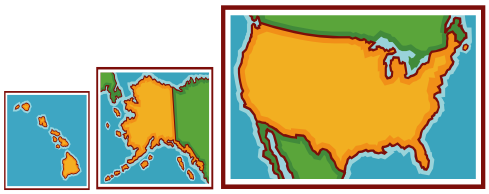


State E-News Roundup

A Compendium of Items from State, Regional and Metropolitan Hospital Association Newsletters

Volume 9, Issue 10 November 2015

Affordable Care Act Implementation

- ***Coverage Expansion***

Montana Hospital Association 10/9/15

Medicaid Expansion Plans Show Progress: Montana Medicaid announced that Blue Cross Blue Shield will provide third party administration for the proposed expansion of coverage to low income adults. Officials are continuing negotiations on a final contract while the insurer works to establish its provider network to provide access to care. Meanwhile, the Centers for Medicare and Medicaid is continuing discussions with Montana officials about the waivers requested by Medicaid. Public comments regarding the waiver are due no later than October 15. Montana is seeking approval of the program in time to begin coverage on January 1, 2016. MHA has provided comment on the State proposal urging the federal government to approve Montana's plan to expand coverage. Meanwhile, hospitals and other providers are beginning to plan for implementation of the new coverage. Montana Medicaid will begin publishing administrative rules for the new program later this month. (Staff Contact: Bob Olsen, Vice President, bob@mtha.org)

Kansas Hospital Association 10/9/15

President's Perspective - We Are in this Together: By now, you have undoubtedly seen the recent communication from Governor Sam Brownback's office regarding KanCare expansion. This communication appears to make a couple of arguments: (1) expansion favors people who don't need help vs. people who do; so, it is both bad policy and "morally reprehensible;" and (2) expansion would only help a few "big city" hospitals that don't need it at the expense of small rural hospitals that do.

Hopefully, you also have seen the response of KHA Board Chair Steve Kelly, which focuses on the facts about expansion and the need of all Kansans to work together to solve problems.

The communication from the Governor's office was obviously unfortunate at best, and it probably is an indication that those who are opposed to taking advantage of the KanCare expansion opportunity are worried that the issue is getting more attention. But I think it would be a mistake to respond "in-kind" with the same type of language. Instead, just like the care that is delivered in hospitals across the state, our arguments must remain "evidence-based." And here, that evidence is on the side of those who favor developing a Kansas plan for expansion. Ultimately, facts and ideas are what will make such a plan reality.

With regard to the second point raised by the Governor's office, during the nearly 30 years I have worked at the Kansas Hospital Association, I have seen many attempts to create divisions among our hospitals. Those attempts have always failed, just like this latest one will. That is because ALL hospitals, from the smallest Critical Access Hospital to the largest tertiary care center, help to form the safety net that protects vulnerable Kansas citizens. ALL hospitals, no matter what size, serve as economic anchors for their communities, providing excellent employment opportunities and improving the quality of life. ALL hospitals, regardless of the number of beds, serve as a valuable community resource. So, to propose that one particular group of hospitals gets left out of the benefits of expansion is not only incorrect, it fails to recognize the strong interdependencies among Kansas hospitals.

This is an extremely difficult issue politically, which obviously makes it harder to navigate. But we must remain focused on providing hospitals all the tools available to deliver the best possible care for their communities in this ever-changing environment. If hospitals continue to stay together and offer "evidence-based" arguments, support for the development of a Kansas plan will continue to grow. --Tom Bell

New Hampshire Hospital Association 10/8/15

New Hampshire Hospital Association Releases New Report on the New Hampshire Health Protection Plan -- Data Shows Continued Reductions in Hospital Use Among Uninsured: The New Hampshire Hospital Association (NHHA) released a report today showing that the New Hampshire Health Protection Plan (NHHPP) continues to have a positive impact on patients, families and the overall healthcare system.

Since the New Hampshire Health Protection Plan was created in August 2014, data reported to the NHHA by its member hospitals has continued to show reductions in the number of uninsured patients seeking care from New Hampshire's hospitals. In fact, as of June 2015, emergency department visits among the uninsured are down 28%, inpatient visits among the uninsured are down 36%, and outpatient visits among the uninsured are down 23% compared to the prior year.
"More than 41,000 low-income Granite State residents now have health insurance coverage and, therefore, access to routine, preventive care – the right care, at the right place, at the right time," said NHHA President Steve Ahnen. "This reduces the overall cost of care, and it also means the cost of care, previously shifted to New Hampshire citizens and businesses, is now mainly subsidized by the federal government."

The NHHA also reported reductions in the amount of uncompensated care provided by hospitals across New Hampshire. This is an important trend that is helping to reduce the hidden tax that gets shifted to insured citizens and businesses through higher costs and higher health insurance premiums. As a result of this drop in uncompensated care, these costs have been substantially reduced, resulting in less pressure on health insurance premiums.

The New Hampshire Health Protection Plan is currently slated to sunset by the end of 2016, which would mean the loss of $400-500 million a year in federal investments in New Hampshire health care. The New Hampshire Hospital Association believes that reauthorization of the NHHPP is imperative to continue the important gains that have been made over the past year to increase access for Granite State residents to the type of primary, preventive care that keeps them healthy, decrease the amount of uncompensated care provided by hospitals, health centers, doctors and others, and reduce cost shifting and hidden taxes.

"The costs of caring for these 41,000 people do not go away if the NHHPP expires," added Ahnen. "It simply means that the positive gains we have seen over the past year will be reversed and the costs of caring for those without insurance will get transferred right back to New Hampshire citizens and businesses."

The Association's full report can be found here.

- ***Enrollment and Outreach***

Texas Hospital Association 10/1/15

Digital Ads Are a Cost-Effective Way to Promote Insure Health Insure Texas: The Insure Health Insure Texas campaign kicks off today. The goal is to promote enrollment of eligible-but-uninsured Texans in the federal health insurance marketplace. As we have been communicating over the last several weeks, the Texas Hospital Association has developed numerous resources that hospitals can use in their communities to promote the message that affordable coverage options are available beginning Nov. 1.

One of the most cost-effective of these resources is digital ads. These can be used on hospital websites and message boards as well as on third-party sites such as local media outlets.

These ads and all other downloadable, free resources for hospitals are available from THA's website.

Hospital marketing and communications staff are encouraged to contact Lance Lunsford or Stephanie Limb at THA on how they can use the campaign resources in their facilities and communities. (Lance Lunsford/Stephanie Limb)

Hospital and Healthsystem Association of Pennsylvania 10/23/15

HAP Meets with Stakeholders, Exchanges Ideas on Upcoming Open Enrollment: Earlier this week, HAP hosted a meeting of hospital representatives, community health centers, navigators, consumer advocates, and other stakeholders to prepare for the November 1, 2015, health insurance marketplace open enrollment. Participants exchanged a variety of ideas that may be helpful in member enrollment and outreach efforts.
Ideas include:

- Link uninsured individuals calling about billing questions with certified application counselors, as appropriate
- Hold enrollment events at sites to which individuals can walk
- Work with other stakeholders, including the faith community, to identify and/or target populations more likely to be uninsured (e.g., individuals exiting the justice system, immigrants, food service workers, etc.)
- Make speakers available to community groups about the topic of access to health insurance and health insurance literacy, including education about the circumstances that allow enrollment outside of the open enrollment time period (e.g., births, marriage, divorce, death)
- Use of "word of mouth," particularly in rural communities, by encouraging individuals who have enrolled to share business cards of certified application counselors with neighbors and family members
- Work with CareerLink offices to make available information about access to health insurance—marketplace and Medicaid—to prospective job seekers
- Work with local media to convey the value of health insurance coverage using personal stories
- When available, provide in-person assistance which is important to help individuals to sort through options and required documentation

In addition, through HAP's work with the Pennsylvania Health Access Network (PHAN), hospital and health system certified application counselors (CAC) are able to participate in regional webinars PHAN is holding to acquaint CACs with insurers on the marketplace. All of the health insurers on the marketplace will be participating and providing information about the products they are offering on the marketplace. Advance registration is required and PHAN requests that organizations consolidate individuals to enroll as one registrant per site.

Illinois Hospital Association 10/27/15

IHA Marketplace Brochures Available: Once again, IHA members can order free health insurance marketplace brochures to help promote the upcoming open enrollment period, which begins Nov. 1 and ends Jan. 31, 2016. This is the third year uninsured Americans can purchase private insurance through the public marketplace, where subsidies are available to offset the cost.

IHA's free brochures provide an overview of the Affordable Care Act's (ACA) health insurance requirement and outline the resources available to Illinois residents seeking health insurance coverage. They are available in English and Spanish, and can be customized for your hospital. Click here for ordering instructions.

Federal health officials have targeted Illinois, where many uninsured live, as one of four states to concentrate enrollment efforts. Officials say getting new enrollees will be more difficult because many of the uninsured have already signed up. About 10.5 million uninsured Americans are eligible for coverage through the marketplace, with almost half between ages 18 and 34.

Enrollees must sign up for coverage by Dec. 15, 2015 for their coverage to begin Jan. 1, 2016. Those who are eligible but do not sign up for coverage face a tax penalty of $695 or 2.5% of their income, whichever is greater.

Through the ACA and Illinois Medicaid expansion legislation, (PA 098-0104), more low-income individuals, including seniors, persons with disabilities, parents/caretakers of dependent children, pregnant women and children are eligible for Medicaid in Illinois. By initiating a health insurance

marketplace application on www.healthcare.gov, consumers will be informed if they are eligible for Medicaid or need to purchase health insurance via the marketplace.

This week, consumers can get a preview of 2016 health insurance plans, prices and subsidies on the health insurance marketplace website before open enrollment begins Nov.1. Last week, the Centers for Medicare & Medicaid Services released a fact sheet detailing the new features and improvements of the marketplace website, based on consumer feedback, to make enrollment quicker and smoother for both returning and new customers. Staff contact: Bill McAndrew

- ***State Health Care Reform/Transformation Initiatives***

Alaska State Hospital & Nursing Home Association 10/1/15

ASHNHA Develops Initiative Focused on Small Hospital Sustainability and Transformation: Over the last year the issue of small hospital sustainability and transformation has emerged as a priority issue at both the state and national level. The ASHNHA Small Hospital Committee has discussed the changing health care landscape, the unique obstacles faced by rural facilities, and strategies for sustainability such as governance models, integration, affiliation, and new care and payment models.

