Arkansas Hospital Association (AHA) legal counsel Elisa White notified the AHA October 11 that the Joint Commission on Accreditation of Healthcare Facilities (JCAHO) has agreed to a revision in its accreditation agreement that will safeguard Arkansas hospitals’ privileged documents from disclosure in the accreditation process. As revised, Section 5 of the agreement now says that:

(1) JCAHO will conduct all of its accreditation activities in accordance with all applicable privileges of confidentiality and immunity under applicable state and federal law;

(2) If the JCAHO requests privileged information, the hospital can notify the JCAHO in writing and the JCAHO will work with the hospital to find an alternative that will both allow the JCAHO to obtain the information it needs for accreditation purposes and maintain legal protections for the requested item; and

(3) If privilege is challenged based on any accreditation activity, the JCAHO will help the hospital fight to maintain the privilege.

White noted that the JCAHO continued to refuse to negotiate on the agreement’s indemnity clause, which favors the JCAHO, and the limitation of remedy clause. She advised that as of October 13, Arkansas hospitals would be able to execute their revised agreements electronically with the JCAHO.

A copy of White’s letter and details about executing the agreement were distributed to AHA member hospitals in an October 11 HOTLINE email from AHA president Phil Matthews.

The Arkansas Hospital Association (AHA) lost a longtime friend and colleague on Saturday. Harry H. Stevens, administrator of Bradley County Medical Center (BCMC) in Warren, died October 15. He was 80 years old. Stevens, a Korean War veteran, was a 40-year resident of Warren. He owned and operated the Pine Lodge Nursing Home there from 1965 until 1975, when he sold the nursing home and began his career at BCMC. Stevens had served as the administrator at BCMC since 1986. In June 2004, Harry received the AHA’s Chairman’s Award in recognition of his service and contributions to BCMC and to the AHA, as well as to the city of Warren and other parts of southeast Arkansas. A memorial service is scheduled for 2:00 p.m., Tuesday, October 18 at the Frazier Funeral Home chapel in Warren.

Patient safety, performance improvement, accountability and community oversight all reflect the growing scrutiny of hospitals and other health service providers. In this climate, hospital leadership must find credible ways to demonstrate to an increasingly healthcare-savvy public that their hospital’s services are of the highest quality. Many believe that accreditation is the most effective way of telling that story and they typically look to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform those services. The JCAHO...
accredits more than half of Arkansas’ hospitals. Many of the hospitals that aren’t accredited, as well as some of the JCAHO-accredited facilities, usually point to the program’s cost as a major barrier and have expressed an interest in hearing about alternative accreditation sources besides the JCAHO.

Although the JCAHO is the most well-known hospital accrediting body, the American Osteopathic Association (AOA) Healthcare Facilities Accreditation Program (HFAP) also has a well-established history of documenting hospital quality through an accreditation process since 1945. The program, which has also been accrediting healthcare facilities for over 30 years under Medicare, is nationally recognized by the Centers for Medicare & Medicaid Services (CMS), state governments, insurance carriers and managed care organizations. The AOA program has been granted “Deeming Authority” by the Centers for Medicare & Medicaid Services (CMS) to conduct accreditation surveys.

To enable hospitals to become familiar with an alternative accreditation program, the Arkansas Hospital Association will offer a five-part telephone series entitled, “Understanding and Assessing the AOA/HFAP Accreditation Process,” beginning November 14. Additional briefings will be held November 28, December 2, 14 and 16, 2005.

Each one-hour session will discuss a separate part of the process, such as making the switch from JCAHO to HFAP, customer/hospital perspectives, and the survey process’s clinical and non-clinical standards. These sessions also will offer insights from representatives of hospitals that have transitioned to the HFAP accreditation program.

Registration information may be downloaded from http://www.arkhospitals.org/calendar.htm.

