August 16, 2012

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ACHE News

Don't Miss This Special Educational Program

Palliative care is uniquely poised to play a key role in health reform through its emphasis on care coordination, patient centeredness and cost containment.

At ACHE's special half-day program, Palliative Care: Impact on Quality and Cost, held Tuesday, Sept. 11, from 8:00 a.m.–12:00 p.m. at the InterContinental Buckhead Atlanta, discover how a palliative care program can help address many of the care delivery, financial and ethical challenges that occur in the continuum of care. Gain a clear understanding of the opportunities palliative care programs can provide to your organization.

This session is offered one time only. Learn more and register today.

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Conveniently Earn ACHE Qualified Education Credits

Without leaving your home or office, ACHe-learning webinars, online seminars and self-study courses provide you with proven strategies you can immediately implement to address the latest healthcare management challenges. These programs also earn ACHE Qualified Education credits, which count toward Fellow advancement and recertification. Upcoming ACHe-learning offerings include:

A Review of Health Law, an online seminar held Oct. 3–Nov. 14, will provide an up-to-date overview of health law in light of health reform to help healthcare executives understand how various legal issues can be understood within a broader context.

Strategic Planning That Works: Integrating Strategy With Performance, an online seminar held Oct. 3–Nov. 14, will provide a practical system for strategic planning that is aligned with annual tactical planning and operating and capital budgets.

Recently published self-study courses include:

- Integrating Global Trends into Your Organization's Strategic Planning
- Understanding the Impact of Financing Decisions

Learn more about these and other programs.

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Take a Fresh Look at Your Philanthropy Efforts

Philanthropy has emerged as a vital revenue source in the current economic climate. The new book *Healthcare Philanthropy: Advance Charitable Giving to Your Organization's Mission* written by Betsy Chapin Taylor emphasizes the important role that the healthcare CEO plays in developing this critical revenue stream.

Taylor's strategy also focuses on nurturing a culture of philanthropy, engaging board members in fund development and aligning charitable priorities with the organization's strategic plan. Finally, she demonstrates how to make a compelling case for support through the power of storytelling and the importance of developing metrics to evaluate your efforts.

Learn more about this and other Health Administration Press publications here.

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Postgraduate Fellowships: Creating Future Leaders

Give back to the field by offering a postgraduate fellowship in your organization. The Postgraduate Fellowship Area on **ache.org** gives you the tools you need to design and post a postgraduate fellowship.

The site serves three audiences: students looking for postgraduate fellowship listings, organizations looking for information on how to design a postgraduate fellowship, and organizations looking to post a postgraduate fellowship on ACHE's online Directory of Postgraduate Administrative Fellowships.

Detailed resources to help organizations develop a fellowship include information on logistics, compensation and benefits, recruiting, onboarding and assessing the fellow.

For more information, visit **ache.org/Postgrad**.

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Medicare Sets Hospital Rates for 2013

Hospitals and psychiatric centers will receive an increase in Medicare payments for inpatient stays in the upcoming year, the Centers for Medicare & Medicaid Services (CMS) announced. Beginning in fiscal year 2013, payments to general acute care hospitals will go up 2.3 percent, and payments to long-term care hospitals will go up by 1.8 percent. The agency projects spending on inpatient hospital services will jump by roughly $2 billion in fiscal 2013, and spending on long-term care and psychiatric stays will increase by $92 million and $36 million, respectively. CMS also proposed five new quality measures to be assessed for long-term care hospitals: percent of in-need nursing home residents given the seasonal flu vaccine; percent of in-need residents given the pneumococcal vaccine; flu vaccine coverage among staff; interventions to improve ventilator care; and restraint rate per 1,000 patient-days.

From Medicare Sets Hospital Rates for 2013
MedPage Today (08/03/12) Pittman, David
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CMS to Release ICD-10 Deadline, Plan Identifier Rule Soon

The Centers for Medicare & Medicaid Services (CMS) has submitted a final rule delaying the ICD-10 compliance date with the Office of Management and Budget for review. The proposed rule released by CMS in April indicated that the ICD-10 compliance date would be delayed one year until Oct. 1, 2014. The rule also contained a requirement that "organization covered" providers who are prescribers obtain a National Provider Identifier.