In response to these issues, ASHNHA is working with the small/rural hospitals to develop an initiative to support sustainability and preparation for the future. We've identified two goals for this effort:

- Increase sustainability - Support hospitals in financial distress and increase financial and operational efficiency to preserve access to health care in rural communities. This will include advocating for sustainable rural hospital Medicaid funding as our Medicaid program undergoes a redesign/reform process.
- Prepare for the future - Establish a "glide path" for rural hospitals for the future. This will include exploring potential new models for rural health delivery that will meet community needs and be sustainable while also supporting rural hospitals in developing the capacity to deliver value-based care.
- Hospital leaders will work together to identify, develop and access tools and resources to support financial sustainability and develop the capacity for value-based care in the future. The group will evaluate new models of rural health delivery and reimbursement. We will also focus attention on proposed Medicaid redesign models and the impact on rural facilities.

A task force of small/rural hospitals has been formed to guide the initiative. The co-chairs of the task force are Dan Neumiester, SEARHC and Bob Letson, South Peninsula Hospital. For more information, contact Jeannie Monk at (907) 586-1790.

Washington State Hospital Association 10/1/15

Cantwell Urges HHS to Use Washington State as a Model: U.S. Sen. Maria Cantwell, a member of the Senate Committee on Finance, is urging the federal Health and Human Services Administration (HHS) to use Washington State's high-performing health care delivery system as a model to reform the Medicare program to focus on the value, not the volume, of health care services.

Saying that Washington State is a national leader in delivering lower-cost, higher-quality health care, Cantwell applauded HHS for making major grants to Washington State to improve health care delivery systems.

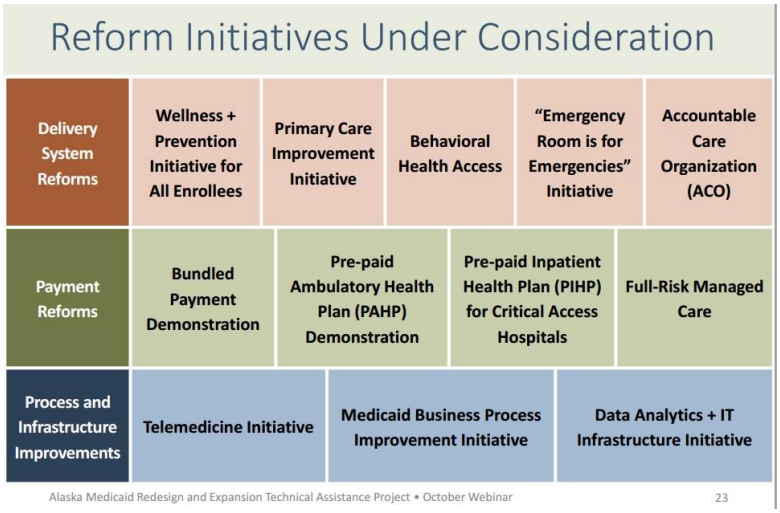
She also called on Congress to enact bipartisan legislation she recently introduced to make Medicare's Accountable Care Organizations (ACOs) more beneficial to providers and patients in rural communities. WSHA strongly supports that legislation — the Rural ACO Improvement Act of 2015 — which allows Medicare to include primary care visits by nurse practitioners, physicians' assistants and clinical nurse specialists in assigning patients to an Accountable Care Organization. Read more here. (Cassie Sauer)

Alaska State Hospital and Nursing Association 10/30/15

Medicaid Redesign Initiative Advancing: Medicaid redesign moves ahead with another stakeholder meeting scheduled for Nov. 10. The contractors are working to narrow the reform alternatives to a smaller subset, which will then be subject to actuarial analysis. Following the Nov. 10 stakeholder session, ASHNHA plans to provide written comments to the Department and consultants on the

remaining options. We will need member input on these reform alternatives, so please take the time to become familiar with them. For a detailed working draft of initiatives click here. A summary of the reform alternatives can be found in this presentation from the Oct. 15 webinar.

The chart below shows a one-page summary of the items under consideration. Since this chart was produced, the Department has eliminated pre-paid ambulatory health plans, pre-paid inpatient health plans for CAHs and bundled payment demonstrations from consideration.



Behavioral Health Issues

New Jersey Hospital Association 10/15/15

NJHA Report Examines Mental Health and Addictions Volume in Hospitals: New Jersey's acute care hospitals continue to care for a growing volume of mental health and addiction cases, in both the emergency and inpatient settings, according to NJHA's updated New Jersey Acute Care Hospital Mental Health and Addictions Volume Report, a compilation of uniform billing information for 2010-2014.

This annual report depicts the demands on New Jersey's acute care hospital-based mental health and addictions system of care and is intended to assist providers, policymakers and leaders in the field as they work to design innovative practices to ensure individuals receive timely access to care.
The report is stratified by age range and insurance status and reflects a five-year trend at statewide and county levels. Emergency department treat-and-release along with inpatient data paint a picture of continued increase for needed services.
Key findings are broken down into two areas. In the emergency department:

- The number of cases with mental health or addiction as a primary diagnosis increased from 141,879 in 2010 to 154,617 in 2014, an increase of 9.0 percent. For a more complete picture of patient volume – mental health or addiction as either a primary or secondary diagnosis – the volume of cases jumped from 412,239 to 534,517, an increase of 29.7 percent.
- Mental health or addiction cases as either the primary or secondary diagnosis accounted for 17.3 percent of all ED volume, compared with 14.4 percent in 2010.
- Medicare HMOs and fee-for-service and Medicaid HMOs and fee for- service all saw significant increases in beneficiaries accessing behavioral health and addiction cases.

And in inpatient admissions:

- 66,251 admitted patients had a primary diagnosis of mental health or addictions, and 304,206 had mental health or addictions as a secondary diagnosis.
- Patients with a primary diagnosis of mental health or addiction accounted for 6.8 percent of all inpatient admissions, while patients with a primary or secondary diagnosis of mental health or addiction accounted for 31.2 percent of total inpatient volume. Mary Ditri, 609-275-4279, mditri@njha.com

Massachusetts Hospital Association 10/19/15

Baker Proposes Sweeping Opioid Crisis Bill: Fulfilling his campaign promise of making the fight against the opioid crisis one of the top priorities of his administration, Governor Charlie Baker on Thursday released draft legislation that severely limits access to the drugs.

Among many provisions of the legislation, prescribing providers would be prohibited from prescribing new patients more than a 72-hour supply of a prescription opioid. Similar to the current Section 12A for mentally ill patients, physicians and certain other providers would be allowed to involuntarily detain patients for 72-hours if they feel that failure to detain would create a likelihood of serious harm due to the patient's substance or alcohol use disorder.

MHA endorsed Baker's intense focus on the opioid issue, which builds on the efforts the hospital community has undertaken over the past year. MHA's Substance Use Disorder Prevention and Treatment Task Force, developed at the direction of the MHA Board of Trustees, created a nine-point guidance document for emergency department (ED) opioid management, which has been adopted by all MHA member acute care hospitals with an ED. The guidelines included a recommended a 5-day limit on the length of prescriptions issued by providers in hospital EDs. The task force's second phase of work, covering all other areas of hospital practice, is underway.

Tim Gens, MHA's executive VP, said, "The hospital community remains a committed partner in confronting this scourge, and commends the governor for his leadership and shared dedication to tackling this devastating public health emergency. There are several proposals of the governor's bill that are new and innovative, and should be of significant benefit. However, several of the proposals raise significant questions regarding their ultimate utility and deserve further examination. This isn't surprising given the complexity of the issues involved.

"MHA and our member hospitals have some concerns regarding certain aspects of the proposal and their potential affect upon patient care. In particular, the proposal regarding involuntary commitments for those with substance use disorders has implications that need to be better understood, including crowding in hospital emergency departments, capacity of hospitals to treat patients, and increased apprehension among opiate users who may no longer feel comfortable approaching hospitals for care. "We look at Governor Baker's proposed bill as an opportunity to collaborate with the administration and legislative leaders to examine these and other issues in order to come up with creative, compassionate, and flexible solutions to address this pervasive problem. We are all united in our common goal to help, in the most effective manner, those patients and families suffering through this terrible crisis. The strong consensus on the goal should help bridge diverse opinions on the means of achieving that goal."

Maine Hospital Association 10/16/15

Hospital Representatives on Opiate Task Force: United States Attorney for the District of Maine Thomas E. Delahanty II, Maine Attorney General Janet T. Mills, and Maine Department of Public Safety Commissioner John E. Morris announced their new Anti-Heroin Opiate Initiative on October 8. The task force will consist of three working groups, focused on treatment, on prevention and harm reduction, and on law enforcement.

- The treatment team will be led by Patricia Kimball, program director at Wellspring in Bangor, and Dr. Mark Publicker, who previously ran the Mercy Recovery Center.
- The prevention and harm-reduction team will be led by Eric Haram, director of Mid Coast Hospital's Addiction Resource Center and William Paterson, substance abuse prevention project director for the University of New England's Coastal Maine Health Communities Coalition.
- The law enforcement group will be led by Portland Police Chief Michael Sauschuck and Sagadahoc County Sheriff Joel Merry, president of the Maine Sheriff's Association. MHA Contact: Jeffrey Austin

Minnesota Hospital Association 10/19/15

Minnesota Crisis Link Website Now Available: Minnesota has launched a Crisis Link website to connect people in crisis, including mental health and substance abuse, to services. The website identifies services by the location of the searcher and includes a live chat service.

