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American Hospital Association

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STAT News at Deadline

Proposed hospital outpatient, ASC rule

The Centers for Medicare & Medicaid Services (CMS) last week projected that payment rates under the outpatient prospective payment system (OPPS) would result in a 1.9% increase next year in Medicare payments for providers paid under the OPPS. The projected payment increase is part of a proposed rule updating payment policies and rates for hospital outpatient departments and ambulatory surgical centers for calendar year 2010.

Among other provisions, the proposed rule includes changes to the hospital outpatient quality data reporting program, and would establish procedures to make the data collected through the reporting program publicly available.

CMS will accept comments on the rule through Aug. 31, and plans to issue a final rule by Nov. 1. Medicare pays more than 4,000 hospitals for outpatient services under OPPS.

For more information on the rule, go to *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

Congress faces busy month on health reform; hospitals oppose House cuts

Following a week-long congressional recess, key health care committees resume work this week on health care reform, with the goal of reporting legislation for floor action by the end of the month. Lawmakers return to Washington amid the hospital field's concerns about reform proposals that could lead to deep Medicare payment cuts.

A draft proposal released by Democratic leaders from the House Ways and Means, Energy and Commerce, and Education and Labor committees calls for at least $150 billion in cuts over 10 years to help fund an expansion in health care coverage. The Ways and Means Committee is expected to begin drafting reform legislation next week that fills in some of the draft's details.

The draft proposal would impose a permanent cut to Medicare's annual hospital market basket updates – the annual inflation adjustment for goods and services used by hospitals – of at least $150 billion over 10 years, and would establish a public plan that could reduce payments by an estimated $36 billion a year by paying hospitals Medicare rates.

During last week's congressional recess, the AHA ramped up its grassroots efforts to derail the proposed cuts. A June 22 AHA "Advocacy Alert" encouraged hospital leaders to urge their representatives to reject the House reform proposal's cuts. The association urged hospital leaders to take advantage of the recess to "help your representative understand that hospitals are for true reform … but arbitrarily cutting hospital payments does not help patients or communities."

The House draft also calls for individual mandates and subsidies to help low-income people and small businesses purchase health insurance. The proposal would create a health insurance exchange with a public insurance plan option, expand Medicaid to about 133% percent of the federal poverty limit, and enact insurance market reforms.

The draft legislation does not specify how Congress would finance the expanded coverage, and the committees have not yet received an official estimate of its costs from the Congressional Budget Office. House Ways and Means Committee Chairman Charles Rangel, D-NY, said he wants to keep costs to no more than $1 trillion over 10 years.

The AHA on June 26 sent hospital leaders a 28-page "Legislative Advisory" that provided the field with legislative details about the draft proposal. (AHA members can find the advisory by visiting the "Health Reform Update" section of *www.aha.org*.) In the advisory,

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Draft definition for EHR users a knotty issue

The draft definition of "meaningful use" of electronic health records (EHR) asks hospitals to do too much, too soon, and needs to give them more time to make the transition to fully functional EHRs, the AHA recently told the Office of the National Coordinator (ONC) for Health Information Technology.

The definition of a meaningful EHR user is critical, because, under the "American Recovery and Reinvestment Act," P.L. 111-005, more than $17 billion in incentive payments would be provided to hospitals and other providers to spur adoption of EHRs. But the measure also carries penalties in the form of Medicare reimbursement reductions if hospitals fail to adopt EHRs by 2015.

ONC's draft definition, released last week, would require hospitals to implement computerized physician order entry (CPOE) systems by 2011 to be considered a meaningful user – a date that the AHA says is unreal-

See Meaningful, Page 7

Long-term care hospital leaders seek support for key issues on Capitol Hill

By Matthew Malamud

Long-term care hospital (LTCH) leaders recently visited Washington, DC, to personally urge Congress to oppose Medicare cuts and to endorse the AHA-backed "Medicare Long-Term Care Hospital Improvement Act," H.R. 2124/S. 935.

After an AHA "Advocacy Day" briefing June 23, more than 40 LTCH leaders from across the country went to Capitol Hill to express their concerns about White

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photo by Stephen Barrett

Long-term care hospitals' Advocacy Day. Long-term care hospital leaders attended an AHA-hosted 'Advocacy Day' briefing (above) and then raised their issues and concerns with lawmakers on Capitol Hill.

TOOLBOX

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HHS halts tax rule, rescinds others

Following up on proposed rules issued in May, the Department of Health and Human Services (HHS) last week delayed planned Medicaid provider tax policy changes until next July and rescinded proposed Medicaid rules limiting outpatient hospital and clinic benefits and ending reimbursement for transporting Medicaid-eligible children to school. The department also scrapped provisions of a Medicaid interim final rule restricting access to case management services.

The 2009 American Recovery and Reinvestment Act (ARRA) blocked the department from implementing the Medicaid regulations before July 1. The rules were issued in 2007 under the Bush administration and met strong opposition from the AHA and many lawmakers on Capitol Hill. The Centers for Medicare & Medicaid Services (CMS) May 1 proposed rules to rescind the Medicaid outpatient, school transportation and case management regulations and to delay provider tax provisions that were of concern to hospitals.

The rescinded regulations would have narrowed the definition and scope of outpatient services under the program, and curbed case management services that some states offer Medicaid patients.

AHA President and CEO Rich Umbdenstock last week said HHS' decision to withdraw the Medicaid outpatient rule "is important for those in need of outpatient services like dental care for children, screenings and physician services in the emergency department."

