American Hospital Association

**HIGHLIGHTS**
**GOVERNING COUNCIL MEETING**
**AHA Section for Small or Rural Hospitals**
**June 2-3, 2005 ★ Chicago, IL**

The governing council of the AHA Section for Small or Rural Hospitals met June 2-3, 2005 in Chicago. Governing council members and several guests participated in a lengthy policy discussion on accountability based on local experiences. In addition, members received reports on legislative initiatives, regulatory policy, and current activities related to community benefit and tax-exempt status. Members also were introduced to the newly proposed AHA Center for Quality and Patient Safety. In addition, members shared their views on and discussed policy for action in the event of a pandemic flu. The Section's governing council roster may be found on the AHA Web site at www.aha.org/aha/key_issues/rural/section/council.html.

**Embracing Accountability:** The Small or Rural Hospitals' governing council meetings were modeled after the January-February AHA Board of Trustees retreat that focused on the theme of "Embracing Accountability." Prior to the meeting, members held conversations with community group leaders about how hospitals are perceived by consumers. Governing council members shared their findings and provided comments on the significance of communication and contact with their community, the role of employees as ambassadors to the community, and on ways a hospital can enhance its relationship with the community. Recommendations on how the AHA can provide assistance to hospitals with regard to community benefit also were shared. As the national advocate for hospitals, the AHA has consistently supported members as they develop fair and compassionate policies to help the uninsured. For more information visit http://www.caringforcommunities.org/caringforcommunities/main/index.html.

**Federal Legislative and Regulatory Update:** Governing council members received an update on the current political environment including the federal budget process and the possibility of pending cuts to physicians being shared by hospitals. Members were briefed on AHA's advocacy framework, key strategies for communicating about Medicaid, and priorities for this year's advocacy agenda including payment, public accountability, limited service providers, liability reform, and coverage. Members also were apprised of the status of federal appropriations for rural health programs and AHA's rural health legislative agenda and the status of several bills including:

- Rural Community Hospital Assistance Act S 933/HR 2350
- Critical Access to Clinical Lab Services Act S 236/HR 1016
- Sole Community Hospital Legislation HR 2961
- Rural Health Equity Act HR 880
- Extending the Rural Home Health Add-on S 300/HR 11
- 340B Discount Drug Pricing Expansion to Include CAHs (not introduced)

Governing council members received a report on the inpatient PPS proposed rule of May 4, 2005, specifically the payment update and changes for quality reporting. Members were alerted to the devastating effect of the proposed transfer policy, which increases the number of DRGs from 30 to 231 at a projected cost of $900 million in 2006. Members also reviewed CMS proposals for outliers, the wage index, low-volume adjustment, necessary provider status of CAHs, and scrutiny of limited service hospitals. AHA is preparing its comments, which are due June 24, 2005.

Governing council members also received a report on CMS's final rule on implementation of Section 1011 of the MMA, which provides for reimbursement to hospitals for provision of emergency services through stabilization for undocumented immigrants. The AHA's legislative and regulatory advocacy agenda for small or rural hospitals can be found on the Section's Web site at http://www.aha.org/aha/key_issues/rural/index.html.

**AHA Center for Quality and Patient Safety:** Steve Ahnen, senior vice president, AHA, oriented members to the strategic direction for the Association in the area of quality and patient safety and introduced the newly proposed Center for Health Care Quality and Patient Safety. Governing council members were very clear that they welcomed greater AHA leadership and involvement in establishing relevant measures for reporting health care outcomes and for becoming directly involved in establishing a process for pay-for-performance even if it meant competing with other organizations. Members emphasized that AHA represents hospitals' interests, but other organizations do not. Therefore, members are looking to AHA to advocate for hospitals regarding performance measurement and public reporting.

Members commented that presently quality improvement priorities are largely derived from sources such as CMS, JCAHO, IHI, QIOs, or the state's department of health. Governing council members commented that they look to state associations, VHA, and local networks as resources for best practices. IHI protocols were mentioned as useful. They identified "how-to" technical assistance tools as helpful for implementing quality and patient safety strategies commenting that they know what to do, but not how to do it efficiently and effectively and suggested designing tools to assist the hospital QI leader. In addition, members supported a clearinghouse activity and suggested a glossary of acronyms, evidence-based standards.

**Pandemic Flu:** Governing council members were briefed on issues concerning the possibility of pandemic flu, including development of new strains of flu virus for which the population has no acquired immunity. Members were informed that it took a minimum of three months to produce a flu vaccine, which could prove to be a serious limitation when responding to a pandemic outbreak of influenza. Members provided their views on how a limited supply of vaccine and anti-viral drugs should be allocated if a pandemic flu would occur. Members commented that communication channels need to be developed between the public health system and hospitals; and that steps outlined in the local bioterrorism plan should be followed as written. Members commented that patient referrals are a local issue and they discouraged designating separate facilities as sites for flu vaccinations because experience has shown that people will go to undesignated facilities to avoid exposure to a disease at designated facilities. Members believed that those who should have priority to receive immunizations include in order, emergency department, immediate care, and emergency medical system physicians and personnel; clinic staff; and lab and x-ray techs. They were confident that staff that was vaccinated would continue to report to work.

Members commented that infection control issues, protocols, and procedures were the role of the Center for Disease Control (CDC) and that state governors needed to assume control of pandemic flu outbreaks in their states, including distribution of stockpiled vaccines. Members discouraged AHA from becoming involved in what they believe is a CDC priority. Governing council members commented that rural populations had few options concerning care for newborns, as a rural hospital was typically the only OB resource in a community. They also believed that if elective surgery were cancelled for six months, the rural hospital would not be able to survive financially. AHA has resources on disaster preparedness and pandemic flu that can be found at http://www.aha.org/aha/key_issues/disaster_readiness/resources/flu.html.

**For more information about the topics covered in these highlights or on the AHA Section for Small or Rural Hospitals, contact John T. Supplitt, senior director, at 312-422-3334 or jsupplitt@aha.org.**