JCAHO Inpatient Psych Measures

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is accepting comments through November 11 on a proposed set of core performance measures for inpatient psychiatric services. The 18 proposed measures were identified by a technical advisory panel (TAP) convened in collaboration with the National Association of Psychiatric Health Systems and National Association of State Mental Health Program Directors. The first meeting of the TAP was held in May 2005 to finalize a framework. Following a call for measures, the TAP reconvened in August 2005 to recommend measures to be posted for public comment from the following areas:

- Assessment
- Treatment Planning and Implementation
- Hope and Empowerment
- Patient Driven Care
- Patient Safety
- Continuity/Transitions of Care
- Outcomes

The measures are being posted for a 30-day public comment period. If you have any questions about this JCAHO project, please contact Celeste Milton, Associate Project Director, at (630) 792-5925 or email her at cmilton@jcaho.org. To access the proposed measures, go to http://www.jcaho.org/pms/core+measures/bh+call+and+nominations.htm.
One of the goals of the Hospital Quality Initiative that was launched in 2002 is to improve hospital quality through accountability and public disclosure of data that will enable consumers to make more informed decisions about their healthcare. As a part of this initiative, the Centers for Medicare & Medicaid Services (CMS) developed the Hospital Consumer Assessment of Health Plans Survey, now referred to as HCAHPS. The purpose of the survey is to collect uniform measures of patient perspectives on various aspects of care received while hospital inpatients. The first national implementation of HCAHPS is planned for 2006 and information collected through the survey will be publicly reported on the CMS Hospital Compare Web site.

According to a new CMS report, implementing a proposed 27-question HCAHPS survey would cost less than $1,000 per hospital if combined with existing patient surveys. The cost would go to an estimated $3,300-$4,575 per hospital if implemented as a separate survey. The study by Abt Associates was commissioned to compare the cost of implementing the current 27-item HCAHPS survey compared with a survey of fewer than 10 questions as suggested by some groups. Abt estimates that implementing the shorter survey would cost $0-$625 per hospital if included in the hospital’s current survey and about $2,436 if implemented separately. The study concludes, “Cost considerations are not a sufficient reason for switching from the current version of HCAHPS to a shorter version.”


The Centers for Medicare & Medicaid Services released its preliminary 2003 hospital wage and occupational mix data on October 7. The data is to be used to develop the proposed fiscal year 2007 wage index, which measures relative differences in the average hourly wage for the hospitals in each labor market area compared to the national average hourly wage. The labor-related portion of the standardized amount (about 71% of the total standardized amount) is adjusted for differences in wage costs between geographic areas.

In general, the urban areas are the Metropolitan Statistical Areas (MSA) as defined by the President’s Office of Management and Budget. Every state except New Jersey and Rhode Island also has a rural area that includes all counties not part of an MSA. Rural areas are designated by their two-digit code.

The wage index values shown in the new release are based on wage data as reported by hospitals on their Medicare cost reports for Fiscal Year (FY) 2003. The public file also includes occupational mix data collected during the 12 months of calendar year 2003 or a four-week period during January 2004, updated to include timely revisions submitted by hospitals for the FY 2006 wage index. Hospitals should review the data, found at http://www.cms.hhs.gov/providers/hipps/ippwage.asp and request any corrections by the December 5 deadline for revisions.

The Centers for Medicare & Medicaid Services (CMS) published its proposed changes to the Medicare Occupational Mix Survey for the first half of 2006. Data from the survey will be used to adjust the wage index for the fiscal year 2008 inpatient prospective payment system. CMS will accept comments on the proposed survey through December 13. Go to http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-20517.pdf to view the proposed changes.
Most hospitals interviewed this year in 12 U.S. communities had recently changed their pricing, billing and collection policies for low-income, uninsured patients or clarified information provided to patients about their policies, according to an October 12 report from the Center for Studying Health System Change. Most of the hospitals had increased the income threshold for full charity care or discounted services, some providing discounts of up to 400% or more of the poverty level. The report also said that thus far the changes have had little impact on hospital bottom lines, and the impact on access to care for uninsured people remains unclear.


