treat certain illnesses and patient perspectives on the quality of care received during hospital stays.

As part of Medicare’s comprehensive quality improvement efforts, the Centers for Medicare & Medicaid Services (CMS) has submitted standardized ambulatory care measures to the National Quality Forum (NQF) for review and comment. The measures will be used to monitor, report on and improve the care provided to Medicare beneficiaries.

An additional set of survey questions to measure patient perspectives on the care they receive when they are hospitalized was also submitted to NQF for their consensus-based endorsement process.

The NQF is a non-profit organization that provides endorsement of consensus-based national standards for measurement and public reporting of healthcare performance data.

CMS will also publish a Federal Register notice asking for public comment and input about the survey questions.

“We have already begun to see improvements in the quality of care available in the nation’s nursing homes and home health agencies since that information has first been measured and publicly reported,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “We’re continuing to work closely with the experts to help us make sure we are asking the right questions to improve the already high quality of care available in the nation’s hospitals and to begin to focus new attention on the quality of care available in doctors’ offices.”

The proposed ambulatory care measures—those that look at the quality of care available in doctors’ offices—are part of an effort with the American Medical Association’s Physician Consortium for Performance Improvement and the National Committee for Quality Assurance. The goal is to measure the improvement of care for such clinical conditions as coronary artery disease and heart failure, diabetes, high blood pressure, osteoarthritis, asthma, behavioral health, prenatal care and preventive care. CMS anticipates that the approved measures will be incorporated into ongoing quality improvement efforts and demonstrations that will be underway in early 2005.

“By collecting this information, we will be able to use these ambulatory care measures to pay providers for improving the quality of care,” said McClellan.

As part of the Hospital Quality Initiative, CMS intends to publicly report a broad set of hospital clinical measures along with measures of hospital patient perspectives on care. CMS has been working closely with the U.S. Dept. of Health and Human Services’ (HHS) Agency for Healthcare Research and Quality (AHRQ) to develop a standardized survey tool to assess patient perspectives, called HCAHPS (hospital edition of the survey formerly known as the Consumer Assessment of Health Plans).

AHRQ’s development of HCAHPS included consumer testing, stakeholder and public input, a pilot test in three states, additional small-scale field tests, and extensive psychometric analysis. CMS anticipates that hospitals will begin data collection using HCAHPS in 2005.

The questions selected for consensus review look at key areas including overall ratings of the hospital, communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information. The recommended questions are meant to complement, not replace, information hospitals currently collect to support improvements they use to support their own improvements in customer service and care.

The revised HCAHPS measures can be found at www.cms.hhs.gov/quality/hospital and the proposed ambulatory care measures are posted at www.cms.hhs.gov.
PUBLIC REPORTING OF DATA

to improve quality of care began in 2003 under the auspices of the National Hospital Quality Alliance, a public-private effort on quality reporting that supported the development of Medicare’s Hospital Quality Initiative. The Hospital Quality Alliance is a joint effort of the American Hospital Association, the Federation of American Hospitals, the American Association of Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations, National Quality Forum, the American Nurses Association, the American Medical Association, the AFL-CIO, AARP, the Consumer-Purchaser Disclosure Project, the National Association of Children’s Hospitals and Related Organizations, CMS and AHRQ. In late November 2004, CMS posted updated quality information reported by nearly 4,000 hospitals on ten hospital measures at www.cms.hhs.gov.

Beginning early in 2005, the hospital quality data will be available on the CMS website for consumers www.medicare.gov or by calling 1-800-MEDICARE (800-633-4227). CMS currently publishes quality information on www.medicare.gov for Medicare- and Medicaid-certified nursing homes, Medicare-certified home health agencies, dialysis facilities and Medicare Advantage plans. The agency’s overall quality initiative also focuses on improving the quality of care in home health agencies, nursing homes and hospitals using hands-on training and resources from Medicare’s Quality Improvement Organizations.

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Contact Paul Phillips today at 501.978.6309 or 800.766.2000 and let him show you all the reasons why our team of financial surgeons should handle your next reconstruction project.
Arkansas hospitals have had the opportunity for four years now to join the Continuous Service Readiness (CSR) program associated with Joint Commission Resources, a division of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The Arkansas Hospital Association began the program with 11 member hospitals in November 2000. As of January 2005, it now has 24 members, with one more expected to join soon. All hospitals are eligible to take advantage of the CSR program, whether accredited or not.