The AHA also expressed strong support for the year-long delay in enforcing "hold-harmless" financing arrangements under the rule limiting taxes that states levy on providers to help pay the state share of Medicaid costs.

Keeping a lid on enforcement of the Medicaid provider tax regulation has been an AHA priority. In May 29 comments to CMS on its proposal to delay the rule, the AHA said the rule could ultimately eliminate provider tax programs, which are authorized by statute.

The association said the rule would make it more difficult for states and providers to understand whether a provider tax program under development could meet the agency's approval.

The rule would "represent a substantial departure from longstanding Medicaid policy by imposing subjective, overly broad standards for determining the existence of hold harmless arrangements," the AHA told the agency.

HHS said it was delaying the provider tax regulation to give CMS more time to determine whether states need additional clarification or guidance.

Umbdenstock said the AHA welcomes the one-year delay, "especially during this time when states are facing great economic pressure and struggling to fund their Medicaid programs."

In announcing the department's decision to scuttle the Medicaid rules, HHS Secretary Kathleen Sebelius said the "regulations, if left in place, would have potentially adverse consequences for Medicaid beneficiaries."

Sebelius said the department's decision to rescind the rules means that "children will continue receiving services through their schools, beneficiaries will be able to access all available case management resources to help them better manage their health care, and outpatient hospital and clinic services can continue to be covered in the most efficient manner."

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Reform

continued from page 1

the AHA reiterated its message that "blunt and arbitrary payment cuts do not help patients or communities, and they are not representative of true health care reform."

Meanwhile, AHA President and CEO Rich Umbdenstock expressed the AHA's strong opposition to the funding reductions being considered on Capitol Hill in an op-ed column that appeared June 30 in *U.S. News and World Report's* on-line edition. (See the column on page 5).

This week in the Senate, the Finance Committee is set to continue discussions aimed at reaching a bipartisan consensus on reform legislation, and the Health, Education, Labor and Pensions (HELP) Committee will resume its markup of a health reform bill. HELP's version of reform legislation is expected to call for a public plan and employer mandates.

The Finance Committee has not reached a decision about including a government-run insurance option in its proposal. Chairman Max Baucus, D-MT, is trying to build consensus around the idea of creating a nonprofit health insurance cooperative that would compete with private health care insurers. Baucus also wants to keep the costs of his bill to $1 trillion over 10 years.

Long-term care

continued from page 1

House and congressional proposals to reduce hospital payments – including LTCH reimbursements – by more than $150 billion over 10 years to help finance the costs of health reform (see above story).

"Reform is not just about cutting" provider payments, says Ellen Smith, president and CEO of Houston-based Dubuis Health System, who spoke at the Advocacy Day event. Dubuis Health System operates 16 LTCHs in six states. Their margins are extremely thin, says Smith, and "it would be a real challenge to continue to provide services to patients" if LTCHs are cut as much as some lawmakers propose.

Smith hopes Congress carefully considers reform options, including proposals to bundle acute and post-acute care hospital Medicare payments and reduce Medicare payments to hospitals with high rates of patient readmissions.

"I understand there is a great sense of urgency in Washington to get things done," she says. "And I understand we've been talking about health reform for many years now, but lawmakers need to be very cautious that the changes we make are thoughtful and well designed. Otherwise, there may be unintended consequences."

LTCH hospital leaders also are pressing Congress to support H.R. 2124/S. 935, which would extend for two years the congressional hold on payment cuts for certain short-stay cases, and on full implementation of the 25% Rule. That rule imposes a payment reduction for LTCH referrals that exceed 25% from a single source. (See a list of senators who support S. 935 at right.)

Smith says the legislation would provide more time to develop "very clear guidelines to make sure that we have the right patients in the right setting." Without congressional action, the moratorium on the so-called 25% Rule – part of the "2007 Medicare, Medicaid and SCHIP Extension Act" – will expire Dec. 29, 2010.

The 25% Rule "sets an arbitrary limit on the number of patients that can come to an LTCH and does not give any consideration to the needs of the patient," says Sean Muldoon, chief medical officer of Louisville, KY-based Kindred Healthcare, which operates 82 LTCHs in 23 states. Muldoon also spoke at the AHA's recent Advocacy Day event.

"Should the [LTCH provisions of the 2007 Medicare law] expire without the extension currently being worked through Congress, our field will revert to the draconian financial policies that existed before 2007," warns Muldoon. "The consequence of those polices would be to limit beneficiaries' access to LTCHs and, secondarily, it would leave LTCHs with untenable payment policies."

photos by Stephen Barrett

SMITH

MULDOON

IOM identifies the top priorities for comparative effectiveness research

An Institute of Medicine (IOM) committee last week recommended that 100 topics receive priority funding from a new national research effort to evaluate the relative effectiveness of different health care services and treatment options.

The committee selected the topics from more than 1,200 suggested by health professionals, consumer advocates, policy analysts and others, including the AHA.

The 2009 "American Recovery and Reinvestment Act" allocated $400 million to the Health and Human Services (HHS) secretary for comparative effectiveness research, and required IOM to recommend how the funds could best support such research.

The advice also may influence research spending priorities for HHS' National Institutes of Health and Agency for Healthcare Research and Quality, which received $400 million and $300 million, respectively, under the act.

Among other recommendations, the committee said the research effort should promote rapid adoption of findings and effective strategies for putting them into daily clinical practice.

For more information on the recommendations, go to the "Reports" section of *www.iom.edu* and click on the June 30 "Initial National Priorities for Comparative Effectiveness Research."