The Crisis Link website is an important online resource for finding services for people in mental health crisis. Additional resources include:

- Crisis phone lines by county, available to the public
- Fast-Tracker, a resource for finding outpatient mental health services, available to the public
- Psychiatric Assistance Line, or PAL, a child and adolescent psychiatric consultation service for physicians
- Minnesota Mental Health Access, a resource for finding outpatient and inpatient mental health services, password required

Hospitals and clinics are encouraged to make the Crisis Link website, local crisis line numbers and Fast-Tracker information available to patients and their families. The information can be posted, available as a handout in the waiting room or offered in other ways.

Oklahoma Hospital Association 10/21/15

Prescription Monitoring Program (PMP) Goes Into Effect Nov. 1 – FAQs Available: HB 1948, the Prescription Monitoring Program, goes into effect Nov. 1. The legislation clarifies language related to the Uniform Controlled Dangerous Substance Act and establishes a Prescription Monitoring Program for all prescribers: osteopathic and allopathic physicians, dentists, veterinarians, optometrists, nurses, and podiatrists. HB 1948 grants the sole responsibility for enforcement of the patient screening requirements to the licensing entity for each profession subject to the Act and a listing of the top 20 prescribers of controlled dangerous substances will be sent to their licensing entity. Read More

Hospital Association of Rhode Island 10/22/15

Overdose Crisis: The Governor's Overdose Prevention and Intervention Task Force has released its draft strategic plan. An online survey is available to provide feedback by October 28. A final community meeting will be held October 26, 7:30 p.m. at the Buttonwoods Community Center, Warwick to discuss the stigma of addiction and overdose and answer questions about the strategic plan.

President Obama directed all federal agencies to require employees, contractors and clinical residents/trainees who prescribe controlled substances to complete training on appropriate prescribing of opioid medications within 18 months, and a refresher course every three years. Agencies that provide health care services or benefits also were directed to submit within 90 days a plan to address any identified barriers to accessing medication-assisted treatment for opioid use disorders or practices inconsistent with reducing disorders and overdoses. State, local and private sector organizations also agreed to increase prescriber training, access to medication-assisted treatment, and use of state prescription drug monitoring programs.

Michigan Hospital Association 10/26/15

Legislative Policy Panel Recommends Support for Kevin's Law: MHA Legislative Policy Panel members recently voted to recommend that the MHA Board of Trustees support House Bill (HB) 4674, introduced by Rep. Tom Leonard (R-DeWitt) and also known as Kevin's Law. The bill would strengthen the existing law that protects individuals with serious mental illness and those around them. HB 4674 was recently reported out of the House and assigned to the Senate Health Policy Committee.

The bill is named for Kevin Heisinger, a University of Michigan graduate student who was killed in a bus station restroom by a man with a long history of schizophrenia who avoided treatment.

A 2004 amendment to the Michigan Mental Health Code allows families and friends of an individual with serious mental illness to petition the court to order assisted outpatient treatment after a serious incident has occurred. HB 4674 would strengthen the existing law by offering early intervention to prevent crises that result in harm to the mentally ill individual or others. The bill would also simplify the process of seeking court-approved treatment.

By addressing the barriers that currently keep families from accessing the most appropriate and least restrictive treatment for their loved ones, the legislation would help those with severe mental illness get needed treatment before a crisis occurs. This reform would also allow individuals who have been released from a hospital to receive continuing care on an outpatient basis. Lt. Gov. Brian Calley has made mental healthcare reform a priority and testified before the House Health Policy Committee, saying this legislation would be key to providing long-term treatment options that are currently difficult to obtain. Members with questions should contact Paige Fults at the MHA.

Community Benefits, Charity Care, and Tax-Exempt Status

Florida Hospital Association 10/15/15

FHA Comments During Balance Billing Forum: Today, the Office of the Insurance Consumer Advocate, Sha'Ron James, hosted a forum on "Finding a Balanced Approach to Unexpected Medical Expenses." The forum featured presentations from State of Florida staff; consumers; Joy Ryan of America's Health Insurance Plans and Jack Hoadley, Ph.D., of the Health Policy Institute at Georgetown University. The stated purpose of the forum was to bring together stakeholders "to collaborate in an effort to find a mutually sound and consumer-focused solution."

FHA General Counsel Bill Bell provided comments as did representatives from Florida CHAIN, the Florida Medical Association, the Florida Association of Health Plans and the Florida College of Emergency Physicians. View footage from the forum online via the Florida Channel. The record for public comment on this issue will remain open with the Office of the Insurance Consumer Advocate through Oct. 22. Questions? Contact Bill Bell at (850) 222-9800.

California Hospital Association 10/30/15

Initiatives Filed Against Hospitals : Three initiatives attacking hospitals were filed with the Attorney General for Title and Summary yesterday, Oct. 29. The initiatives would cap executive compensation at $450,000 in private hospitals/health systems, limit hospitals' revenue (excluding children's and public hospitals) and establish a 5 percent charity care requirement on not-for-profit hospitals. New developments are occurring daily as discussions continue with numerous stakeholders. CHA is evaluating options, will take appropriate actions, and will provide reports to the membership during this dynamic process.

New Jersey Hospital Association 10/30/15

NJHA Board Appoints Property Tax Task Force: The NJHA Board of Trustees yesterday designated members and approved the charge for a new task force on property tax issues for nonprofit hospitals.
Kevin Slavin, president and CEO of St. Joseph's Healthcare System, will chair the task force, which is composed of 13 CEOs, legal counsel and other top executives from NJHA member hospitals.
The Board formally created the task force in September in response to a tax court decision by Judge Vito Bianco regarding Morristown Medical Center. The Judge stated in his opinion that many areas of the hospital and the physicians that provide care there operate as for-profit entities, and he ruled that much of the operation was not eligible for a local property tax exemption.
The NJHA tax force will examine several issues raised by the case and will work to "develop a policy solution to bring certainty regarding the issue for N.J. hospitals," according to the task force's charge.
Betsy Ryan, 609-275-4241, eryan@njha.com

Health Information Technology and Telehealth Issues

Washington State Hospital Association 10/1/15

Change to Washington Law on Consumer Data Breach Notification: A recent state law change has strengthened consumer data breach notification requirements. Under the new law, notice to consumers of a data breach must include specific information and be provided under a new, shorter timeline.

WSHA worked closely with the state Attorney General's Office to develop important exceptions to the law for hospitals complying with the notification requirements under the federal Health Information Technology for Economic and Clinical Health Act (HITECH). Please see WSHA's recent bulletin for more information. (Zosia Stanley)

Massachusetts Hospital Association 10/12/15

Care, Consumer, Business Coalition Promotes Telemedicine: A coalition of 16 healthcare, consumer, and business organizations on Wednesday announced its endorsement of HB267 – "An Act Advancing and Expanding Access to Telemedicine Services" – that will receive a public hearing before the legislature's Joint Committee on Health Care Financing on Tuesday, October 13.

The 16 organizations of the coalition are: the Massachusetts Hospital Association, the Conference of Boston Teaching Hospitals, the Massachusetts Council of Community Hospitals, Atrius Health, the MAVEN (Medical Alumni Volunteer Expert Network) Project, the Massachusetts Psychiatric Society, Health Care for All, the ACT!! (Affordable Care Today!!) Coalition, the Association for Behavioral Healthcare, the Massachusetts Association of Behavioral Health Systems, the Case Management Society of New England, the Seven Hills Foundation, the National Association of Social Workers – Massachusetts Chapter, Planned Parenthood Advocacy Fund of Massachusetts, American Well, and AMD Global Telemedicine.

Telemedicine is the remote diagnosis and treatment of patients through on-line communication. It improves care and makes it more efficient by giving patients convenient access to primary care providers and greater access to specialists located outside their geographic area. This is particularly helpful for hard-to-access services such as behavioral health or surgical consults, and for patients with mobility limitations, major distance or time barriers, or transportation limitations. Expanding statewide access to telemedicine will enhance the ability of all residents to receive critical and life-saving treatment on a timely basis, regardless of economic means, physical ability, or geographic location.

Telemedicine also helps to reduce hospital readmissions, decrease lengths of stay, and cut down on emergency room visits. For many employers, the availability of telemedicine as part of an employee benefit package has been found to result in an overall cost reduction without shifting costs to employees, while also improving the health and productivity of workers.

Despite all of these advantages, certain laws have stalled the advancement of telemedicine in the commonwealth. By requiring insurers and the Medicaid program to provide coverage for these services and establishing parity for reimbursement for medical services provided via telemedicine technologies, HB267 will enhance patient access to the care that they need, no matter their location.

Washington State Hospital Association 10/22/15

Merritt Hawkins Releases a New White Paper Exploring Telehealth: Washington Hospital Services Industry Partner Merritt Hawkins has released a new paper entitled Telehealth: The Integration of Telecommunications into Patient/Provider Encounters. It explores how telehealth has impacted the physician-patient experience, how widespread telehealth solutions have become national, typical reimbursements and the most common telehealth platforms adopted. Click here to see a preview copy of this paper. To receive a complimentary full copy of the paper or to find out more about the opportunities provided by Merritt Hawkins, please contact Paul Unsworth at paulu@wsha.org or (206) 577-1806. (Paul Unsworth)

Louisiana Hospital Association 10/26/15

Board of Pharmacy Finalizes Remote Access and Telepharmacy Access Rules: This month, the Louisiana Board of Pharmacy published a final rule in the October edition of the Louisiana Register that would permit hospital pharmacists to remotely access the hospital's dispensing information system from any location for the purpose of processing medical orders under certain conditions. The board also finalized a rule, which can be found in the Louisiana Register, that helps expand access to telepharmacy in retail settings by easing staffing requirements, but the rule does not apply to hospital pharmacies. (Mike Thompson, mthompson@lhaonline.org)

Wisconsin Hospital Association 10/30/15

WHA's New Task Force on Telehealth Identifies Barriers, Opportunities: Telehealth is increasingly vital to our health care delivery systems, enabling health care providers to connect with patients and consulting practitioners across vast distances. Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech in-home patient monitoring and more convenient and cost-effective, high-quality care options. Telehealth has moved into the mainstream.