The goals of the CSR program are to assist participating member hospitals and health systems in a continuous survey readiness process designed to improve quality of care, reduce expense for compliance with JCAHO standards, reduce stress associated with the preparation for the triennial JCAHO survey, and be in a state of continuous readiness for surveys. For an annual membership fee of about $4,600 (or less for hospitals with an average daily census of 40 or less), members have access to a dedicated regional representative who conducts three-hour quarterly consulting visits, three educational workshops for a nominal registration fee, telnet and Web-based education, and 24-hour voicemail and e-mail access to the regional representative.

With the increased emphasis on quality of patient care, hospitals are encouraged to consider membership in the CSR program. For information about the program, call Beth Ingram at (501) 224-7878 or e-mail her at bingram@arkhospitals.org.

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Arkansas Legislature Hears AHA Study Findings

The Arkansas Hospital Association (AHA) presented findings of its recent study on Medicaid Underpayments for Hospital Services during the September 16 meeting of the House and Senate Interim Committees on Public Health, Welfare and Labor. Tom Watson of BKD, the accounting firm that conducted the study, reviewed the report and recommendations with committee members. Several on the committee expressed an understanding about hospitals’ need for an increase in the state’s $675 cap on Medicaid inpatient per diem rates, which has been in place since 1996.

AHA executive vice president Phil Matthews noted that the 46 Arkansas hospitals included in the study received about $33 million less in Medicaid reimbursements for inpatient and outpatient services in 2002 than it cost them to care for Medicaid-covered patients. He told the committee that the report was not intended to be critical of the Arkansas Department of Human Services (DHS), but to support a request that Medicaid funding for the 2006-2007 biennium include the additional dollars needed for an increase in the cap amount.

Speaking for the Department of Human Services, state Medicaid director Roy Jeffus said the department does not disagree with the report finding or with the argument that the cap should be raised. He said that the current DHS budget request being presented to the legislature to cover state fiscal years 2006 and 2007 does not include funding to do that, as the study was not available at the time budgets were being developed. The DHS budget proposal includes approximately $20 million in additional Medicaid funding for FY 2006 and almost $123 million for FY 2007. Those amounts will be necessary to maintain the various Medicaid programs at current levels with no growth.

Hospitals and Health Systems Continue to Face Challenging Environment

The nation’s hospitals continued to face many challenges in 2003—including the increasing costs of providing care to patients, rising demand for care, workforce shortages, caring for those without health insurance given the rising number of uninsured, emergency readiness preparedness, and soaring medical liability insurance premiums—as reflected in the results of the latest American Hospital Association (AHA) Annual Survey. Results of the survey were released late in October in AHA Hospital Statistics 2005, a reference source on hospitals published by the AHA subsidiary Health Forum.

“America’s hospitals continue to play an important role in the communities they serve and healthcare providers work increasingly hard to meet the challenges they face today,” said AHA President Dick Davidson. “For example, in addition to healthcare services provided in their facilities, many hospitals are developing and implementing long-term plans to improve the health and wellness of their communities. Hospitals’ dedication to their mission is stronger than ever. AHA will continue to work with community hospitals across the nation to meet the challenges they face so hospitals can keep their doors open and deliver quality care to all who need it.”

New to this year’s AHA Hospital Statistics is a section entitled “Trends: An Overview of 2003” that highlights the events affecting healthcare in 2003 and reports on survey data that identifies and adds perspective to longstanding and emerging trends.

Among continuing trends, the survey reports hospitals’ financial health remained fragile, with roughly one-third of America’s hospitals operating in the red. Overall, payments failed to keep pace with the cost of caring for patients, causing operating margins to decline. In particular, Medicare reimbursed 95 cents of every dollar hospitals spent caring for Medicare patients, continuing a pattern of declining reimbursements over the past five years. Medicaid reimbursement dropped to 92 cents on the dollar. However, while hospitals saw improvements in their investments that caused overall margins to increase slightly, continued volatility in the markets means this is not a stable and reliable source of income.

AHA Hospital Statistics also shows that more Americans are turning to hospitals for care, continuing a trend seen over the last several years. In 2003, hospitals saw more than 34.7 million inpatient admissions and nearly 111 million emergency visits—an increase in emergency visits of 11.6 percent in five years. However, America’s community hospitals experienced the first decline in outpatient surgeries—down by 1.1 percent—in more than two decades reflecting the impact of the proliferation of ambulatory surgical centers.
Managing Emergencies: It’s All in a Day’s Work

If your job was responding to disasters, setting up and providing medical assistance in the wake of catastrophic natural or man-made events, and simultaneously “thinking ahead” in order to provide proactive training so others can be prepared in the case of national medical emergencies, your career would keep you running, hopping and keen-minded at the very least.