Sens. who support 'Long-Term Care Hospital Improvement Act'

Long-term care hospital leaders recently came to Washington, DC, to urge Congress to oppose Medicare cuts to hospitals to pay for health care reform, and to support the "Medicare Long-term Care Hospital Improvement Act," H.R. 2124/S. 935. (See the story on page 1.) The AHA-backed bill would extend for two years the congressional hold on payment cuts for certain short-stay cases and full implementation of the 25% Rule, which imposes a payment reduction for LTCH referrals that exceed 25% from a single source. The following senators support S. 935, which was introduced by Sens. Kent Conrad, D-ND, and Orrin Hatch, R-UT. The House version was introduced by Rep. Earl Pomeroy, D-ND. Urge your senators and representatives to cosponsor this important legislation for long-term care hospitals.

Arkansas
Blanche Lincoln (D)

Colorado
Michael Bennet (D)

Georgia
Saxby Chambliss (R)
Johnny Isakson (R)

Idaho
Mike Crapo (R)
James Risch (R)

Iowa
Tom Harkin (D)

Kansas
Pat Roberts (R)

Kentucky
Jim Bunning (R)

Louisiana
David Vitter (R)

Massachusetts
John Kerry (D)

Michigan
Debbie Stabenow (D)

Mississippi
Thad Cochran (R)
Roger Wicker (R)

North Dakota
Kent Conrad (D)

Ohio
George Voinovich (R)

Oregon
Ron Wyden (D)

Pennsylvania
Arlen Specter (D)

South Dakota
John Thune (R)

Tennessee
Lamar Alexander (R)

Utah
Orrin Hatch (R)

Total: 21

AHA LEADER MEETS WITH HHS SECRETARY SEBELIUS. AHA President and CEO Rich Umbdenstock last week discussed key hospital issues with Department of Health and Human Services Secretary Kathleen Sebelius. In a meeting at the secretary's office, they discussed the Centers for Medicare & Medicaid Services' proposed inpatient prospective payment system rule for fiscal year 2010, the "American Recovery and Reinvestment Act's" impact on hospitals' adoption of electronic health records, health reform and the Hospital Quality Alliance, among other issues. Accompanying Umbdenstock was former AHA board member Maynard Oliverius, CEO of Topeka's Stormont-Vail HealthCare, and Kansas Hospital Association CEO Tom Bell.

UMBDENSTOCK

SEBELIUS

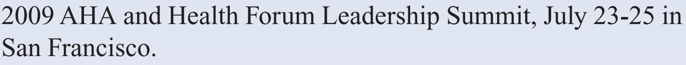
AHA

EDITORIAL

Health care role models

In communities across America, hospitals and health systems are leading thousands of local, collaborative initiatives to improve not just health, but also the quality of people's lives. Winners of the AHA's NOVA Award reflect the best of these efforts.

Each NOVA Award winner is distinguished by the community partners who work together to make life better in their community. This year's AHA NOVA Award winners will be honored at the 2009 AHA and Health Forum Leadership Summit, July 23-25 in San Francisco.



The AHA created the NOVA awards in 1993 to pay tribute to the bright stars of health care who go beyond caring for the ill and injured to help people live healthier, more productive lives, and to create a fund of ideas other hospitals could draw on.

Also to be recognized at the Leadership Summit: the winners of the 2009 "Circle of Life Award: Celebrating Innovation in End-of-Life Care." (See story on page 7). The Circle of Life Award pays tribute to hospitals, physicians, nurses and others who are leading the way toward better care at the end of life.

Circle of Life Award winners include hospitals, long-term care facilities and other organizations whose caregivers are having a profound impact on patients, families and communities at their most vulnerable time of life. And they are making inroads into one of the most difficult aspects of health care by stretching the current boundaries of who is served, how services are integrated into a seamless continuum and how palliative and end-of-life services mesh with traditional medical treatment.

Join in the celebration. It's not too late to sign up for this month's Leadership Summit. Just visit *www.HealthForum.com/LeadershipSummit.*

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What to fix in health care and what t

By Herbert Pardes, M.D.

President Obama deserves great praise for having the courage and vision to promote health care reform. Before the American Medical Association, he set goals of improved quality, contained costs and better access to care – and, equally important, vowed to tackle difficult problems like malpractice reform.

It is long overdue that we move in this direction. To be most effective, health care reform must cover the 46 million uninsured people and change what can be improved – while protecting what works well in medicine.

Though you don't hear it often these days, there are many great things about health care in America. Our education system provides doctors, nurses and health care workers with top-notch training. We have the world's leading medical researchers and research institutions. Our hospitals and medical facilities, which provide innovative, expert medical care, have lengthened life expectancy and improved quality of life for people at all income levels.

Today, what's bad with the system is threatening what's good about it. While expanding access to care and ever-improving quality, we simply must reduce costs. It is the sky-high costs that reduce access to care.

Obama is right to be focused on these costs, and I hope he looks long and hard at one of the biggest sources of the problem: malpractice insurance. It is driving physicians out of practice, discouraging young M.D.s from entering the profession in the first place and distorting the way too many doctors practice medicine.

Malpractice insurance premiums have risen so far, so fast that today we are at the point that many doctors who have never been sued nevertheless cannot afford it. For many hospitals, escalating premiums are taking away critical resources for staff and other hospital needs – even, in some instances, threatening their financial viability.

I've seen the numbers in my hospital and others. There are some very troubling vital signs.