In August, WHA surveyed their Physician Leaders Council (PLC) and found that telemedicine is currently being used, and hospitals and health systems hope to expand its use in the future. However, PLC members identified multiple barriers for expanding the use of telemedicine, with reimbursement cited as the most common issue. These factors, along with more recent developments including the Wisconsin Medical Examining Board's (MEB) adoption of draft telemedicine language, provided the impetus for WHA creating a task force. The WHA Task Force on Telehealth held its first meeting October 26.

Thought leaders from throughout the state convened and begin laying the groundwork for multiple telehealth strategies and initiatives that pose particular relevance for WHA members. The 16-person Task Force reviewed the current telehealth landscape both nationwide as well as in Wisconsin.

"WHA has certainly done their homework in preparing for this first meeting," remarked Tom Brazelton, MD, UW Hospital medical director for telehealth. David Mortimore, HSHS care integration and delivery innovation manager, added, "What WHA is doing is really groundbreaking. Getting us together in the same room discussing issues that affect us all will definitely move the entire issue forward."

Task Force members then began to review MEB's draft language on telehealth. Members identified multiple points of concern. WHA will continue the detailed analysis of the draft language and will synthesize member's comments. The Task Force will continue to meet on a regular schedule to address issues pertinent to WHA members' policies and strategic initiatives around telehealth.

Hospital Transparency Initiatives

Florida Hospital Association 10/2/15

Bruce Rueben, Florida Hospital Association President Statement on Governor Scott's Press Release Regarding Hospital Transparency: We are disappointed at the tone of today's announcement, which pre-empted the work of the Commission on Healthcare and Hospital Funding. The press release failed to consider the policy recommendations presented at today's meeting, including a comprehensive approach to help consumers understand the cost of health care.

Florida hospitals have long been public in our support for a responsible approach to transparency. We are committed to securing meaningful policy that ensures our patients and their families are able to make informed health care decisions.

"FHA looks forward to working with all stakeholders on a solution that is in the best interest of the patients and communities we serve."

Hospital and Healthsystem Association of Pennsylvania 10/9/15

HAP Launches MONAHRQ Website, Provides Quality, Utilization, Cost Information to Members: HAP is pleased to announce that its new members-only resource providing health care quality, utilization, and cost information now is available through the HAP website.

The new resource—HAP MONAHRQ—leverages the Agency for Healthcare Research and Quality's "My Own Network powered by AHRQ" (MONAHRQ) software and the Pennsylvania Health Care Cost Containment Council's (PHC4) calendar year (CY) 2014 inpatient discharge data.

HAP MONAHRQ also includes measures from the Centers for Medicare & Medicaid Services' Hospital Compare, Nursing Home Compare, and Physician Compare.
In order to access HAP MONAHRQ, members first must be logged in to the HAP website. (Please click here to create a HAP website account.)

Logged-in members will see the link to HAP MONAHRQ on left side of HAP's "Quality" page.
Once you are logged in, you then can click on the "Access MONAHRQ" button. From there, you will be able to access CY 2014 hospital measure results in Pennsylvania, based on aggregated data.

The website has:

- Many easily understandable, evidence-based health care reports about quality, cost, and patient experience
- Comparisons of hospital quality
- Rates of use of specific inpatient services
- Hospital profiles, which show location, patient experience ratings, and cost by the top diagnosis groups at that hospital
- Maps of hospital service use rates for conditions and procedures, shown by county or region
- Nursing Home Compare and Physician Compare profiles and measures

This new resource represents great strides forward in making hospital quality, utilization, and cost data easily accessible to HAP members. HAP encourages you to log in to the HAP website and browse this new tool.

The HAP MONAHRQ website will be updated as more recent data and features become available. Contact HAP's Martin Ciccocioppo, vice president research, with questions.

Florida Hospital Association 10/6/15

My Word: Hospital Data Will be Easier to Use: Lately, there has been much interest in hospital price transparency. The attention has centered on what hospitals do to provide patients with information that allows them to better know the cost of their care.

Florida hospitals have been providing price, cost and quality data to the state and federal governments for years. For example, we report extensive amounts of clinical-performance, financial and operational data to the Florida Agency for Health Care Administration and Department of Health.

There is a tremendous amount of information already available on hospital costs and prices, but, clearly, either people don't know about it or do not find the data easy to use.

That is why the Florida Hospital Association is working on a new website that will display this data in a publicly available, easy-to-use format. The goal is to provide useful data that help people make health-care decisions.

Absent from the recent discussion are two critical facts: Most health care is provided outside of hospitals, and most of the best health-care data reside with health-insurance plans.

States like Colorado and New Hampshire collect the most complete health-care data sets through All Payer Claims Databases. Florida should do the same in order to better understand the true cost of care and how to improve access to high-quality services.

Utilizing comprehensive data can help us understand the impact of big cost drivers like treatment of the uninsured, prescription drugs, defensive medicine, health-care pricing policies and a newly emerging challenge to patients: the financial consequence of lower-cost health insurance based on narrow provider networks.

An APCD will provide the most effective source of usable data to improve health-care costs, access and quality in Florida. But FHA-member hospitals are not waiting to deliver on our responsibility to provide useful price and performance information.

We are ready to work with all stakeholders, including providers, insurers, consumers, the business community, lawmakers and state officials, to improve the usefulness of the data we provide today. Hospital data is a good start, but we must work toward a more comprehensive data set that captures the full scope of where we invest our health-care dollars. Collaboration and a good-faith effort by all stakeholders is the best approach to improving our understanding of the cost and value of Florida health care.

Florida Hospital Association 10/22/15

Commission on Healthcare and Hospital Funding: On Tuesday, the Commission on Healthcare and Hospital Funding met in Tallahassee to discuss both price transparency and certificate of need (CON) issues.

Dr. Keith Smith, Medical Director/CEO for the Surgery Center of Oklahoma described his ambulatory surgery center business model and website. His website lists prices for various surgeries and he does not accept Medicare or Medicaid payments. He indicated he has no accounts receivable. Next, Marisol Fitch, CON unit supervisor for the Agency for Health Care Administration (AHCA), described the programs still regulated by CON and the programs that have been deregulated. She also mentioned the programs that have certain quality or licensure standards attached to them. View the presentation in its entirety. The presentations ended with an update on the reported hospital financial data by Ryan Fitch, chief of the Bureau of Central Services for AHCA. He indicated that the latest 2014 data is in now and there were no new trends from his last report to the Commission.

The Commission's next meeting is scheduled for Nov. 10 in Ft. Myers. For additional information, contact FHA General Counsel Bill Bell at (850) 222-9800 or Kim Streit, vice president of health care research and information, at (407) 841-6230.

Insurance Reforms (State)

Maine Hospital Association 10/2/15

Bureau of Insurance Holds Hearing on Profiling Rule: The Long-Awaited Hearing on the Bureau of Insurance Profiling Rule Drew a Tiny Crowd on Tuesday: The rule, which requires insurance carriers to disclose both the methodology and the data behind the various profiling/tiering/rating systems in use today, was the result of legislation filed on behalf of the Maine Hospital Association two years ago. The rule, Chapter 380, may be found on the Bureau of Insurance website here.
The rule has basically four parts:

- A requirement that carriers describe their methodology;
- A requirement that carriers disclose the data, to any provider that requests it, related to that requesting provider;
- A process for clarification prior to a formal appeal; and
- A formal appeal process.

The Bureau has clearly made a good faith effort to capture the goal of the bill, which MHA describes as allowing providers to better understand the criteria by which they are judged. If profiling programs are to drive change, the providers that are being rated must be able to understand them.
MHA's concern is whether the carriers will embrace the spirit of the law/rule. There are different levels of "description" that could be provided. If carriers provide minimal, vague or unhelpful descriptions, then apeals to the Bureau may be necessary.

MHA hopes that carriers will see the benefit of having a second set of eyes review the data before it is used in a profiling program.

Written comments may be submitted to the Bureau no later than October 13. MHA Contact: Jeffrey Austin

New Jersey Hospital Association 10/5/15

Senate Committees Seek Answers on Horizon's OMNIA Plan: Two Senate committees held a marathon joint hearing today on the tiered network OMNIA product unveiled last month by Horizon Blue Cross Blue Shield.

The Senate Health, Human Services and Senior Citizens and Senate Commerce committees convened the meeting at 10:30 a.m. and it continued into the late afternoon.

Horizon officials were asked to testify on the OMNIA product after the rollout of the plan received extensive attention by state legislators. Horizon officials answered questions related to transparency in the metrics used to select hospitals for tier one, network adequacy requirements and the impact that the product will have on inner city hospitals. Late this afternoon, the committee also had heard testimony from Summit Medical Group and the Department of Banking and Insurance, but several others awaited their turn to testify including representatives of the Health Care Quality Institute, Rutgers Center for State Health Policy, Holy Name Medical Center, St. Peter's University Hospital, Virtua and others.
The OMNIA product has been made available in the State Health Benefits Plan for state workers for the open enrollment period beginning Oct. 1 for plan year 2016. Horizon officials said they also plan to make it available in the health insurance marketplace for the plan year beginning in January 2016. Neil Eicher, 609-275-4088, neicher@njha.com

New Jersey Hospital Association 10/9/15

NJHA Examines Policy Questions Related to Tiered Networks: NJHA is pursuing several policy questions as the statewide dialogue over tiered networks continues.

The discussion is prompted by the OMNIA Health Alliance, a new proposal from Horizon Blue Cross Blue Shield of New Jersey that introduces two tiers of hospitals across the state. The proposal has generated a great deal of interest and debate in the healthcare community and also among legislators. Yesterday, NJHA's Executive Committee, comprised of a core group of hospital and system CEOs, met via conference call and directed NJHA staff to research several policy questions related to the proposal. The Executive Committee, along with Virtua CEO Rich Miller to provide South Jersey representation, will discuss the issue in depth and take it to the NJHA Board for further direction.

NJHA has not taken a position on the OMNIA proposal, but has stated that areas like access to care, consumer education and the potential for exacerbating out-of-network issues should be monitored. NJHA also has stated that transparency is an important part of the process.

The four specific policy questions before the Executive Committee and the Board are:

- How is payment for emergency care handled?
- How will we ensure there is sufficient consumer education on tiered networks?
- Has there been sufficient transparency regarding the criteria for selection?
- Do the Department of Banking and Insurance regulations need to be updated?