In the case of Billy Conner, Emergency Manager with the Veterans Administration’s Emergency Management Strategic Healthcare Group, you would also find yourself in the role of compassionate caregiver and all-around problem solver.

Conner, who has served our nation for more than 38 years—first through 20 years in the Navy and Air Force, then 18 years with the VA’s Emergency Management team—is a man who brings ideas and people together so that all of us are better prepared and better equipped to handle emergency medical situations.

“Our job is to manage the federal medical assistance coming into a disaster site,” he says. “Most often, this involves nursing teams from the VA system, since we are a national system and can physically move people quickly in and out of emergency response roles.”

Most recently, he was deployed to the aftermath of Hurricane Charley in Florida this summer. “Our role there was to set up a Special Needs Shelter in the Venice, Florida area,” he says. “We took in 189 elderly patients who were frail, but mostly able to care for themselves in more ‘normal’ situations.”

But when such people must leave their homes because of storm damage, the situation can quickly evolve into a medical emergency.

Conner and his team of 45 nursing and medical staff kept track of their 189 “new friends,” as Conner calls them, while the federal government helped these storm victims find housing options. The states try to get people out of these shelters and back to more regular housing situations as quickly as possible.

“My role, in this case, was to take care of the medical staff, to make certain all the nurses and staffers had what they needed in the way of hotel/motel accommodations, meals, transportation in and out of Florida, daily transportation to and from the facility, and other necessities,” he says. “I guess I take care of the people who take care of the people.”

Conner says learning from each other is a distinct advantage, even in the midst of responding to a disaster, when nurses from across the nation gather in one spot to help heal the sick or tend the elderly. “This time we had three Native American nurses on the team, and they reminded us, through their actions, about what’s involved in a commitment to nursing,” he says. “In a normal, day-to-day situation, it’s easy to think that ‘nursing’ is all we should be doing,” he explains, “but these people reminded us that nursing involves all aspects of care, from delivering meals to helping patients do their washing—even doing it for them in some cases. It’s a whole different package in disaster response. Nursing takes on a totally new definition.”

The situation in Venice after Charley was a lucky one, Conner says. “We were able to move into a nursing home facility that had recently closed, so the set-up was right from the start, with nursing stations, patient rooms, etc.”

But sometimes the medical care facilities
Conner has managed were more on what he smilingly calls the “austere” side. “After the hurricanes in the Virgin Islands, I set up a medical care facility in what had been a street-side bus stop. Before I could move the doctor and nurses in, I had to give the tiny shelter a good cleaning. There had been cows in there, if you know what I mean.”

“Every time I go on a disaster, it’s different,” Conner says. “You get to see all the facets of setting up a medical care facility from the ground up. It’s really neat!”

Conner believes in relationship building as the key ingredient to a successful disaster management program. “If you have worked with people to develop a response plan prior to a disaster—whether it’s on the local, state or national level—you have a trust relationship with these people and are able to act more confidently,” he says. An example: The nurse acting as Chief Nurse at his facility in Venice, Florida was someone he had worked with in the past. “We knew each other and how we operated, and could do our jobs without getting in each other’s way. We were confident that the work was getting done right. It makes all the difference in the world.”

When not in real-time disaster-response mode, Conner reviews medical emergency response plans from across the globe. He then writes response plans and develops training sessions for medical response teams throughout the state of Arkansas, readying them for natural disasters and the entire gamut of bioterrorism response needs. “I try to think of what will be necessary in the case of different types of emergencies, then I write plans and conduct training sessions to help people be ready—just in case,” he says.

One of his brain-children is a Little Rock metro healthcare facilities discussion group. “We needed to get past each hospital thinking of itself as a lone facility, and start talking together about how we’ll work as a team in the case of a regional emergency. It has really helped,” he says. “It’s evidence of the relationship building that is one of Conner’s true gifts.”

During the week of the recent Clinton Presidential Library opening ceremonies, he took it upon himself to provide twice-daily reports on metro area hospitals’ bed census by department, including ER status. “I provided the information to the State Emergency Management team, the Health Department, the city offices of Little Rock and North Little Rock, MEMS (emergency medical service), the various hospitals and the FBI. In case something had happened, it seemed like a good idea to know which hospitals could take which kinds of cases immediately,” he said.