Because of inflated malpractice insurance, our nation is losing obstetricians and neurosurgeons, to name a few. Some hospitals have had to stop delivering babies or face closing their doors for good because the cost of malpractice insurance and the risk of lawsuits are too great.

This is especially true in New York. Eighteen percent of the nation's $3.7 billion in malpractice claims are paid in New York – by far the largest of any state, according to 2007 data from the Kaiser Family Foundation. New York has only 6% of the nation's population. California, which has already tackled malpractice reform, pays one third the claims of New York – even though it has almost twice as many people.

If we do not cap "pain and suffering" awards, which is probably the single most important way to drive down premiums, we should at least agree that doctors be protected from being sued if they did nothing wrong. So called "safe haven" reforms, an approach Obama has

Card check measure would hurt the natio

By Rep. Howard "Buck" McKeon, R-CA

McKeon

Jobs. They're the heart of our economic engine, transforming to meet the new realities of a changing global marketplace. They're also a trusted barometer of economic health, and judging by employment figures, our economy remains far from healthy.

The U.S. economy shed 345,000 jobs in the month of May. More than 2.5 million Americans have lost their jobs this year alone, with a total of 5.7 million jobs lost since the recession began in December 2007.

The unemployment rate is 9.4%, its highest level in more than 25 years. It's also 1.4% higher than the Obama administration forecasted as the unemployment peak in its urgent push to pass a nearly trillion-dollar economic stimulus package that – to date – hasn't delivered the jobs that were promised.

It's clear that America needs an economic policy that will create jobs. And it's even clearer that we don't need policies that will hamper innovation or make it harder for American businesses, large and small, to keep and create new jobs.

That's why the card-check plan – euphemistically dubbed the "Employee Free Choice Act" (EFCA), although it offers employees anything but – is exactly the wrong elixir for what ails our economy.

In March, Dr. Anne Layne-Farrar, an economist with the non-partisan firm LECG Consulting, released an analysis of the card-check plan.

Her study used Canadian economic experiences to predict the impact of card-check legislation on the American economy. Canada has seen similar shifts in union certification and arbitration policies as those proposed in the card-check plan, allowing for a compelling comparison to the potential consequences for the U.S. economy if this undemocratic plan were to become law.

"If EFCA were to increase the percentage of private sector union membership by between 5 and 10 percentage points, as some have suggested, my analysis indicates that unemployment would increase by 2.3 to 5.4 million in the following year and the unemployment rate would increase by 1.5 to 3.5 percentage points in the following year," Dr. Layne-Farrar found.

"[Card check] is a proposal that could organize workers against their wishes and impose a contract that neither workers nor management approved." - Rep. McKeon.

There are obvious reasons why card-check would cost our economy jobs. Unfortunately, these economic realities are being ignored by the special-interest groups standing behind the legislation. Still, any serious discussion about job creation and economic growth needs to consider what's at

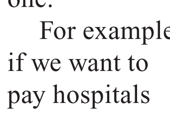
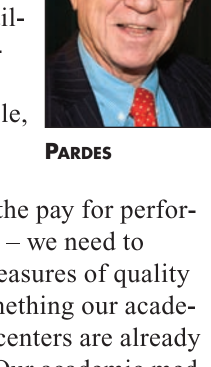
to leave alone

suggested, would ban lawsuits in cases where doctors and hospitals have followed accepted medical practices. Doctors would be allowed to deviate from accepted practices if medical need dictates. Lawsuits for true negligence would continue.

True malpractice reform will reduce premiums and help reduce "defensive medicine," the extra, and sometimes unnecessary, tests many doctors order to protect themselves from suits. A McKinsey study estimated defensive medicine adds as much as $150 billion to $190 billion each year to health care costs.

These reforms are needed to reduce substantial proposed cuts in Medicare and Medicaid payments, which on their own could threaten the viability of many hospitals.

How we reimburse hospitals for the work they do will be important. If we do it wrong, we may inadvertently cause critical harm to the delivery of medical care, including centers for critical care and specialized care. Especially vulnerable are our academic medical centers, where doctors are trained, innovation is born and medical research is conducted. Academic medical centers are uniquely qualified to help Obama improve medical care while making it available to everyone.

PARDES

For example, if we want to pay hospitals for quality – the pay for performance model – we need to ensure our measures of quality are valid, something our academic medical centers are already working on. Our academic medical centers also are excellent places to develop and test information technology systems, which will be an important lynchpin of health care reform to improve efficiency and medical outcomes, while reducing costs.

Medical institutions should all welcome the chance to work with Obama to make reform a reality. We need to look at the entire system, change what needs changing and preserve quality care delivery.

Pardes is president and CEO of New York-Presbyterian Hospital. This column first appeared in the June 21 New York Daily News and is reprinted here with the author's permission.

on's workforce

stake.

Although the term "card check" has come to represent the entire proposal, it refers specifically to the most infamous provision contained in the so-called Employee Free Choice Act – the union certification scheme that replaces secret-ballot elections with a public sign-up process.

These card-check sign-ups would become the norm for union organizing, putting workers in the middle of a very public tug-of-war between those who wish to organize and those who don't. A worker's position would be known to all based on the decision to sign or not sign the union authorization card.

Workers could be subject to intimidation, public pressure, and even coercion under the public sign-up process envisioned by card-check. Privacy would no longer exist in workplace-organizing votes.

And what happens after the cards are signed? In many instances, workers and employers would see a truncated contract negotiation followed by a virtual federal takeover of the workplace.

EFCA calls for binding interest arbitration, an inside-the-Beltway term for forced government contracts. An arbitrator – perhaps some nameless, faceless federal bureaucrat – would be empowered to unilaterally dictate contract terms if a union and employer cannot reach agreement within 120 days.