The Executive Committee aims to expedite the discussion and convene the full Board by the end of October. Betsy Ryan, 609-275-4241, eryan@njha.com

Maine Hospital Association 10/2/15

Bureau of Insurance Holds Hearing on Profiling Rule: The long-awaited hearing on the Bureau of Insurance profiling rule drew a tiny crowd on Tuesday. The rule, which requires insurance carriers to disclose both the methodology and the data behind the various profiling/tiering/rating systems in use today, was the result of legislation filed on behalf of the Maine Hospital Association two years ago. The rule, Chapter 380, may be found on the Bureau of Insurance website here.

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MHA hopes that carriers will see the benefit of having a second set of eyes review the data before it is used in a profiling program. Written comments may be submitted to the Bureau no later than October 13. MHA Contact: Jeffrey Austin

New Jersey Hospital Association 10/7/15

Senators Seek Greater State Oversight of Tiered Plans: State Sens. Joe Vitale (D-Woodbridge) and Nia Gill (D-Montclair) sent a joint letter today to Acting Attorney General John Hoffman requesting a delay of the Horizon OMNIA product and creation of a new oversight mechanism for such plans.

The request follows on the heels of Monday's joint hearing by the Senate Health, Human Services and Senior Citizens and Senate Commerce committees on the new tiered network product. In a statement today, the two senators said they are requesting a delay until the AG's office "establishes a permanent oversight mechanism for the process for tiering and rating health care providers in New Jersey."

While the sponsors acknowledge the potential benefit of cost savings through this type of product, the letter details concerns about the rollout of the plan to consumers and the lack of oversight by the Department of Banking and Insurance. The letter calls for a response by Oct. 13.

Oklahoma Hospital Association 10/7/15

HealthChoice "Select" Proposal Aired in Public Hearing: HealthChoice will pay its members $100 to use a "Select" provider for colonoscopies and sigmoidoscopies in 2016, according to information presented at a public hearing on Sept. 30.

HealthChoice is the insurance product for public employees operated by the state of Oklahoma's Employee Group Insurance Division (EGID).

EGID is proposing the new Select provider network, which will offer certain services to HealthChoice at a bundled price that includes physician fees. EGID will waive out-of-pocket costs for members that use Select providers. Because colon cancer screening is already covered without cost sharing under the Affordable Care Act, EGID plans to offer bonus cash to members choosing a Select provider for colonoscopy and sigmoidoscopy.

Facilities can view the Select payment rates by logging in to the HealthChoice fee schedule listings page.

EGID intends to add services, including shoulder arthroscopy and CT scans of the head, to the Select program in the second quarter of 2016. Other services, identified by input from members and providers, will be added later in 2016 and beyond. Providers joining the Select program can choose to participate in one or more categories of service under the program. The list of participating Select providers and Select services will be maintained on the HealthChoice website.

A copy of EGID's presentation at the Select public hearing is available here.

Louisiana Hospital Association 10/19/15

LDI Sends Request to Providers About High Deductible Reporting: The Louisiana Department of Insurance (LDI) mailed a notice last week to all hospital administrators regarding the reporting template to fulfill House Concurrent Resolution 187 (HCR 187). HCR 187 urges and requests that LDI study the effects on the increasing amount of deductibles and coinsurance obligations required by many of the health insurance plans on the market today. The High Deductible Reporting Framework template is available in an Excel format that can be downloaded from the LDI website. Once downloaded, save a copy and complete according to the instructions. Completed information should be submitted to HCR187@ldi.la.gov by Jan. 1, 2016. Your cooperation in submitting this information to LDI is critical to assessing the fiscal impact of these plans on hospital accounts receivable. If you have any questions about completing the survey, contact VP of Healthcare Reimbursement Scott Cornwell at scornwell@lhaonline.org or Healthcare Reimbursement Analyst Kathryn Mount at kmount@lhaonline.org.

Liability Issues and Reforms

Wisconsin Hospital Association 10/16/15

Courtroom Advocacy: WHA Advocates for Medmal Cap at Court of Appeals On October 15, the Wisconsin Hospital Association along with the Wisconsin Medical Society and American Medical Association, filed a joint amicus brief with the Wisconsin Court of Appeals supporting the constitutionality of Wisconsin's $750,000 medical malpractice non-economic damage cap enacted in 2006.

In Ascaris Mayo v. IFPCF, the District I Court of Appeals is hearing arguments on whether the cap can be unconstitutional "as applied" to a particular plaintiff but constitutional for other plaintiffs, as well as whether the cap is constitutional overall. In 2005, the Wisconsin Supreme Court held in the Ferdon case that Wisconsin's previous $350,000 non-economic damage cap was unconstitutionally low, but also held that a higher cap could be constitutional.

"Wisconsin's unique, balanced medical malpractice system that includes a cap on non-economic damages is a key policy that has helped Wisconsin retain and attract high quality physicians to Wisconsin communities," said WHA President/CEO Eric Borgerding. "Without a sufficient supply of physicians in communities throughout the state, Wisconsin's high rankings in health care quality and access would not be achievable."

Tom Pyper, an attorney with Whyte Hirschboeck Dudek, who wrote the brief on behalf of WHA and the Wisconsin Medical Society, explained, "Just as a state's general litigation environment is an important factor in the decisions businesses make when deciding where to locate, a state's medical liability environment affects physician decisions to practice in a particular state. Accordingly, Wisconsin's medical liability system affects its ability to compete with other states to attract and maintain sufficient numbers of physicians to continue to provide high-quality, cost-effective health care for Wisconsin residents."

The brief notes a Northwestern University study showing the impact on physician location decisions following the loss of Illinois' non-economic damage cap in 2010. "Half of all graduating medical residents or fellows trained in Illinois leave the state to practice medicine elsewhere, in large part due to the medical liability environment in Illinois."

Attracting and retaining high-quality physicians to Wisconsin communities impacts not just the health of communities, but also has an impact on economic development in Wisconsin. Just this week UW-Whitewater released a study connecting health care quality and access to a state's ability to attract and retain business.

"Access to high-quality local care also impacts employers' decisions to locate or maintain jobs in Wisconsin," wrote Pyper in the WHA and Society brief. "'Because Wisconsin provides some of the best health care in the nation, companies located here or that choose to locate within the state will provide their employees with exceptional health care at competitive rates, enjoy lower-than-average premium increases and improve productivity and job satisfaction—leading to a strong competitive advantage for Wisconsin's employees and employers.'"

The brief also emphasizes that the non-economic damage cap is a part of a larger balanced system that includes the unique Injured Patients and Families Compensation Fund. Unlike plaintiffs in other personal injury cases whose medical bills, lost wages and other economic losses may exceed the defendant's assets and insurance coverage and thus be unrecoverable, Wisconsin's mandatory Injured Patients and Families Compensation Fund provides unlimited loss coverage ensuring that medical malpractice plaintiffs are compensated for all of their medical bills, lost wages and other economic losses.

"The [Injured Patients and Families Compensation] Fund places malpractice award recipients in a better position than other injured parties—recipients are guaranteed recovery from the Fund," wrote Pyper. "[O]ther injured parties are not guaranteed recovery, left instead to hope that a tortfeasor has sufficient insurance coverage."

Finally, the brief argues that the Legislature is in a better position to make these far-reaching policy decisions than the courts.

"The trial court's 'as applied' challenge is actually a facial challenge," wrote Pyper in the brief. "[B]y questioning whether an individual award from the Fund will threaten the overall policies supporting the cap, the trial court usurped the role of the Legislature to make policy decisions on an aggregate basis for the good of all residents rather than on an as applied basis for the good of the current plaintiff."

The case will be decided by the Court of Appeals in the coming months. Following that decision, the parties will have an opportunity for the Wisconsin Supreme Court to review the decision.

Washington State Hospital Association 10/29/15

WSHA Joins Amicus Brief in Case on a Provider's 'Duty to Warn': WSHA has joined other health care associations to file an amicus curiae (Friend of the Court) brief in the case of Volk v. DeMeerleer. The case before the Washington State Supreme Court addresses the scope of the duty of medical providers to warn third parties when a patient makes vague threats of violence but no actual threat to an identifiable victim.

In 1987 the legislature adopted a statute that prescribed the extent to which a provider has a duty to warn potential victims of a patient's threat to them. In Volk, the Washington State Court of Appeals Division III expanded that duty in a very concerning way, substantially increasing the liability of physicians and hospitals. The Court of Appeals decision threatens the integrity and confidentiality of the patient-physician relationship, especially for patients in need of mental health treatment who greatly benefit from a secure and confidential relationship with their physicians. (Zosia Stanley)

California Hospital Association 10/28/15

New Law Aims to Protect Conservatees' Rights -- Hospitals Advised To Review Conservatorship Orders: Gov. Brown has signed AB 1085 (Gatto, D-Glendale), which allows a court to grant a conservator the power to enforce a conservatee's right to receive visitors, telephone calls and personal mail. The bill also allows the court to direct a conservator to allow specific visitors, telephone calls and personal mail. This bill was introduced as a result of a highly-publicized situation in which radio host Casey Kasem's second wife allegedly prevented daughters with his first wife from visiting him. The law also requires a conservator to inform certain persons, and an agent under a power of attorney for health care to inform any individuals identified by the patient, of the patient's death. Hospitals should always get a copy of conservatorship orders for conserved patients and read them to fully understand the authority of the conservator and any limitations. The law takes effect Jan. 1, 2016.

Medicaid and Hospital Payment Issues

Alaska State Hospital & Nursing Home Association 10/9/15

Recap of Provider Tax Stakeholder Meeting: Last Friday the state's consultant, Myers & Stauffer, held a public work session on provider taxes. You can review a copy of the presentation here. Most of the presentation time was spent providing an overview of provider taxes and the state's process.

A few highlights of the presentation:

- Based on their analysis to date, Myers & Stauffer has eliminated 12 of the 19 classes that can be taxed from consideration.
- Remaining classes for further analysis include inpatient hospital, outpatient hospital, nursing facility, home health services, outpatient prescription drugs, ambulatory surgery center services, and "other" (RPTC, PCA services, behavioral health, and HCBS waiver).
- Note that federal, state and tribal facilities are excluded.
- The next step for the consultant is to develop detailed modeling to evaluate the remaining classes.