Conner says he thinks his gifts are “organizing” and “being a good listener.” He cites the past year—a difficult one for him, personally—as helping him develop his listening skills. “My son committed suicide just one year ago,” he says. “I can honestly say it has changed the way I approach my job. When you go through something like this yourself, you are more apt to understand how another person feels when they are going through a time when they feel they’ve lost everything. I have learned how they feel. I understand.”

His years in Emergency Management have taken him from Hurricane Andrew to the Northridge Earthquake, from ice storms in New York to floods in Georgia. “I love my work,” he says. “I wouldn’t trade it for anything.”

Arkansas wouldn’t trade Billy Conner for anything, either. He’s a keeper.
Editor's Note: In Part 1 of this article, which appeared in the Fall issue of Arkansas Hospitals, governance consultant Mac McCrary and healthcare attorney Harold Simpson discussed the emergence of niche providers, particularly specialty hospitals, as a growing form of competition between physicians and hospitals.

Part 2 of this article, which appears below, describes a process, as well as strategies and tactics, that hospitals can use to more successfully deal with competition. It also emphasizes the importance of building trust and collaboration among hospitals and physicians to establish relationships based on fair dealing and mutual benefit.

Part 2

To help their hospitals more successfully deal with competition in their markets, we encourage boards to first consider adopting an overarching process under which they can position a number of strategies and tactics. This process should begin with the creation of a written governance policy that might include the following:

• The hospital was created for the sole purpose of meeting community needs.
• The board will vigorously defend the organization against the actions of any party whose behaviors impair the hospital’s ability to meet community needs.
• The board will work diligently to always be in a position to know and understand community needs.
• The board will always include in its strategic plans any party whose behaviors, in the opinion of the board, demonstrate a desire to help the organization achieve its stated vision.

We recommend that the process begin with an intense communication effort directed both to the medical staff and to the community at large. It is critical for the small group of physicians who are generally receptive to new ideas to be aware of the board’s attitudes and expectations regarding competition from physicians or anyone else. Once this group of leaders understands the board’s intentions, it is more likely that they will consider supporting or partnering with the hospital’s efforts to identify and meet community needs.

An additional benefit of medical staff communication is building support among the group of physicians who are not likely to invest in a specialty hospital. These are the internists, primary care physicians and others who admit most of the hospitals’ patients and who understand that their livelihood is closely tied to the continuing economic viability of the hospital. They must understand the board’s intentions if there is to be any chance of them applying peer pressure with specialists whose competitive behaviors may impair the hospital’s ability to meet the needs of the community.

A critical part of the communication process is the continual sharing of data and first drafts of analyses with key physician leaders. Giving them opportunities for input and advice before final decisions are made is critical to building trust with the medical staff.

Communication with the com-
munity should be designed to build understanding in the community that the hospital is not economically invulnerable and may have to defend its ability to fund certain “safety net” services. This level of communication could include articles, newsletters, a speaker’s bureau, and other mechanisms.

Early in this process the board should appoint a committee to perform staff work on behalf of the board and to formulate recommendations for the board’s consideration. This group should consist of the CEO and selected members of the senior administrative staff, board leaders and medical staff leaders. It is important that physicians who are in a position to benefit economically from the committee’s work, not be included in the membership of the committee.

The work of the committee should focus on data collection and analysis. This would include looking at issues such as:

- What community healthcare needs are and what they are projected to be,
- What services exist,
- How effectively those services meet the needs, and
- What services are needed to meet both current and projected needs.

The process should also include an analysis of all of the current and potential competing entities in the market and their impact on the hospital. The committee should attempt to examine each physician’s relationship with those entities and whether that relationship enhances or impairs the hospital’s ability to fulfill its charitable mission. On the basis of this information and analysis, the committee then formulates recommendations for the board’s consideration. These recommendations might include a number of items relative to the board’s attitude about competition and its impact on the hospital’s ability to meet community needs such as:

- Changes in the hospital’s physician recruitment plan,
- Proposals for hospital/physician joint ventures,
- Adoption of economic conflict-of-interest policies.