This government arbitrator would decide everything from wages, hours, and benefits to opportunities for promotions and the use of subcontractors. If workers get a raw deal, that's just too bad. If the contract would put the employer out of business and eliminate those jobs entirely, again, that's just the way it is.

To recap, this is a proposal that could organize workers against their wishes and impose a contract that neither workers nor management approved. Its reach could extend to businesses as small as a dozen workers or fewer, driving up the cost and complexity of doing business.

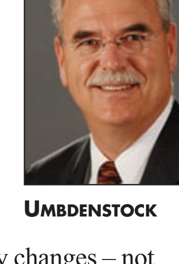
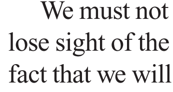
If the question is how to keep and create jobs in this country, the answer is to start by rejecting policies that would destroy them.

McKeon is a member of the House Education and Labor Committee, which has jurisdiction over workplace issues in the House. This column first appeared June 24 in Roll Call and is reprinted here with the author's permission.

Hospitals can't afford the health care cuts Obama, Congress are considering

By Rich Umbdenstock

It promises to be a very hot summer in Washington as the health reform debate takes center stage and various options are discussed.

UMBDENSTOCK

We must not lose sight of the fact that we will need good policy changes – not just payment cuts – if we hope to find long-term solutions to the health care challenges vexing America: 46 million uninsured, an aging population, an epidemic of obesity and chronic disease and the need for a more coordinated system of care.

The men and women working in America's hospitals see the challenges we face and the opportunities for change that are needed. Providing coverage to our nation's uninsured is vitally important and a goal that hospitals support strongly.

And there are reforms that must take place: lasting changes that emphasize wellness and prevention; removing the barriers to hospitals, physicians, nurses, and other caregivers to working together to better coordinate care for patients; and allowing caregivers to remain focused on improving patient care–not on navigating a complex, red tape-ridden system.

And the best part about these solid policy changes is that they all have associated cost savings. These are the changes hospitals strongly support.

What hospitals cannot support, and hospitals cannot sustain, are budget cuts on the magnitude of nearly a quarter trillion dollars. Cuts in the government programs that serve our nation's seniors, disabled, poor, and children to the levels that are being discussed would put in jeopardy the many services on which communities rely.

Specifically, gutting the Disproportionate Share Hospital programs under Medicare and Medicaid as President Obama recently proposed – programs designed to help hospitals care for large numbers of uninsured and that help make up for government underfunding –and doing so before coverage has been activated could threaten further the ability of hospitals to provide care.

For those hospitals that will continue to care for large numbers of Medicaid patients, these reductions will have a devastating impact. Blunt cuts are not the reform our nation needs. Hospitals recognize and agree that care must become more affordable, and hospitals are taking steps within their organizations–without legislation–to do their part to make changes that improve patient care and save costs.

We applaud these hospitals and are working to spread their learnings throughout the nation.

Make no mistake – many of America's hospitals will not be able to withstand the cuts that the administration and the Congress are considering. They already are experiencing increases in charity care and nonpayment for services as the economic downturn affects more and more Americans and their employer-provided insurance coverage.

The public will judge reform efforts on whether such changes improve care for themselves and their families and will support the organizations and caregivers they depend upon to deliver needed health care.

We urge the administration and Congress to adopt thoughtful reform that addresses the underlying challenges our nation faces. Our communities and patients depend upon it.

Umbdenstock is president and CEO of the AHA. This column first appeared in the June 30 on-line version of U.S. News and World Report.

Banning physician self-referral is an important step toward health reform

Banning physician self referral to hospitals in which the doctors have an ownership interest is an important step toward health care reform, wrote AHA President and CEO Rich Umbdenstock and Federation of American Hospitals President Chip Kahn in an op-ed column that appeared in the June 30 *Louisville Courier-Journal*.

"Eliminating physician self-referral will benefit both patients and communities, because it saves taxpayer money, ends a serious conflict of interest and, above all, allows full-service community hospitals to provide vital care for all those in need," they said. Although a congressional moratorium and subsequent Department of Health and Human Services' administrative action generally held physician-owned hospitals in check from late 2003 to 2006, the practice is on the rise again, Umbdenstock and Kahn stated.

The two national hospital leaders noted that their organizations support a physician self-referral ban with limited exceptions for existing facilities that meet strict investment and disclosure rules. You can read the entire op-ed column by going to the "Opinions" section of *www.courier-journal.com,* and clicking on the "Important Step for Health Reform" op-ed for June 30.

HRET surveys testing practices

The AHA's Health Research & Educational Trust (HRET) affiliate, in partnership with the Centers for Disease Control and Prevention (CDC), is surveying 1,000 hospitals on their HIV testing policies and procedures to better understand the opportunities and challenges the nation faces in identifying and treating people with HIV.

The CDC estimates that as many as 25% of the 1.2 million Americans who are HIV positive are unaware that they are infected with the virus.

HRET mailed the survey last week to the hospitals' CEOs for completion by infection control staff.

Community benefit reports can help tell your hospital's story of service

Through its "Community Connections" initiative, the AHA offers tools and services to help hospital leaders tell their "stories" to the community, media and policymakers about how their hospitals are living out their mission to improve peoples' lives and health.

North Shore-LIJ Health System in Great Neck, NY, understands the importance of telling its story of community service. North Shore is among a growing number of hospitals that prepare annual community benefit reports to describe some of the ways in which they make a difference for their patients and communities.