The state will be holding webinars with potentially affected provider groups with the goal of sharing information and "working with trade associations and their consultants to ensure modeling accuracy." The schedule of stakeholder webinars is listed in the education opportunities section of the newsletter. Please note that while these are provider-specific webinars, the call-in information in online, so the meetings should be considered public.

ASHNHA is scheduling member only briefings with our consultant, HMA, to engage members on provider tax options and models. It is critical to have your involvement in this process. HMA will show the impact of different assumptions and we will discuss our values as we make decisions on provider tax strategy. Email invitations for meetings on Oct. 15 at 8:30 am and Oct. 22 at 8:30 a.m. have been sent to all CEOs/CFOs. You are welcome to invite others from your facility or system to attend. If you did not receive the invitation or have questions contact Jeannie Monk at Jeannie@ashnha.com.

California Hospital Association 10/7/15

Support Continues to Grow for CHA-Sponsored 2016 Hospital Fee Ballot Initiative: More than 540 organizations and individuals, including the California Association of Nurse Practitioners, the Los Angeles County Business Federation, the East Bay Leadership Council and the Saban Community Clinic (formerly the Los Angeles Free Clinic), have endorsed CHA's hospital fee ballot initiative. The measure, which will appear on the November 2016 ballot, will allow hospitals to continue accessing billions of dollars in federal funds to help pay for care provided to Medi-Cal patients.

A statewide campaign to enact the initiative is gearing up. One of the campaign's key goals is to build a broad and extensive coalition of supporters across the state. To date, 171 hospitals, clinics and health care districts have endorsed the measure, as have 41 health care associations, 20 community-based organizations, 42 elected officials and 73 business organizations, with many more endorsements expected over the next few months. To assist in coalition-building activities, the campaign has launched a new website called "Keep A Good Idea Working." Read more

Connecticut Hospital Association 10/8/15

Hospitals Continue Advocacy in Opposition to Governor's Cuts: CHA and hospitals continue to meet with legislators and urge them to intervene and stop the $192 million in hospital cuts. Meanwhile, nearly 40,000 letters have been sent to legislators and the Governor since he made the rescissions on September 18. (Join the campaign here).

This week, the Governor said that Connecticut hospitals made a profit of $916 million in 2014. CHA issued the following statement in response:

- The Governor's statement that hospitals had a $916 million profit in 2014 is misleading for two reasons. First, it fails to disclose that a substantial portion of the $916 amount relates to extraordinary accounting transactions. Second, it implies that nothing much has changed since 2014 for hospitals – glossing over the fact that the Governor has significantly stepped up his gouging of the sick and hospitals that care for them since then.
- In 2014, the entire University of Connecticut Health Center recorded in non-operating income $459 million in state appropriations including its academic and research institutions not related to patient care. In addition, WCHN recorded an addition to non-operating income of $297 million related to Norwalk Hospital and its related organizations becoming part of the Western Connecticut Health Network. These transactions are one-time events. Removing them, the picture for 2014 is half as rosy as the Governor portrays.
- Second, in 2014 the state taxed hospitals $134 million a year. The Governor doesn't mention that in 2015 the he doubled that amount to $268 million. He also doesn't mention that his latest changes more than double the amount again to $556 million in 2016.

The Governor's latest moves, if left to stand, will have increased the tax on the sick by $422 million since 2014 – taking nearly every dime hospitals have.

Miscellaneous Items

Maine Hospital Association 10/2/15

More Than 60 People From 25 Hospitals Attended Last Week's Menu for Change: Maine Hospitals Lead the Way to Better Health at MHA: In addition to eating a healthy lunch packed with lots of fruits and vegetables provided by MaineGeneral Health, participants also heard the case for hospitals offering healthy food in their cafeterias and to their patients.

Paul Stein, chief operating officer at MaineGeneral Health, gave the keynote, emphasizing the importance of hospitals setting an example for providing delicious, healthy food.

Jennifer Obadia, PhD, New England regional coordinator with Health Care Without Harm, moderated a discussion about how hospital food purchasing and processing can play an important role in the health of the environment, economy and community. Barbara Haskell, CDM, CFPP, executive chef/manager of food services at Blue Hill Memorial Hospital, and Sheila Costello, nutrition services manager at Waldo County General Hospital, talked about local foods. Alex Gingrich, director of nutrition services at Spring Harbor Hospital, discussed composting.

Patricia Watson, MS, RD, LD, CDE, director of food and nutrition services at Stephens Memorial Hospital; Carl Constanzi, PhD, Let's Go! Oxford coordinator and Jeffrey Space, director of nutritional services at Pen Bay Healthcare, described removing soda from their hospitals. They discussed how they made the change, kept employees engaged and the effects on their bottom lines.

Mike Sabo, director of hospitality services at Southern Maine Healthcare, and Corinne Cook, MSM, RD, LD, sodium reduction in communities grant coordinator at MaineHealth, taught participants how to make healthy food look and taste good and how to make it sell.

Roundtable discussions included vendor/distributor relationships, making the case, patient food, food accessibility and sustainable materials.

The program was sponsored by the Harvard Pilgrim Health Care Foundation, in partnership with the Maine Hospital Association, MaineHealth, Let's Go! and Health Care Without Harm. MHA Contact: Carol Sinclair

Missouri Hospital Association 10/6/15

Health Care Trends Emphasize Importance of Succession Planning: With nearly 70 percent of health care CEOs planning to retire in the next 10 years and CNO retirements on the rise, succession planning has moved to the forefront of strategic initiatives. According to a B.E. Smith white paper, the average cost of replacing a leader is at a minimum $50,000. For a CEO, the cost can reach as much as $1.5 million. Although surveyed leaders expect to fuel leadership growth in 2015 through succession planning, two-thirds do not have an existing succession planning program in place. To successfully meet organizational needs and prepare for inevitable challenges, succession plans should extend to all management levels. MHA Staff Contact: Meredith Carroll

California Hospital Association 10/7/15

Governor Signs CHA-Sponsored Bill on Medical Waste Management: Gov. Brown has signed SB 225 (Wieckowski, D-Fremont), a bill sponsored by CHA to clarify and streamline requirements of the Medical Waste Management Act. The bill took effect immediately upon signature by the Governor on Sept. 28. The bill:

- Clarifies the definition of biohazard bag.
- Requires a hazardous waste transporter of medical waste to maintain a tracking document, as specified, for the purpose of tracking medical waste from the point when the waste leaves the generator facility until the waste receives final treatment.
- Requires the tracking document to be maintained only by hazardous waste transporters, and not by generators transporting waste.
- Revises the container labeling requirements for specified medical wastes from “HIGH HEAT OR INCINERATION ONLY” TO “HIGH HEAT” or “INCINERATION ONLY.”

Details about the new law can be found at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB225.

Healthcare Association of New York State 10/8/15

HANYS has a New Website: With the new HANYS.org, you can

- quickly and easily access on your phone or tablet all of HANYS' resources, email, analyses, events, reports, and news;
- find our latest advocacy tools, analyses, and educational opportunities right on the home page;
- navigate the site by streamlined color-coded content areas;
- choose your home page navigation to focus on content geared to executive, finance, quality, government affairs, or all HANYS' staff; and
- save your favorite HANYS' communications to a customized list so you can clean out your email inbox.

The new website will be continually updated to ensure we are providing you the most current and relevant information you need to adapt and thrive in the midst of complex healthcare changes.
For more information, please contact Shannon Hutton, Director, Online Communications, at (518) 431-7763 or at shutton@hanys.org.

Illinois Hospital Association 10’/12/15

Illinois Hospital Association and Metropolitan Chicago Healthcare Council Boards Approve Creation of Integrated Organization -- Influential Hospital Associations to Form One Integrated Entity in 2016: The Boards of the Illinois Hospital Association (IHA) and the Metropolitan Chicago Healthcare Council (MCHC) have authorized the organizations to enter into a combination agreement for the purpose of creating a statewide, integrated organization. The integrated organization, which will be called IHA, will begin combined operations in January 2016.

In a joint statement, Dean M. Harrison, President and CEO, Northwestern Memorial HealthCare and IHA Board Chair, and Michael S. Eesley, CEO, Centegra Health System and MCHC Board Chair said: “This decision marks the beginning of a truly historical shift for Illinois healthcare. Together, the leadership at IHA and MCHC are building a dynamic, integrated organization, with a powerful, unified voice that will support member healthcare institutions, and drive continued innovation to benefit the health of all Illinoisans.”

Current IHA President & CEO Maryjane Wurth will lead IHA. She will be assisted by MCHC President & CEO Dan Yunker, who will be an Executive Vice President, and President and CEO of the Midwest Healthcare Institute, a regional entity that will offer innovative solutions to hospitals and healthcare organizations as well as serving as an incubator for innovation and development; and by IHA Chief Government Relations Officer A.J. Wilhelmi, who will serve as Executive Vice President for Advocacy, Policy and Member Services, and will lead the organization's advocacy initiatives in the Metropolitan Chicago Area, Springfield and in Washington, DC. Together, this executive team will lead strategy and operations for the IHA.

"IHA brings together the best talent, best services and best programs to help drive more value to our members and transform our state's healthcare delivery system," said Wurth. "We are the trusted voice and resource for Illinois healthcare."

Five long-term goals have been identified for IHA, according to Wurth:

- Strengthen and align advocacy and influence leadership to reform the delivery of healthcare in the state of Illinois;
- Enhance the ability to assist in performance improvement and to facilitate the transformation of hospitals and health systems;
- Enhance offerings in technology, data and information to support the management of population health and systems of care;
- Expand the array of trusted business and performance solutions through the Midwest Healthcare Institute to help hospitals and health systems transform the delivery of care; and
- Enhance operational effectiveness through innovative solutions.