The board then concludes the process by either approving the recommendations or sending them back to the committee for additional work. This process should be designed to base all decisions on the organization’s fiduciary duty to identify and meet the needs of its community. It is predicated on the common sense attitude that the hospital is required to defend itself against behaviors that impair its ability to perform its obligations. The process should provide opportunity for meaningful input and make a good faith attempt to include any party or entity whose behaviors cause the board to believe they support the board’s goal to achieve the hospital’s mission. It also should offer an opportunity for any who do not support that goal to decide to opt out of being part of the organization.

**Strategies and Tactics Hospitals Have Used**

As the board committee works through the process described above, the board can consider several strategies and tactics that have been successful for other hospitals.

**Understand your market**—Many hospitals create workgroups to continuously assess the likelihood of a competitor entering their market as well as to assess the market share of various physician groups relative to the hospital’s market share. Boards should also insist that their executives know how strong or weak their relationship is with their medical staff and what issues might motivate particular specialty groups to enter into competition with the hospital. Finally, boards should thoroughly understand which business lines and practice groups are most important to their hospital’s profitability and candidly assess the level of their executive groups’ business skills (risk analysis and mitigation, negotiation, financial forecasting, etc.) In short, we advise an ongoing investment in processes and structures that keep the board informed about the local environment relative to the possibility, source and impact of new competitors.

**Lobby to gain competitive advantage**—Consider working simultaneously at the national, state and local levels to leverage the influence and political clout of the board to gain legislative hurdles to competition. Realize, however, that while you may get what you asked for, this technique can have unexpected consequences. For example, Ohio hospitals lobbied for and won legislation delaying the construction of new niche providers. But the new laws included a grandfather clause, not requested by the hospitals, which created a flood of new applications for specialty facilities.
Boards must understand that, while potentially effective, lobbying is a slow process that may not quite turn out the way they wanted.

Take a tough stance against competitors—This strategy necessitates a clear, written economic conflict-of-interest policy statement from the board that describes their expectations regarding physician competition. Among other things the policy should list which services are and are not acceptable for physicians to be involved in. For example, where does the board draw the line on the continuum between hospital ownership, ambulatory surgery center (ASC) ownership and rendering services in the physician’s office?

There are several basic considerations in adopting an economic conflict of interest policy:

• What is the rationale for the policy?
• Is the policy based on actual, existing harm to the hospital—and/or on perceived potential harm?
• What documentation is there for the rationale?
• How are competing entities defined?
  • Limited to just other hospitals?
  • Include other entities such as ASCs?
• What kind of interest in the competing entity is required for application of the policy?
  • Direct or indirect ownership interest?
  • Employment or other contractual relationship?
• What does the policy preclude?
  • Service in a medical staff leadership role?
  • Staff appointment and clinical privileges?
• Does the preclusion take place immediately upon adoption of the policy—or only on new or renewed appointment?

In any event, application of the policy to an individual physician should be on an objective—rather than a subjective—basis and should not distinguish among physicians on the basis of volume or value of referrals.

While a viable strategy, boards that employ this approach to dealing with competition need to thoroughly understand what they’re getting into. Physicians are likely to protest against this approach, and boards should be aware that doctors can be as tough with the hospital as the hospital can be with them. Intense communication with the medical staff and with the community at large is required to minimize backlash against the hospital that can be generated by this approach. The board and the administrative team must decide in advance whether they have the courage to stand against the potential pressure that can be generated by physician opposition. They must also understand the critical importance of staying this course once they have started it.

While getting tough with physician competitors is an option that merits serious consideration, we close this section with a recent comment from the chair of a board that tried it. He said, “If a hospital does not think it is spending enough in legal fees, a board decision to use economic credentialing can correct that situation very quickly!” You can decide to play hardball with your medical staff, but it should be considered as a last resort.

Work to build trust between the hospital and medical staff—When boards understand what physicians want they usually find 1) money is not the only physician motivator and 2) hospitals and physicians have common interests in clinical outcomes, patient satisfaction, physician input into clinical processes and numerous other issues. They also find that low levels of physician trust in hospitals often impede efforts to align the interests of the two groups and that board leadership is the required catalyst to re-build trust.