AHA members can find North Shore's report – and similar reports from other hospitals – by clicking on the "Community Connections" icon at *www.aha.org* and going to "Telling the Hospital Story: Going Beyond Schedule H."

The stories below are from North Shore's community report and are reprinted here with the health system's permission.

Financial assistance … Adrian's story

Adrian Gordon, a 20-year-old uninsured student at Manhattan Community College, was ejected from a car's rear window and fractured his spine in a horrific car crash on the Long Island Expressway.

Rushed to North Shore University Hospital in Manhasset, NY, he underwent emergency surgery on his C-6 vertebrae at the Harvey Cushing Institutes of Neuroscience Spine Center. When he awoke from surgery, Gordon only was able to move his eyelids.

Two weeks later, he thought he was dreaming when he felt sensation in his toes. Later, when he discovered he could move them, he recalls, "I stayed away all night wiggling my toes to make sure I wasn't dreaming."

Gordon was transferred to the Southside Hospital rehabilitation unit in Bay Shore, NY, for intensive therapy. Thanks to his determination and the treatment he received, he was able to walk out of the hospital with the aid of crutches less than three-and-a-half months after an accident almost left him paralyzed.

As part of its financial assistance program for uninsured patients, the North Shore-LIJ Health System covered 99% of Gordon's medical bills.

Gordon was majoring in accounting and finance before the accident. As a result of his experience, he plans to change his major to sports medicine. "After the care and support I received, I really want to help others and give something back to show how much I appreciate all that was done for me," Gordon says.

Adrian's story. North Shore University Hospital in Manhasset, NY, came to Adrian Gordon's financial aid.

Vulnerable families … Olga's story

It has been a long time since Olga Hernandez, who is in her 60s, had to care for young kids.

"My youngest child is 30 years old and a lot has changed in raising children since he was small," Mrs. Hernandez said.

She said navigating the public health insurance system and exploring options for multiple special needs isn't easy.

"My son and his girlfriend are drug users and my grandchildren were born drug-addicted," said Mrs. Hernandez, who gained custody in 2007 of William, 2, and Gregory, 7. "I didn't know where to go until the nurse at the school told me about North Shore-LIJ's mobile health program. It has been a godsend and a safe haven."

She said the mobile van's program director, Alec Thundercloud, M.D., goes beyond the call by helping her address concerns ranging from dental and behavioral health issues to speech-related concerns for William and Gregory. "They follow up and call me at home to make sure my grandchildren are getting the care they need," she said. "The mobile health program is helping me give my grandchildren a chance."

Olga's story. Olga Hernandez says North Shore's mobile health program is "helping me give my grandchildren a chance."

New moms are thankful for Providence Kodiak's 'kindness'

Providence Kodiak Island (AK) Medical Center is well on its way to surpassing the Department of Health and Human Services' "Healthy People 2010" goal of increasing to 75% by 2010 the proportion of mothers nationwide who breast-feed their babies.

In fact, more than 90% of moms who give birth at Providence opt to breast-feed thanks to Kodiak KINDNESS, a program of the hospital that provides mothers with free information and support on breast-feeding technique and infant nutrition.

All mothers who give birth at Providence are invited to participate in the program. Mothers receive periodic check-ins by phone and home visits by expert staff to ensure they are breast-feeding correctly, and that infants are developing properly. They have access to hospital-grade breast pumps and other breast-feeding aids and infant nutrition workshops. The program also teaches mothers about proper bottle-feeding techniques and how to properly mix formulas.

For Kimberly Almandmoss, who gave birth at Providence on May 6, breast-feeding her son Finnegan "Finn" was important. The first-time mother said that labor was very difficult, culminating in a Cesarean section birth. And, if it weren't for Kodiak KINDNESS, breast-feeding may not have been possible for her.

At first, Finn was not properly "latching on" to Almandmoss and it took longer than normal for her to begin producing milk, she said. So Kodiak KINDNESS provided her with a device that helps to overcome both problems. The supplemental nursing system consists of a container for milk that hangs around the mother's neck and is connected to a tube. The infant sucks on the tube and the sensation is supposed to stimulate the production of breast milk.

It worked. Finn is now a healthy two-month-old and breast-feeding normally. "He's just a delight," she says. "He's smiling now, playing, cooing … It's as if nothing ever happened."

Almandmoss' success is typical of moms who have participated in the program since it began in July 2006, says program coordinator Heather Preece, a pediatric dietician and lactation consultant for Providence.

Before the program started, Preece's expertise was summoned usually after a mother was already experiencing difficulty breast-feeding. Kodiak KINDNESS helps mothers from the beginning, which in turn, increases duration rates.

"I have a list as long as my arm of the reasons why it's important for women to breastfeed and continue as long as they can," says Preece. Benefits include a reduced risk of post-birth bleeding and pre-menopausal breast cancer among mothers and fewer infections and hospitalizations among infants.

For more information on Kodiak KINDESS, contact Heather Preece, program coordinator, at (907) 481-2489 or *Heather.Preece @providence.org*. - ***Matthew Malamud***

Kodiak KINDNESS. Kimberly Almandmoss (left) and Heather Preece (right) of Kodiak KINDNESS, with baby Finn.

Meaningful

continued from page 1

istic. "Because CPOE implementation depends on other EHR components, requires significant cultural changes, and entails significant costs, CPOE should not be required" until at least 2015, the AHA wrote David Blumenthal, M.D., ONCHIT's national coordinator.