"This integrated model provides us the unique opportunity to redefine what it means to be a health and hospital association," said Yunker. "Bringing together the talent and expertise of both organizations will produce positive innovation in the marketplace that will benefit healthcare organizations and patients in Illinois as well as on a regional and national level."

This integration will enhance the ability of the Illinois healthcare community to meet the "Triple Aim" of healthcare—improving care, improving population health and reducing costs by leveraging both organizations years of service to the healthcare community.

Washington State Hospital Association 10/29/15

The New WSHA.org is for You -- What's a Website For?: The simplest questions to ask can be the hardest to answer. We struggle with analogies of what a website replaces, and there are so many right answers. Phone book. Library. Television. Store. Clubhouse. Classroom. (Doctor's office? Pharmacy counter?) We haven't run out of ideas yet.
So when the time came to rebuild WSHA's Internet home, we considered all these possibilities and more. Most fundamentally, we wrestled with how we can use our website to meet the needs of our audience — both the current audience, and the audience of the future.

We're excited to roll out the new site this month. It retains the most needed features of the old site and creates some new places for content to grow over time — for example, the video page.

One of the places we're most excited to grow is the new section devoted entirely to patients. It has information about hospital locations, of course, but also quality and pricing data, and information about hospital bills and financial assistance.

More and more, patients are taking control of their own health care choices. We want to help ensure the public has access to the information they need for both personal and governmental decision-making.

Some other features include:

- A new bookstore, full of materials that can be downloaded or ordered from WSHA;
- Newly designed space for member-focused content, and headline news integrated with hospital listings (e.g., Summit Pacific Medical Center and EvergreenHealth);
- A new landing page for media;
- Staff listings that describe the work people do, and connect you to their recent news (eg., Cassie Sauer).

- And of course, the site also contains current information about WSHA's policy and advocacy work, our patient safety programs, and other statewide initiatives, such as Honoring Choices Pacific Northwest and Healthier Washington.

Quality, Patient Safety and Post Acute Care Issues

Colorado Hospital Association 10/26/15

Hospital Surge Capacity and the Use of "Hall Beds": The Colorado Department of Public Health and Environment (CDPHE) contacted CHA with clarification recently obtained from the Centers for Medicare & Medicaid Services (CMS) regarding the use of hall beds in the hospital, particularly their use in the emergency department (ED). CDPHE staff have verbally been directed to write a deficiency for the use of hall beds if it appears that they are being used to "expand capacity" on an everyday basis. The department clarified that the use of hall beds is appropriate in response to particular events that may differ from facility to facility. For example, the use of hall beds to increase capacity is appropriate in response to a mass casualty event or the known/anticipated increased access to health care services via EDs on weekends. It is notable that the intermittent use of hall beds in these circumstances will still require the hospital to make provisions for confidentiality (i.e., privacy curtains) and patient safety (i.e., call buttons/bells).

Again, if a CMS survey includes a review of the ED and it appears (as demonstrated by such findings as the presence of hall beds or based on staff interviews) that hall beds are being used to increase capacity, CMS has directed state surveyors to write a deficiency. Resolution of the deficiency usually requires the adoption of practices that differentiate between those patients who present with non-emergent conditions from those with life- or limb-threatening conditions, and finding a way to manage those non-emergent patients in another area of the hospital. Otherwise, the only options available are to stop using hall beds in the ED or increase capacity by constructing additional space for patient management. For more information, contact Gail Finley, CHA vice president of rural health and hospitals, at gail.finley@cha.com or 720.330.6011.

Rural and Critical Access Hospital Issues

Virginia Hospital & Healthcare Association 10/16/15

Virginia Rural Hospital Improvement Collaborative Participants Meet: Senior leaders representing Virginia's rural hospitals which are participating in a yearlong operation improvement project met for the third of four scheduled in-person learning sessions Monday in the Shenandoah Valley. This week's session was held on the campus of Augusta Health in Fishersville. Partially funded by the VHHA and Virginia Department of Health's (VDH) Office of Rural Health, the project is being led by a team from the Studer Group, a nationally recognized firm that assists health care organizations achieve and sustain high performance. The project utilizes a coaching framework known as Evidence-Based Leadership that aligns leaders' goals and behaviors with organizational goals, and provides an accountability framework to help participating hospital partners achieve results. During this week's session, participants reviewed strategies for effective Hourly Rounding and began an in-depth discussion about Bed Side Shift Reports. The Studer Group also arranged for Vernon Johnson, CEO of Dale Medical Center, a small rural hospital in southern Alabama, to attend the meeting as a guest speaker who shared lessons learned from a career as an executive in a small rural facility. Participants in the collaborative will continue to have monthly group coaching calls through the end of this year and will meet for a final in-person session in January. VHHA and VDH have started discussions with participants about possibly extending the work for an additional year. If that occurs, new hospitals would be invited to join. Any rural Virginia hospital interested in participating should contact Abraham Segres at asegres@vhha.com. – Abraham Segres

Maine Hospital Association 10/30/15

Use of Professional Interpreters Halves Number of Clinical Miscommunications, Study Says: A study published in Medical Care, the official journal of the Medical Care Section of the American Public Health Association, found that using professional interpreters halved the number of clinically important communication mistakes compared with improvised interpretation by family, friends or other members of the medical team. Professional interpreters led to fewer miscommunications whether they were in

person or via video conferencing, the study found. Researchers looked at the transcripts of primary care visits involving 32 Spanish-speaking Latino patients and 14 clinicians. MHA Contact: Sandra Parker

Scope of Practice and Professional Licensing Issues

Oklahoma Hospital Association 10/7/15

Proposal for Multi-State Licensure of Nurses Moves Forward: Representatives from OHA attended the Oklahoma Board of Nursing (BON) education session to learn from nationally recognized experts on a proposed Nurse Licensure Compact. On Sept. 28, the BON voted to pursue the Compact legislation for the 2016 Oklahoma Legislative Session so that nurses with domicile in Oklahoma can uniformly obtain a multi-state license. In order for the Compact to be ratified by states, it must be enacted into law.

The Compact adheres to three policy goals that nursing licensure be (1) a state based license; (2) nationally recognized; and (3) locally enforced. The compact contains uniform licensure requirements, a grandfathering in provision, authority to obtain and submit criminal background checks and prompt reporting to Nursys® of participation of nurses in alternatives to discipline programs. The BON has requested the support of the OHA, which will be considered by the OHA Council on Policy & Legislation for possible support during the 2016 Oklahoma Legislative Session. For more information, contact LaWanna Halstead or Sandra Harrison, (405) 427-9537. (Sandra Harrison)

California Hospital Association 10/20/15

New Law Addresses Supervision, Documentation Requirements for Physician Assistants: Hospitals should update their policies and procedures. Gov. Brown has signed SB 337 (Pavley, D-Agoura Hills), sponsored by the California Academy of Physician Assistants, requiring the medical record of each patient treated by a physician assistant (PA) to identify the physician responsible for supervising that PA for that episode of patient care. Hospitals will need to adopt policies and procedures and train any PAs practicing in their facility to ensure that this requirement is met. The law becomes effective Jan. 1, 2016.

SB 337 also provides new mechanisms for a supervising physician to demonstrate adequate supervision of a PA functioning under protocols. Under existing law, a supervising physician must review, countersign and date a sample of at least five percent of a PA's cases within 30 days of treatment. Under the new law, the supervising physician and PA will be permitted to meet monthly, at least 10 months per year, to review at least 10 medical records of patients treated by the PA functioning under protocols. These "medical records review meetings" may occur in person or by electronic communication. The physician and PA are required to jointly sign and date documentation of the review meeting. Read more

Hospital and Healthsystem Association of Pennsylvania 10/23/15

HAP Encouraged By Stakeholder Discussions on Modernizing Professional Nursing Law: Yesterday, the state House Professional Licensure Committee held an informational hearing about House Bill 765 (Topper, R-Bedford), which would remove the current requirement that a Certified Registered Nurse Practitioner (CRNP) must establish a collaborative agreement with a physician. HAP submitted a letter to the committee about the bill, in which it shared its "neutral" position and the fact that it is encouraged by the important dialogue.

HAP reinforced that it remains strongly opposed to statutory and regulatory barriers that unduly prevent any health care practitioner from caring for patients fully within their statutorily defined scope of practice. However, HAP's position on House Bill 765 (as drafted) is that the specific impact that collaborative agreements—a main component of the bill—have on hospitals or health systems varies greatly. It noted that it is imperative that we work collectively to ensure that Pennsylvania's Professional Nurse Law isn't such a barrier.

HAP board member Michael A. Young, FACHE, president and CEO, PinnacleHealth System, testified that, in the case of PinnacleHealth, he is supportive of removing the collaborative agreements.

"We are encouraged that key stakeholders are beginning to suggest changes that could lead to an appropriate middle ground and allow legislation that would modernize the Professional Nursing Law to

move forward," said HAP's Michael Consuelos, M.D., senior vice president, clinical integration. "As these ideas generate deeper discussion, HAP will evaluate the impact they could have on how physicians and certified registered nurse practitioners care for patients across the continuum of care."

Workforce, Staffing and Employee Relations Issues

California Hospital Association 10/5/15

Governor Signs Bill Allowing Meal Period Waivers to Continue for Hospital Employees: Today, Gov. Brown signed SB 327 (D-Azusa), the bill sponsored by United Nurses Associations of California (UNAC) and cosponsored by CHA, to reject the appellate court decision in Gerard v. Orange Coast Memorial Medical Center. That decision, currently under review by the California Supreme Court, held that: 1) wage order 5 section 11D, allowing employees in the health care industry to waive one of their two meal periods regardless of shift length, was invalid; and 2) the decision was retroactive, so hospitals could be liable for up to four years in premium pay for "missed" meal periods.

The bill amends the labor code to confirm that health care employees can waive one of their two meal periods, even when their shift exceeds 12 hours. As urgency legislation, it goes into effect immediately. Read more

Healthcare Association of New York State 10/9/15

HANYS' New Report Explores Emergent Healthcare Workforce Titles and Functions: HANYS' new report, Exploring Emergent Healthcare Workforce Titles and Functions, indicates that as hospitals and health systems prepare for the challenges of a changing healthcare environment, they are developing their own solutions to address key care coordination functions locally by re-deploying staff titles such as care coordinators, case managers, and patient navigators.