The Part A premium for voluntary enrollees in calendar year (CY) 2006 has been set at $393.00 per month. This is a 5% increase over the CY 2005 premium of $375.00. There are approximately 523,000 voluntary enrollees in Medicare Part A; 1,000 are eligible for a reduced premium of $216.00. This premium is paid by individuals 65 years or older who are not otherwise eligible and certain disabled individuals who have exhausted other entitlements.

In 1992, Congress created the 340B program to lower the cost of drugs purchased by a limited number of entities serving a high number of low-income and uninsured individuals, such as federally qualified healthcare centers and nonprofit hospitals providing care to a disproportionate share of Medicaid patients. Under the 340B program, pharmaceutical manufacturers are required to provide eligible 340B entities discounts on outpatient drugs as part of the manufacturers’ Medicaid participation agreement.

Last week, Senators John Thune (R-SD) and Jeff Bingaman (D-NM) introduced S. 1840, a Senate companion to the Safety Net Inpatient Drug Affordability Act (H.R. 3547). The two senators agreed that there is a need to modify the 340B program due to the rising cost of prescription drugs and to extend these discounts to the inpatient side of disproportionate share hospitals, as well as to critical access hospitals.

The bill, backed by the American Hospital Association, would expand the 340B drug discount program for certain safety net hospitals to include inpatient drugs and would apply to critical access hospitals. The program allows eligible safety net providers to buy drugs for patient use at a significant discount, on average about 50% less than average wholesale prices. However, it’s currently limited to outpatient drugs and excludes critical access hospitals. Rep. Jo Ann Emerson (R-MO) introduced the House bill in July.
All About Arkansas

(Little Rock) **St. Vincent Infirmary Medical Center** has received five-star ratings for clinical excellence in Joint Replacement Surgery, Spine Surgery and in Overall Orthopedic Services according to a study released by HealthGrades, an independent healthcare ratings company. The report ranks the hospital among the Top 5% in the Nation and as the state’s top-ranked hospital for each procedure.

(Fort Smith) **St. Edward Mercy Medical Center** was recently named a *Consumer Choice Award* winner for the second year in a row as the most preferred hospital in the region for best quality and image. St. Edward Mercy was one of only three hospitals in Arkansas to be honored. The ranking comes as a result of the National Research Corporation’s (NRC) annual Healthcare Market Guide study, a survey of nearly 140,000 households representing 400,000 consumers in the contiguous 48 states and Washington, D.C.

(Malvern) **HSC Medical Center** announced October 3 the launch of a new Web site and the addition of Discovery Hospital, an online service that provides hospitals with information designed to assist individuals in managing their own personal health. The new Web site at [http://www.hscmc.org](http://www.hscmc.org) features a directory of the hospital’s services, an interactive career center, physician directory, medical library and a monthly newsletter with health tips that everyone can use in their daily lives. Plus, patients can access thousands of pages of useful information on a wide array of healthcare topics.

The AHA Calendar

October 2005
19  AHA Board of Directors Meeting, The Peabody Little Rock
19-21 AHA Annual Meeting and Trade Show, The Peabody Little Rock
25  Audio Conference – Physician Relations: Basics to Improved Quality & Strategic Success – Improving Hospital/Physician Relations
26-28 HFMA (Financial Management) Quarterly Seminar, Holiday Inn Select, Little Rock
27  AAMSS (Medical Staff Services) Fall Conference, Wyndham Hotel, North Little Rock
27  Audio Conference – Establishing an Effective Hospital Staffing and Productivity Culture 2005 – Introduction to the Productive Workforce: Key Factors
28  Health Care Fraud & Compliance, Presented by the Arkansas Bar Association Health Law Section

