Protecting patients from five million incidents of injury and harm related to the medical care they receive is the goal of the Institute for Healthcare Improvement’s (IHI) 5 Million Lives Campaign. Obtaining the participation and support of 4,000 U.S. hospitals is the key to accomplishing it. Informing more hospitals about the voluntary program to generate their interest in participating is one of the first steps and primary reason why three IHI representatives were in Little Rock last week as the Arkansas Hospital Association and the Arkansas Foundation for Medical Care sponsored the official kick-off for Arkansas’ part of the campaign.

Following opening remarks by Arkansas Attorney General Dustin McDaniel, Campaign Manager Joe McCannon, Central Region Field Coordinator Jonah Borelli and Kathy Duncan, a Registered Nurse who happens to be from Marshall, Arkansas, reviewed the program, with a focus on two of the campaign’s 12 intervention strategies, Deploying Rapid Response Teams, which was an strategy included in the original 100,000 Lives Campaign that ended last June and a new intervention, getting Boards on Board, adopted for the program’s expanded scope of stopping 5 million medical errors by December 2008.

Participating hospitals are asked to voluntarily:

- Deploy Rapid Response Teams...at the first sign of patient decline
- Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction...to prevent deaths from heart attack
- Prevent Adverse Drug Events (ADEs)...by implementing medication reconciliation
- Prevent Central Line Infections...by implementing a series of interdependent, scientifically grounded steps
- Prevent Surgical Site Infections...by reliably delivering the correct perioperative antibiotics at the proper time
- Prevent Ventilator-Associated Pneumonia...by implementing a series of interdependent, scientifically grounded steps
- Prevent Pressure Ulcers...by reliably using science-based guidelines for their prevention
- Reduce Methicillin-Resistant Staphylococcus Aureus (MRSA) Infection...by reliably implementing scientifically proven infection control practices
- Prevent Harm from High-Alert Medications...starting with a focus on anticoagulants, sedatives, narcotics, and insulin
- Reduce Surgical Complications...by reliably implementing all of the changes in care recommended by the Surgical Care Improvement Project (SCIP)
- Deliver Reliable, Evidence-Based Care for Congestive Heart Failure...to reduce readmissions
- Get Boards on Board...Defining and spreading the best-known leveraged processes for hospital Boards of Directors, so that they can become far more effective in accelerating organizational progress toward safe care

The AHA encourages all of its hospitals, including Critical Access Hospitals, to participate in the campaign. It is a way not only to voluntarily work to reduce occurrences of hospital-acquired infections, adverse drug reactions, surgical errors, pressure sores, and other events harmful to patients, but also to raise the profile of hospitals’ proactive response to medical errors with a larger public audience.
The Arkansas Department of Health and Human Services notified the Arkansas Hospital Association last week that supplemental federal assistance may now be available for expenses incurred as a result of providing services to evacuees of Hurricanes Katrina and Rita. Hospitals not reimbursed previously or currently for services provided to evacuees, may be eligible for additional funding. For more information, please contact Dawn Zekis at the Arkansas Department of Health and Human Services at (501) 683-0173 or Dawn.Zekis@arkansas.gov.

A bill introduced March 9 by Rep. John Tanner (D-TN) would freeze the 75% Rule for inpatient rehabilitation facilities (IRF) and units at the current 60% level. Reps. Kenny Hulshof (R-MO), Nita Lowey (D-NY) and Frank LoBiondo (R-NJ) are among 83 co-sponsors of H.R. 1459, which is similar to S. 543, which was introduced in the Senate last month.

Currently, 60% of admissions to an IRF or a hospital distinct-part rehabilitation unit must be related to 13 specific conditions for the hospital to be exempt from Medicare’s acute care inpatient prospective payment system. Without legislation, the threshold rises to 65% beginning July 1, 2007 and 75% in July 2008, making it harder for Medicare patients to get the rehabilitation care they need.

In addition to freezing the IRF threshold at 60%, the bills, both supported by the American Hospital Association, would set a national medical necessity standard to address inconsistent and harsh local coverage determinations by Medicare Fiscal Intermediaries.

The American Hospital Association, Catholic Health Association of the U.S., Federation of American Hospitals and organizers for Cover the Uninsured Week (CTUW) invite hospitals to participate in a March 22 teleconference on CTUW activities and congressional efforts to reauthorize the State Children’s Health Insurance Program. Participants will learn how to take part in CTUW activities April 23-29, which can include hosting a health or enrollment fair for children.

In addition, this year’s activities will include a national event March 14 to release data on the uninsured, followed by town hall meetings and community forums during the congressional Spring District Work Period. To participate in the hour-long call at 2 p.m. Eastern Time March 22, RSVP in advance to Phillip Hinz at phinz@chausa.org, or (314) 253-3484. For more on CTUW and planning resources, visit http://www.covertheuninsured.org.

The House Appropriations Committee has approved an emergency supplemental spending bill for the war efforts in Iraq and Afghanistan after removing a provision that would rescind Section 1011 funding for hospitals that provide healthcare services to undocumented immigrants. The provision sought to reclaim and use for other purposes unspent funds allocated to hospitals in fiscal years 2005 and 2006 under Section 1011 of the Medicare Modernization Act.

In a letter to the committee, the American Hospital Association said a lag in implementation and complex rules prevented hospitals from accessing the funds for nearly two years, and that the MMA stipulates the unspent funds shall remain available to hospitals.
The Joint Commission is conducting a free one hour telephone conference call on Friday, March 23, at 1:00 p.m. C.T. Joint Commission President Dennis S. O’Leary, M.D., and Jerod Loeb, Ph.D., executive vice president for Research, will discuss a new report from The Joint Commission, Improving America’s Hospitals: A Report on Quality and Safety. This report examines how America’s accredited hospitals performed collectively against evidence-based quality measures for heart attack, heart failure and pneumonia care between 2002 and 2005, as well as aggregate hospital performance on national and state levels in complying with the Joint Commission 2005 National Patient Safety Goals.