Seven of the characteristics of trusting relationships were described by two noted healthcare leaders, Michael Annison and Dan Wilford, in their book, Trust Matters: New Directions in Health Care Leadership. These characteristics are: commitment, familiarity, personal responsibility, integrity, consistency, communication, and forgiveness and reconciliation. These characteristics and the book that contains them, provide a common sense road map for boards that want to begin a process of improving the level of trust their medical staff has in their hospital. In addition, we emphasize that hospitals should always find out how they can help the medical staff and act on that information before they ask the medical staff to help the hospital. We also suggest that when hospitals act to resolve a medical staff need, they should publish their action plan and the results of implementing the plan—even if it was not successful. Finally, it has been our experience that if boards are attentive, continued on page 34
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they will find numerous instances where physicians are consistently doing things to help the hospital. Boards should offer a very public and totally sincere “thank you” to those physicians. An essential part of building trust with the medical staff is developing reporting systems that allow an organization to identify wins and celebrate them appropriately.

Partner with the physicians where appropriate—This tactic is based on having the hospital embrace the reality that sharing ownership and control of niche competitors is sometimes better than dealing with them on a head-to-head competitive basis. It requires a no-nonsense, business-like attitude about selecting and dealing with the best available partners. It is usually based on the hope by all parties that the new venture will generate incremental earnings for all, due to improved efficiencies for the hospital and physicians and improved outcomes and convenience for patients. These partnership ventures are normally more effective when hospitals realize and accept the fact that they cannot include every physician on staff in these arrangements (unless they want to structure some type of tiered ownership structure). Boards are well advised to have the discipline to determine, in advance, the vision, strategies and criteria that form the basis of partner selection. What interests and motivates potential physician partners should be carefully explored because it is not unusual to find that certain physicians are more interested in control and efficiency than they are in ownership and its related problems. This and other business issues (exit strategies, business purpose, quality expectations, governance issues, reserve powers, ROI expectations, etc.) are best communicated by the board in a written set of guiding principles for joint ventures. In order to get the most mileage from this partnering approach, we strongly advise hospitals to combine these partnerships with a continuous, relentless push to make their clinical and business environments more and more physician-friendly.

Keep up with legal developments. The emergence of niche providers, and specialty hospitals in particular, is a “hot” area that is rapidly developing. Laws, regulations and court decisions are literally changing daily. Fundamental assumptions under which hospital boards have operated for decades are being challenged. It is critical that hospitals consult their legal counsel concerning the present legal status of our suggestions before implementing them.

In summary, we offer this article as a call to action for hospitals to get ready to deal with the issues of specialty hospitals and physician competition before the crisis occurs. While confrontation between the hospital and its medical staff is unpleasant, trustees must be willing to defend the organization’s ability to pay the cost of providing safety net services and to remain economically viable. We encourage boards to consider a combination of some or all of the strategies and processes described above as a roadmap for action. Even if a hospital is already dealing with niche competitors, it would serve the hospital’s long-term mission if the board begins to align the hospital’s business interests with those of its medical staff, improve its understanding of its market and re-build trust in the hospital-physician relationship.

About the Authors
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Review for: Arkansas Hospitals
Tool Enhances Culture of Safety

The American Hospital Association (AHA) November 10 joined the Agency for Healthcare Research and Quality (AHRQ) in unveiling a new tool to help hospitals evaluate their progress in creating a culture of safety. The “Hospital Survey on Patient Safety Culture” enables hospitals to assess employees’ attitudes about patient safety, teamwork within and across units, openness of communication, response to errors and other key components of a culture of safety.

Nancy Foster, AHA senior associate director for public policy development, said the AHA will encourage members to use the survey to obtain a more complete picture of the quality of care they provide and identify opportunities for improvement. “Creating an organizational culture in which staff are aware of the critical role they can play in patient safety is fundamental to patient safety improvement,” she said.

Paul Schyve, M.D., senior vice president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), said conducting the survey would help hospitals meet JCAHO accreditation requirements.

To access the survey and a user’s guide, visit http://www.ahrq.gov/qual/hospculture.

Congress Helps Hospitals on Several Fronts as Lame Duck Session Ends

The 109th Congress adjourned November 20 after passing a fiscal year 2005 omnibus spending bill that addresses almost all of the AHA’s advocacy agenda for the lame duck session. The American Hospital Association (AHA) thanks all those hospital leaders who advocated for the hospital field’s position on these important issues!

The spending figures cited here, while approved in the omnibus bill, do NOT reflect an across-the-board reduction of 0.8% that will be made to all non-defense, non-security spending.

75% Rule: Congress put a moratorium on enforcement of the 75% Rule for inpatient rehabilitation services until 60 days after the Government Accountability Office (GAO) completes a formal assessment of the rule’s impact on access to the services. HHS would reissue the rule after taking into account GAO’s recommendations.