November 2005
2   AHA Metropolitan Hospital District, AHA Headquarters, Little Rock
2-3 Case Management: An Essential Component for Health Care Excellence, Holiday Inn Presidential Conference Center, Little Rock **(Limited to 80 people)**
4   AHHRA (Human Resources) Fall Conference, Holiday Inn Select, Little Rock

**Editor's Note:** *The Notebook* will not be published October 25 due to the Arkansas Hospital Association’s 75th Annual Meeting and Trade Show being held this week at The Peabody Little Rock and Statehouse Convention Center. The next issue of *The Notebook* will be published November 1.
Final Thoughts

Getting a consensus on the Arkansas Hospital Association’s (AHA) single most important achievement over the past 75 years would be difficult, if not altogether impossible. A credible case could even be made for a few of the AHA’s accomplishments over the last five years. Two of them that come to mind almost immediately were actions that should positively impact the health of Arkansans for years to come.

The first was the association’s role in getting a spending plan for Arkansas’ $1.62 billion share of the National Tobacco Settlement Fund. The AHA took another lead role with the coalition of healthcare providers who had supported the failed attempt in 1992 to pass a cigarette tax to help fund Medicaid. The group, now called the Coalition for a Healthier Arkansas Today (CHART), developed a plan that would earmark the full amount that Arkansas receives for health-related purposes over the fund’s 25-year life. In January 2000, the AHA helped to mount a statewide campaign during which CHART members bussed across the state to explain the plan to people and to gain support from legislators who would have to approve it.

When lawmakers reached an impasse on the plan during an April 2000 special session, Governor Huckabee set his sights on getting voter approval for the CHART proposal in the November general election. The AHA was actively involved in the election campaign, and on November 7 voters said yes to CHART’s ideas with a solid 65%-35% margin.

More recently, the AHA was responsible for a 2005 law prohibiting the smoking of tobacco products in hospitals and on their grounds. It was a way for the association’s board and members to show that Arkansas hospitals not only talk about improving community health, but also are willing to walk the walk and do something about it.

In between, the AHA worked in 2000 against an effort to abolish certain state and local sales taxes that would have sapped $144 million from annual state revenues. Then, in 2002 the association helped to defeat a proposed constitutional amendment to “ax the sales tax” on food and medicines. The amendment would have taken between $400 million and $600 million from state coffers each year with no suggestions on how to replace it. Either of the tax reductions most likely would have led to a state Medicaid crisis.

Passing a state tort reform law in 2003 would have to make everyone’s top ten list of significant achievements. The AHA joined in the fight early as part of another coalition, the Committee to Save Arkansas Jobs, in the successful run at overhauling Arkansas’ civil litigation system. The law gave a way to help hospitals curb crippling medical liability costs and thwarted a potential exodus of healthcare providers from the state.

Following the September 11, 2001 terrorist attacks in New York and Washington, and again following Hurricane Katrina in August 2005, America became fully aware of hospitals’ strategic importance to the nation’s emergency response system. The AHA has had a direct hand in working through countless emergency response issues aimed at better preparing Arkansas hospitals for these often overlooked essential responsibilities.

Some AHA members might point to a 2001 move that resulted in an Arkansas Medicaid “upper payment limit” program as the most important financial achievement. It would be hard to argue with a program that has netted more than $100 million in supplemental Medicaid hospital payments that otherwise wouldn’t have been available.

So, what would you say was the AHA’s most significant achievement? Whatever the choice, it’ll be trumped in the future by another one, bigger and more outstanding. Maybe it will have something to do with the current move toward hospital transparency and accountability. Those issues won’t go away, and will most likely expand. But, that’s okay, as long as the reporting requirements are reasonable and the data meaningful, and it serves to improve the state’s healthcare quality and status.

After all, that’s the very reason a small group of hospital leaders got together 75 years ago and formed the Arkansas Hospital Association.

(This is the final installment of the historical re-cap leading up to the AHA’s Diamond Anniversary 75th Annual Meeting.)