Time will be provided during the conference call for participants to ask questions. To register, click on http://www.surveymonkey.com/s.asp?u=554073486130. Upon registration you will be provided the toll-free telephone number and password for the call. Please print out the page or write down the telephone number and password. You will NOT receive an e-mail confirmation.

If you are unable to participate in the call, a transcript and a playback option will be available on The Joint Commission Web site and on your secure extranet site, following the program.

More Hospitals Using HIT

The American Hospital Association’s second snapshot of how hospitals are using information technology (IT) found that nearly 50% of all responding community hospitals reported moderate or high use of health IT in 2006, compared to a response of 37% in 2005. Hospitals reported dramatic increases in the use of real-time computerized alerts to prevent negative drug interactions, increasing to 51% of hospitals in 2006 from 23% in 2005.

Sixty-nine percent of responding hospitals reported they had either fully or partially implemented electronic health records (EHR). The study also found that spending on health IT systems is high and growing. The median capital spending per bed for system implementation was $5,556 in 2006. The median operating costs, which cover ongoing expenses, were $12,060 per bed, a 4.5% increase over 2005. A copy of the survey results is available at http://www.aha.org/aha/content/2007/pdf/070227-continuedprogress.pdf.

The AHA Calendar

March 2007
27 Building Bonds: Pathways to Better Board/CEO Relationships (Online Governance Education Program)
29 EMTALA Update 2007: Ensuring Compliance – Webinar #2292
30 Patient Falls, Embassy Suites, Little Rock
30 AHHRA (Human Resources) Spring Conference, Embassy Suites, Little Rock

April 2007
4-6 HFMA (Financial Management) Spring Annual Meeting & Installation of Officers, Clarion Resort, Hot Springs
12-13 AHA Board of Directors, Red Apple Inn, Heber Springs
15-21 National Volunteer Week
18 AHEF Spring Meeting, Holiday Inn Select, Little Rock
24 Raising the Bar: Using Board Self-Assessment to Increase Leadership Effectiveness (Online Governance Education Program)
American dramatist Paddy Chayefsky wrote movie scripts filled with black comedy that derived humor from some serious situations. His screenplays for *Network* and *The Americanization of Emily* are prime examples. Another is his 1971 work, *The Hospital*, which, within a tale about the trials of large urban hospital, unfolds a mystery involving two doctors and a nurse who were mistaken for patients and die from avoidable medical errors.

In the end, the “killer” admits to disguising the staffers as real patients in retribution for their mistakes that caused the death of an elderly man who “was relentlessly subjected to the benefits of modern medicine.” However, he denies guilt, saying that they were “ritual victims of their own institutions.” He had only rendered the unlucky threesome unconscious and placed them in hospital beds. From there, one was given wrong medicines, another sent to an operating room for incorrect surgery and the third parked in an emergency room, before being “promptly, simply...forgotten to death.”

That was pretty heady stuff 35 years ago. If art really does imitate reality, there were concerns over medical errors almost three decades before the Institute of Medicine released its now famous 1999 report on unnecessary hospital deaths and the Institute for Healthcare Improvement’s (IHI) 2004 report on U.S. medical errors that occur mostly in hospitals.

I thought about that movie last week when representatives of several Arkansas hospitals gathered in Little Rock for the official kick-off for Arkansas’ leg of IHI’s *5 Million Lives Campaign*. Ironically, the real reason for the gathering can be traced back to another writer who was concerned about medical errors 2,400 years ago.

Hippocrates was the ancient Greek physician who is often cited as the Father of Medicine. He was the first to reject the views of his time that illness was caused by superstitions or by possession of evil spirits or by disfavor of the gods. Instead, he believed it had a physical and a rational explanation. He believed that rest, a good diet, fresh air and cleanliness were an integral part of health and the natural healing process.

He made those and other invaluable contributions to medicine and healthcare around 400 B.C. However, Hippocrates’ most lasting contribution might be the Oath of Medical Ethics that he developed for physicians to follow in caring for patients.

Among his thoughts was one in which he cautioned future physicians, “As to diseases, make a habit of two things — to help, or at least to do no harm.” More than 500 years later, the Roman physician Galen translated the idea into Latin as *primum non nocere*, meaning “First, do no harm.”

The phrase defines a way of thinking which places the welfare of the patient above other concerns. It is a principal precept that all medical students are taught as a reminder that they must consider the possible harm that any intervention might do to a patient. *Primum non nocere* is a fundamental principle for all healthcare providers, whether individuals or organizations. *First, do no harm*: it is a duty and a responsibility.

Patients assume that the care intended to help them should, at the very least, not hurt them. Yet, despite the hard work and best intentions of caregivers, preventable medical errors occur. Truthfully, they occur much too often. That’s the reason why more than 25 Arkansas hospitals already have joined thousands of others across the country as part of the IHI campaign programmed to eliminate or substantially reduce unintended physical injury resulting from or contributed to by medical care.

The focus on patient safety is the basic reason why the Arkansas Hospital Association board of directors endorsed the IHI *5 Million Lives Campaign*. Protecting patients from five million incidents of medical harm over the next two years is an awesome undertaking that may seem like an impossible goal. It can be achieved only if every hospital does its part.

The AHA encourages participation in this voluntary program and hopes that every Arkansas hospital will commit to this national endeavor to improve patient safety.