Patient safety: The House and Senate could not come to agreement on their separately approved versions of the Patient Safety and Quality Improvement Act, which would allow confidential and voluntary reporting to help hospitals and others improve patient safety. The AHA will push to ensure that the legislation is reintroduced in the next Congress.

The legislation also provides fiscal year 2005 spending for these hospital-related programs:
- Children’s Graduate Medical Education: $303.2 million
- Rural hospital outreach and other programs: $88 million
- State survey and certification: $260.8 million
- Medicare and Medicaid Services to update the conditions rehab facilities must meet to qualify for reimbursement under Medicare.

TB standard: The legislation blocks OSHA from enforcing an onerous and unnecessary TB fit-protection standard that would have forced hospitals to conduct annual fit-testing of respirators worn by healthcare workers.

Preparedness: The legislation provides $495.4 million for the National Bioterrorism Hospital Preparedness Program.

Nursing education: The legislation secures $151.9 million for nurse education, including programs under the Nurse Reinvestment Act.

Visa waivers: This legislation was previously passed by both the House and Senate, and extends the State 30/J-1 Visa Waiver Program for two years. It allows state health agencies to annually hire up to 30 “J-1” foreign physicians to practice in rural and inner-city communities.

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What Do the Election Results Mean for Healthcare?

George W. Bush remains president, and the Republicans remain in power in both the House and the Senate. What does it mean for healthcare, from the viewpoint of the American Hospital Association?

- Senate Republicans, who will have a 55-seat majority instead of the current 51-seat majority, will be more emboldened to pursue their initiatives...including Medicaid reform.
- Despite the added majority in the Senate, achieving medical liability reform remains a challenge...it will still be difficult to attain the 60 votes needed for reform.
- The House will continue to be polarized, with conservative Republicans gaining several seats from Democrats.
- Efforts to reduce the deficit remain likely, meaning strong attempts to cut Medicare and Medicaid.
- Tax-exempt status of non-profit organizations, along with hospital billing and collection issues, will continue to draw attention.

Analysis Looks at Bush Plan Health Agendas

Prior to the nation’s November election, the Lewin Group, a nonpartisan healthcare and human services research and consulting firm, presented an independent comparative analysis of the proposed health plans of President George W. Bush and Democratic presidential nominee John F. Kerry at the National Press Club in Washington, DC.

The analysis centered on two key questions: How many people who currently lack health insurance would become covered under each candidate’s program? And, how much money would each program cost the federal and state governments, consumers and other financial contributors over the 10-year span following implementation in 2006?

The comparison was printed in a pre-election edition of Arkansas Hospital Association’s The Notebook.

A review of the Bush Plan’s answers to the questions indicates that: The Bush Plan would cover 8.2 million new people by broadening private insurance coverage through individual tax credits and deductions.

On the cost side of the equation, the president’s proposal will cost approximately $227.5 billion.

Medical malpractice reform, increased use of health information technology, new approaches to medical error reporting and a patient’s bill of rights remain centerpieces of the Bush Plan.

To read the full analysis, go to http://www.lewin.com/Spotlights/Features/Lewin_Candidates_Health_Plan_Analysis.htm

California Passes Proposition Supporting Stem Cell Research

California is the first state in the nation to approve state funds to be used for embryonic stem cell research. Voters passed Proposition 71 November 2, allowing up to $3 billion to be spent on the research and research facilities over the next ten years.

According to the Office of the Attorney General of California, the proposition establishes the California Institute for Regenerative Medicine to regulate stem cell research and provide funding, through grants and loans, for such research and research facilities. It also establishes the constitutional right to conduct stem cell research, but prohibits the Institute’s funding of human reproductive cloning research.

An oversight committee to govern the Institute is also established in the proposition, which provides General Fund loans up to $3 million for the Institute’s initial administration/implementation costs and authorizes issuance of general obligation bonds to finance Institute activities up to $3 billion, subject to an annual limit of $350 million. Finally, the proposition appropriates monies from the General Fund to pay for bonds.

Proponents of the proposition say the measure’s successful passage assures California’s status as a world center for stem cell research, and should help researchers in their quest for cures for cancer, AIDS, Parkinson’s Disease, Alzheimer’s Disease, spinal cord injuries, and other maladies. Opponents cited objections to the killing of human embryos and financial concerns as reasons for opposing the measure.