In its letter to ONC, the AHA outlines what hospitals can reasonably accomplish over the next few years as they move toward becoming "meaningful" EHR users.

"We suggest the definition of meaningful use in 2011 should first aim to get the majority of hospitals up and running with the basic components of an EHR system that can be built upon," the association stated. Those components should include clinical documentation of patient demographics; problem and medical lists; discharge summaries and labor and radiology reports and diagnostic tests, the AHA said.

Such functions as nursing documentation and assessments; electronic access by pharmacists to formularies; medication bar coding and drug to drug, drug to allergy and drug to formulary checks, among others, could be added in 2013, the AHA said.

In other comments, the AHA told ONC that that the government should not require hospitals to share or "exchange" clinical data or report quality measures unless it has standards in place to support those connections.

The draft definition also includes quality measures that do not exist, and others that are not endorsed by the National Quality Forum (NQF) or adopted by the Hospital Quality Alliance (HQA) – the two organizations that are the primary consensus groups for hospital quality reporting, the AHA observed. "It would be extremely challenging for these measures to be developed, specified, tested and endorsed by the NQF and HQA in time for implementation beginning in 2011," the AHA said.

The AHA on June 24 sent a "Special Bulletin" on the draft defition to hospital leaders. AHA members can find it by clicking on "Health Information Technology" under the "Issues" section of *www.aha.org*, and clicking on "AHA Special Bulletin: Meaningful User of EHRs. Weigh in Now!" for June 24.

Shirley Ann Munroe inspired leadership award

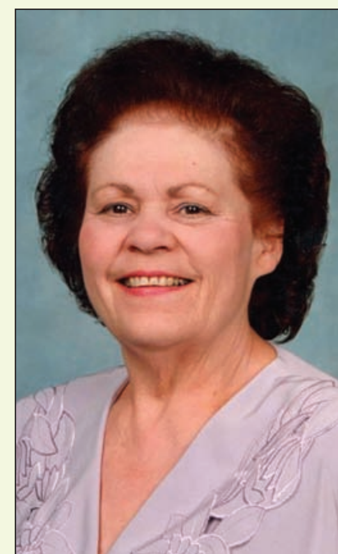
Shirley Ann Munroe, a rural health care leader and former AHA vice president, died June 7 at age 85. She served as the first director of the AHA's Section for Small or Rural Hospitals.

The AHA established the Shirley Ann Munroe Leadership Award in her honor in 1990, the year after she retired from the association. The award recognizes small or rural hospital executives and administrators who have achieved improvements in local health delivery and health status through their leadership. The award's 20th winner will be named this year.

When it established the award, the AHA said that "Shirley Ann Munroe set a standard of dedication and leadership that continues to inspire her professional peers in small and rural hospital administration."

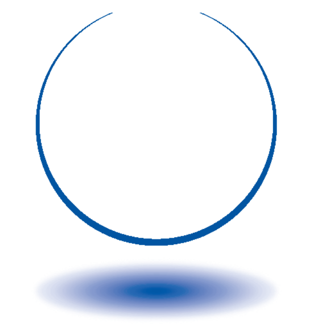
Munroe was administrator of then 43-bed Hillside Hospital – now Adventist Health Ukiah (CA) Valley Medical Center – from 1956 to 1977, when she joined the AHA. She served as an AHA vice president in Chicago for 12 years.

The AHA said Munroe's legacy is a benchmark for professional hospital management, rural community health development, and health care representation and



Monroe

Honoring programs that expand the reach of palliative, end-of-life care



Three programs that expand the reach of palliative and end-of-life care will be recognized later this month as the 2009 recipients of the "Circle of Life Award: Celebrating Innovation in End-of-Life Care," along with two others that were awarded citations of honor.

Four Seasons Hospice & Palliative Care in Flat Rock, NC.; Oregon Health & Science University (OHSU) in Portland, OR; and Wishard Health Services in Indianapolis, will each receive a Circle of Life Award July 24 at the AHA and Health Forum Leadership Summit in San Francisco.

"Dealing with life-threatening illness and end-of-life decisions is difficult for all involved and our Circle of Life honorees understand that respect, compassion and honesty are vital aspects of palliative care," said AHA President and CEO Rich Umbdenstock. "As our nation looks to true health reform, end-of-life and palliative care will be important components and these honorees are truly inspirational and help serve as models.

In announcing the awards, Circle of Life sponsors noted that Four Seasons Hospice & Palliative Care serves more than 2,230 people a year and offers a full range of hospice and palliative care, research and bereavement services. OHSU's palliative medicine and comfort care team earned high marks for its focus on research and education, which has enabled the organization to make impressive strides in improving the quality of care. Wishard Health Services was cited for serving more than 600 patients a year with an interdisciplinary care team that includes nurses, doctors and chaplains.

Citations of Honor were awarded to Gilchrist Hospice Care and Greater Baltimore Medical Center in Towson, MD, and St. John's Regional Medical Center and St. John's Pleasant Valley Hospital in Oxnard and Camarillo, CA.

This is the 10th year for the Circle of Life Award, which is sponsored by the AHA, the American Association of Homes and Services for the Aging, the Catholic Health Association, and the National Hospice and Palliative Care Organization & National Hospice Foundation, with support from the California Healthcare Foundation in Oakland, CA, and by the Archstone Foundation in Long Beach, CA. The American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association also are 2009 Circle of Life co-sponsors.

For more information on the Circle of Life Award, visit www.aha.org/circleoflife.