"Faced with the rapid transformation of how to deliver patient care, hospitals and health systems have created new roles in their organizations to facilitate critical coordination," said HANYS President Dennis Whalen. "These professionals are key to the interdisciplinary care teams on the front lines of achieving the triple aim of better access, improved quality, and lowering healthcare cost."

The report provides the results of HANYS' 2015 Nursing and Allied Professionals Workforce Survey. Key findings include:

- More than 90% of hospital and health system respondents reported using new and emerging titles such as case manager (68%), patient navigator (56%), care manager (49%), care coordinator (34%), community health worker (33%), and health coach (16%).
- A majority of responding hospitals that reported using these titles said they require either a Bachelor's or Associate's degree for the position.
- The percentage of registered nurses (RNs) with a Bachelor of Science in Nursing (BSN) degree remained the same as last year, at 57%. Thirty-one percent hold an Associate's degree.
- Nearly half (47%) of respondents indicated difficulty recruiting experienced nurses, and 52% reported difficulty recruiting nurse managers.
- The following percentage of respondents anticipated growth in outpatient settings for the following professions: RNs (60%), medical assistants (53%), nurse practitioners (NPs) (66%), physician assistants (PAs) (64%), care coordinators (60%), licensed clinical social workers (46%), and nurse managers (44%).
- The following percentage of respondents anticipate growth in inpatient care for the following professions: RNs (50%), NPs (53%), PAs (50%), and care coordinators (44%).

The survey was conducted by HANYS, Greater New York Hospital Association, and Center for Health Workforce Studies, with support from Western New York Healthcare Association, Rochester Regional Healthcare Association, Iroquois Healthcare Alliance, and Suburban Hospital Alliance of New York State. Contact: Sherry Chorost

Minnesota Hospital Association 10/12/15

New Workplace Violence Prevention Resources Available: The Minnesota Department of Health (MDH) and MHA are making available new resources for hospitals for implementation of the new workplace violence prevention law. MHA members have provided sample plans, policies and other resources to help implement or sustain a violence prevention program that are available on the MHA website as well as the MDH website. Other resources available on the websites include the gap analysis

tool (in both paper and online format) to help hospitals identify gaps and form an action plan for this work and a list of organizations that have signed on to this work. Sample training materials for health care workers will be added to the toolkit of resources as they are developed.

MDH is also hosting webinars to prepare hospitals to meet the new requirements and answer questions about the law. The first webinar, which took place Oct. 6, provided an overview of the law and shared information about setting up a violence prevention committee. Slides from the webinar will be available on the MDH website.

A second webinar will be held Monday, Nov. 16, at 11 a.m. to review how to prepare prevention and response plans, how to complete the gap analysis and how to collect data under the new law. Register online to attend the webinar. For more information, contact Nora Vernon, quality/safety clinical specialist, MHA, 651-603-3507.

Massachusetts Hospital Association 110/19/15

Healthcare Has Evolved; Ratio Argument Hasn't: In the 15-plus years in which a single nursing union has attempted pass a government-mandated nurse-to-patient ratio law, much has changed in the Massachusetts healthcare system, except one thing – RN ratios are still a scientifically unsound way to improve patient care.

On Tuesday, October 20 the Public Health Committee, chaired by Sen. Jason Lewis (D-Winchester) and Rep. Kate Hogan (D-Stow), will hold a hearing on the union bill.

Even though Massachusetts is in the midst of the most innovative and sweeping healthcare reform effort in the nation, and even as hospitals work daily to carry out proven team-based, facility-wide initiatives that are improving patient care, the union's leadership insists on its ratio strategy.

"MHA and its member hospitals know that patient care is best determined by the caregiving team at the bedside, not by a fixed formula mandated by the government," said Pat Noga, RN, PhD, MHA's VP of Clinical Affairs. "The number of patients a nurse should care for at any one time must be based on the sickness or acuity of the patient – which can vary from hour to hour – the education, skills and experience of the nurse, the technology available in the hospital, and the specialized team available to care for a patient's needs. MHA and its member hospitals on Tuesday will be urging the committee to once again reject the notion of legislators mandating patient care decisions by law rather than by caregivers at the patient's bedside."

California Hospital Association 10/20/15

Healthcare Laboratory Workforce Initiative Transitions to CHA: Originally spearheaded by the Hospital Council of Northern and Central California, the Healthcare Laboratory Workforce Initiative (HLWI) was created to develop innovative solutions to the laboratory workforce shortage. As laboratory science and technology have advanced rapidly in recent years, the regulatory challenges facing hospital laboratories have also been on the rise. Because of the increasing need for hospital statewide representation on clinical lab issues, including workforce shortages, the HLWI has transitioned from an advisory body housed within the Hospital Council to a standing statewide CHA committee. In addition, the HLWI has broadened its purview to include clinical issues that impact hospital laboratory efficiencies and practices, as well as patient care.Read more

Massachusetts Hospital Association 10/26/15

A Flawed Nurse Union Proposal: The Joint Committee on Public Health's October 20 hearing on a government-mandated RN-ratio bill provided no new arguments from the nursing union that has attempted to get the bill passed for nearly 15 years.

The committee heard the union's familiar claim that studies advocate specific staffing formulas, but the union did not back up claims with evidence. In reality, not a single study advocates for a specific ratio number, instead noting that the individual needs of patients, the education and training of the nurse, and the technology employed in the hospital are all important factors of patient care.
In fact, the case against mandated ratios is clear when one reviews the evidence from California – the only state in the country to try mandated ratios over the last 20 years. At least nine California hospitals have closed since the ratio law passed there, and some of them identified the ratio law as the cause. Massachusetts exceeds California on a number of clinical quality measures, is much better than California on the critical in-hospital mortality measure, and exceeds the Golden State in patient

satisfaction scores, including measures relating to nursing communication with patients and other nursing-intensive functions.

MHA and the Organization of Nurse Leaders of MA, RI, NH, and CT testified against the union bill, stressing that patient care is extraordinarily complex and cannot be improved by a legislative mandate that focuses on just one part – albeit an important part – of the caregiving team.

“What we oppose is a bill that limits the flexibility,” said Maria Ducharme, RN, president of ONL. “Unlike other industries such as the daycare industry, hospitals can't turn patients away. Patients are different, patients' needs are different. And the flexibility that is limited in this type of a bill would significantly impact the care that can be delivered to patients.”

Tim Quigley, RN, the VP of Nursing Services and CNO at South Shore Hospital, told the committee of his real-world experience of handling fluctuating numbers of patients coming into a very busy ED and then being admitted to the hospital. He said if you set ratios in one part of a complex system, backups will inevitably occur, which will hurt – not help – patient care. He also noted since patients are entering the hospital with longer and longer lists of medications, the nurses in his facility supported the addition of pharmacists to the caregiving team to assist in the medication reconciliation requirements needed to enhance patient care.

Paul MacKinnon, RN, PhD, corporate VP and CNO at HealthAlliance Hospitals, noted that his facility solicits – and acts upon – thousands of suggestions from RNs and the caregiving team to improve care, which is a better improvement strategy than imposing a fixed ratio on one part of the team.

Other testifying included Cathleen Colleran-Santos R.N., DNP, the president-elect of the American Nurses Association – Massachusetts. She told the committee, “Registered nurse staffing is a complex process that requires the consideration of many factors. Appropriate nurse staffing is a balance of registered nurse experience with the needs of the recipient of nursing care services in the context of the practice setting, acuity, and situation. Thus safe staffing standards need to be responsive and dynamic given the minute-to-minute changes that can occur in the acute care setting.”

MHA’s Executive VP Tim Gens and VP of Clinical Affairs Pat Noga, RN, PhD, also testified against the union’s bill. Noga said, “Mandated fixed staffing ratios ignore the fact that every patient is different, the education and experience level of every nurse is different, the technology used at a hospital is different, and patient care units in every hospital are different. Staffing needs vary from patient to patient, shift to shift, care team to care team."

Minnesota Hospital Association 10/26/15

Keeping Hospitals Safe for Patients, Visitors and Staff -- A community conversation is needed to prevent and respond to violence: Minnesota hospitals are places of healing, and hospitals strive to ensure that we remain safe for our patients, visitors and staff. As part of that commitment, each hospital works closely with its local law enforcement agencies to prevent, prepare for and respond to violence, as well as aggressive patients or visitors. The recent tragic shooting at St. Cloud Hospital is another reminder that the increasing violence in our society does not stop at the doors of a hospital, school, church, college, courtroom or government building.

Patients who need medical care but pose a security risk are especially concerning for both hospitals and law enforcement. The Minnesota Hospital Association is encouraging law enforcement leaders and other stakeholders to join us in exploring additional steps that can be taken to provide the highest quality care in the safest way possible. Both hospitals and law enforcement are challenged to find the right setting for people who need medical care but are violent, aggressive or pose a security risk. Just as jail may not offer the best medical or mental health treatment, hospitals may not offer the most security for people who are violent or dangerous. The safety of our patients, their loved ones and our dedicated staff who provide care demands that we address these challenges together.

The Minnesota Hospital Association and our members have been encouraging and participating in community conversations about preventing and responding to incidents of violence in health care settings for several years. Our hospitals are continually working on violence prevention and training for health care staff, as well as refining security plans. In 2014, the Minnesota Department of Health convened health care organizations, including the Minnesota Hospital Association, to create nation-leading tools for health care organizations to assess their preparedness for violent situations. And, in

2015, MHA supported legislation ensuring that hospitals have preparedness and incident response plans as well as annual training for staff.

Minnesota hospitals are supporting our staff in helping to identify risks for violence and put effective strategies in place. They are meeting regularly with their interdisciplinary workplace violence prevention committees and are increasing training, including training in de-escalation techniques, so staff are prepared for managing aggressive behavior, emergency incidents and worst case scenarios like an active shooter. To learn more about what Minnesota's hospitals are doing, visit http://www.mnhospitals.org/patient-safety/current-safety-quality-initiatives/workplace-violence-prevention.