The measure passed with 59% of voters voting Yes, 41% voting No.
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| AFMC/MMCS **                                  | Medical Management Consultants |
| AHA Services, Inc.  *****                     | Medifax EDI       |
| Alberici Healthcare Constructors              | MediTract, Inc.   |
| Administrative Consultant Service, Inc.        | The MHA Group     |
| AFMC/MMCS **                                  | Mid-South Marking Systems |
| AHA Services, Inc.  *****                     | Mobile Instrument Service & Repair |
| Alberici Healthcare Constructors              | Modern Biomedical and Imaging, Inc. |
| Administrative Consultant Service, Inc.        | Modular Services Company |
| AFMC/MMCS **                                  | Morris & Dickson Co., L.L.C. |
| AHA Services, Inc.  *****                     | MultiPlan, Inc.   |
| Alberici Healthcare Constructors              | NAAD              |
| Administrative Consultant Service, Inc.        | Nabholz Construction  * |
| AFMC/MMCS **                                  | Osteoporosis Services, Inc. |
| AHA Services, Inc.  *****                     | Patient Line Products |
| Alberici Healthcare Constructors              | PDI - Professional |
| Administrative Consultant Service, Inc.        | Disposables International |
| AFMC/MMCS **                                  | Pinnacle Health Group |
| AHA Services, Inc.  *****                     | PPOplus           |
| Administrative Consultant Service, Inc.        | Professional Credit Management, Inc. |
| AFMC/MMCS **                                  | Publishing Concepts, Inc. |
| AHA Services, Inc.  *****                     | QHR  *            |
| Alberici Healthcare Constructors              | Quest Diagnostics |
| Administrative Consultant Service, Inc.        | Ramsey, Krug, Farrell & Lensing  *** |
| AFMC/MMCS **                                  | SBC               |
| AHA Services, Inc.  *****                     | Service Professional |
| Alberici Healthcare Constructors              | Sign Systems Inc. |
| Administrative Consultant Service, Inc.        | Snell Prosthetic and Orthotic Laboratory |
| AFMC/MMCS **                                  | Spectron Corporation |
| AHA Services, Inc.  *****                     | Stephens Inc.  *  |
| Alberici Healthcare Constructors              | Stericycle, Inc.  |
| Administrative Consultant Service, Inc.        | Sterling Healthcare |
| AFMC/MMCS **                                  | Stryker Medical   |
| AHA Services, Inc.  *****                     | Sysco Food Services Arkansas |
| Alberici Healthcare Constructors              | Taylor Made Ambulance |
| Administrative Consultant Service, Inc.        | Team Health       |
| AFMC/MMCS **                                  | Telco Federal Credit Union |
| AHA Services, Inc.  *****                     | Teletouch Communications |
| Alberici Healthcare Constructors              | The SSI Group     |
| Administrative Consultant Service, Inc.        | TME, Inc.  *      |
| AFMC/MMCS **                                  | Tri-Tec Medical   |
| AHA Services, Inc.  *****                     | TVI Corporation   |
| Alberici Healthcare Constructors              | UNCSI             |
| Administrative Consultant Service, Inc.        | Uniforms 2 U      |
| AFMC/MMCS **                                  | United Excel      |
| AHA Services, Inc.  *****                     | VoiCert/The White Stone Group |
| Alberici Healthcare Constructors              | West-Com Hospital System |
| Administrative Consultant Service, Inc.        | Wittenberg, Delony & Davidson Architects |
| AFMC/MMCS **                                  | Z Z Z Chair       |
Last year, during the debate over the Medicare Prescription Drug bill, Arkansas senior Senator Blanche Lincoln took a stand for the state’s hospitals. In a vote divided mostly along party lines, Senator Lincoln cast her vote in favor of the bill, in spite of pressure from fellow Democrats who opposed it. In doing that, she helped pass landmark legislation that not only will provide for a first-time drug benefit for Medicare-covered individuals, but also will bring about $800 million in added Medicare payments for Arkansas hospitals over the next ten years.

In recognition of her support for hospitals and the communities they serve, and for her outstanding contributions to the health and welfare of the people of Arkansas and the nation, the Arkansas Hospital Association (AHA) board of directors, during its August meeting, named Senator Lincoln as recipient of the association’s 2004 Statesmanship Award. In addition, the award recognizes the contributions the senator has made as a member of the Senate committees on Finance, Agriculture, Nutrition & Forestry, the Special Committee on Aging and the Select Committee on Ethics. The award was presented during the AHA’s 74th Annual Meeting October 6-8 in Little Rock.
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.