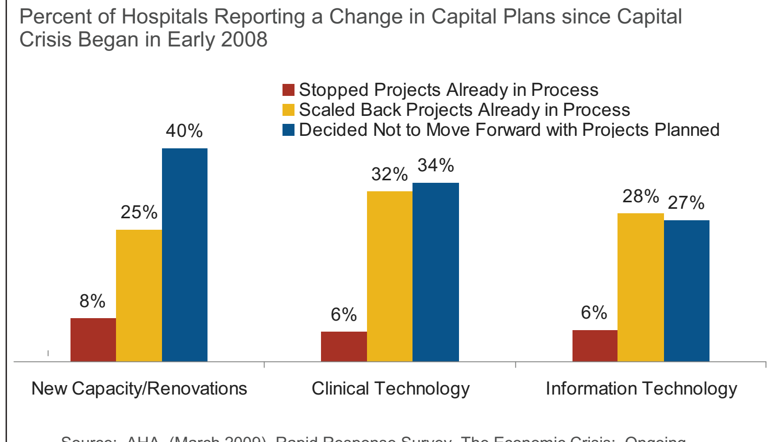
Poor economy curtails IT projects

The "American Recovery and Reinvestment Act," P.L. 111-005, increases federal support for health information technology (IT) in the nation's hospitals. More than $17 billion in incentive payments are intended to encourage hospitals and other providers to adopt IT. But the measure also carries penalties in the form of Medicare reimbursement reductions if hospitals fail to adopt electronic health records by target dates.

The promise of federal IT funding comes as the ailing economy forces many hospitals to stop or scale back on IT and other projects. The table below, from the AHA's "The Economic Crisis: The Toll on the Patients and Communities Hospitals Serve," shows the economy's impact on hospitals' IT and clinical projects and facility renovations.

For more on the report, go to the "Research and Trends" section of www.aha.org.

Projects scaled back or eliminated include facility upgrades as well as clinical and information technology.



Source: AHA. (March 2009). Rapid Response Survey, The Economic Crisis: Ongoing Monitoring of Impact on Hospitals.

The Quality Corner

Reporting on new quality measure

Hospitals participating in the Medicare pay-for-reporting program have until Aug. 15 to report whether they participate in a systematic database for cardiac surgery, the Centers for Medicare & Medicaid Services has announced.

The agency last week posted on the "My QualityNet" Web site instructions for hospitals and vendors submitting data on the measure.

Cardiac surgery is one of 13 new quality measures that hospitals participating in the pay-for-reporting program must submit to receive their annual payment update for fiscal year (FY) 2010 under the inpatient prospective payment system final rule for FY 2009. Hospitals that do not perform cardiac surgeries will be able to indicate that for their data submission.

For more information, go to *http://www.qualitynet.org*.

AHA urges CMS to drop proposed IRF certification changes

The AHA has called on the Centers for Medicare & Medicaid Services (CMS) to withdraw proposed revisions to the certification criteria for inpatient rehabilitation facilities (IRF). The revisions are included in the IRF prospective payment system proposed rule for fiscal year 2010 and draft revisions to the IRF medical necessity guidelines.

"CMS fails to articulate any inadequacies of the current facility criteria," the AHA said. "Given that IRFs already must satisfy substantial facility criteria similar to those of other hospital settings, and may face a significant financial penalty if they fail to do so, we do not believe further IRF facility criteria are warranted at this time."

The AHA's June 26 comments also were directed at the agency's proposal to revise section 110 of the Medicare Benefit Policy Manual, which provides the medical necessity guidelines for IRF patients. The AHA warned that CMS' "rewrite" of the IRF medical necessity guidelines constitutes new policy that must be proposed through formal rulemaking.

CMS is expected to publish a final IRF rule by Aug. 1. The proposed rule would apply to more than 200 freestanding IRFs and more than 1,000 IRF units in acute care hospitals, and would be effective for discharges beginning Oct. 1.

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Reduce proposed SNF payment cut: AHA

In a June 26 comment letter, the AHA urged the Centers for Medicare & Medicaid Services (CMS) to reduce a proposed $1 billion Medicare payment cut for skilled nursing facilities (SNF) in fiscal year (FY)2010 that adjusts for utilization patterns in 2006 that exceeded CMS' projections.

In addition, the AHA said the agency should allocate the payment cut over a two-year period to minimize instability for SNF providers, especially hospital-based SNFs, which in 2007 had a Medicare margin of negative 80%. The AHA also recommends that CMS reevaluate and postpone for one year the rule's proposal to update the SNF payment system in FY 2011, citing several concerns with the data used by CMS to develop the proposed changes.

CMS urged to change LTCH proposed rule

The AHA recently urged the Centers for Medicare & Medicaid Services (CMS) to withdraw a coding and documentation adjustment included in the proposed rule for long-term care hospitals (LTCH) in fiscal year (FY) 2010. CMS proposes a 2.4% market basket increase for LTCHs in FY 2010, which would be offset by a 1.8% reduction to account for documentation and coding behavior in 2007 and 2008. In a June 26 comment letter on the proposed rule, the AHA urged the agency "to revisit its calculation of the proposed 1.8% cut to explicitly examine real case-mix change for LTCHs in 2008, 2007 and the years prior to establish a pattern of change." The letter urges CMS to use this new analysis on real case mix-change to reduce the proposed coding and documentation adjustment of negative 1.8%.

Flu vaccination guide

The Joint Commission last week released a guide to help health care organizations increase flu vaccination rates among health care workers. You can find it by clicking on the "Patient Safety" section of *www.jointcommission.org* and going to "Infection Control."