From CMS Poised to Release ICD-10 Deadline, Plan Identifier Rule
Health Data Management (08/12) Goedert, Joseph
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Robert Wood Johnson Foundation to Fund ACO Projects

The Robert Wood Johnson Foundation will offer grants of up to $400,000 each or up to $1.2 million for up to three projects that study how markets can help or hinder accountable care organizations (ACOs) when it comes to achieving results in quality, cost, patient experience and health disparities. ACOs operating in the private market will be eligible for the studies, and they must also use risk-based payment models, measure quality and be responsible for the health of a select group of individuals. The foundation said that safety net ACOs were of particular interest. Grants will begin in March 2013.

From What Works for an Accountable Care Organization?
Modern Healthcare (07/31/12) Evans, Melanie
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More Medicare Hospital Reporting Demands Set for 2013

The Centers for Medicare & Medicaid Services has issued its final rule for Medicare inpatient prospective payment systems at acute care and long-term care facilities for the 2013 fiscal year. The final rule, to be published Aug. 31 in the *Federal Register*, includes new quality reporting measure for hospitals for readmissions of perinatal and hip and knee replacement patients, overall admissions, use of surgery checklists and care transitions. The rule also contains payment provisions that reward hospitals for lower rates of central line-associated bloodstream infections and reduce hospital payments for high readmission rates for heart attack, heart failure and pneumonia.

From More Medicare Hospital Reporting Demands Set for 2013
Health Data Management (08/12) Goedert, Joseph
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Stage 3 List for Meaningful Use Coming Soon

Although the Stage 2 meaningful use rule has yet to be finalized and the Stage 3 measures will not be implemented until 2016, the Health IT Policy Committee considered the Stage 3 criteria at its Aug. 1 meeting. Some of the recommendations depend upon the health information exchange criteria in the Stage 2 rule, and electronic health records (EHRs) need to become more sophisticated before providers are ready for Stage 3, which also will require them to perform Stage 1 and Stage 2 measures more often or with more patients. The Stage 3 draft recommendations touch upon such things as sharing care summaries and care plans; the use of EHRs for drug-drug and drug-allergy interaction checks; advance directives for senior patients; and the collection of more extensive demographic data, like occupation and gender identity. Paul Tang, MD, the committee's vice chair, says that the final Stage 3 rule will be submitted to the Office of the National Coordinator for Health IT in May 2013.

From Stage 3 List for Meaningful Use Coming Soon
Healthcare IT News (08/02/12) Mosquera, Mary
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Increased Health IT Use Requires More Hospital Investment

In order for hospitals, physicians and nurses to practice medicine efficiently and provide quality care, wireless connectivity and wired network traffic must be managed carefully as hospitals increasingly rely on electronic health records (EHRs) and other health IT. Jon Morris, CIO and senior vice president of the WellStar Health System, says that IT has expanded hospitals' use of IT into more complex functions within EHRs and clinical care, such as using wireless blood pressure cuffs to automatically transfer readings to patient charts. Experts say that the influx of data from health IT and EHRs requires quality network infrastructure that is reliable to meet all demands. Hospitals will have to invest in existing facilities or upgrade to new networks that can ensure data is transferred within five seconds or less. Experts also note that connectivity is even more important as hospitals adopt cloud computing and health IT software vendors develop mobile applications for specific care functions.

From Hospital Networks Take Key Role in Health Care as IT Makes Further Clincial Advances
Computerworld (07/31/12) O'Connor, Fred
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Hospital Boards Can Simplify Capital Planning

Anthony Montagnolo, executive vice president and COO of the ECRI Institute, says hospital boards can simplify capital spending by improving the capital planning process instead of looking over the capital budget annually or individually approving large capital outlays. To improve the capital planning process, they need to complete a self-assessment that involves four key considerations. First, boards should assess the state of the hospital's current clinical technology infrastructure compared to that of its peers and its strategic intent, creating a clinical technology scorecard that is frequently updated and reviewed once a year. Second, the board should understand the major clinical technology changes that could strengthen or weaken the organization down the road, and then it should ensure that a sustainable financial plan is in place to fund clinical technology needs during the next five years. Finally, the board should strive for an evidence-driven clinical technology decision process that is transparent and aligned with its strategic priorities.

From A Plan for Smarter Spending
Trustee (07/12) Montagnolo, Anthony J.
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Hospitals Fear Cuts in Aid for Care to Illegal Immigrants

Hospitals are required under federal law to treat anyone who arrives at the emergency room, but some of the nation's most financially-strapped hospitals--those that care for a high volume of illegal immigrants--stand to lose about half of the $20 billion in annual reimbursements given them once the Affordable Care Act goes into full effect. This is due to the fact that the healthcare law does not cover the 11 million people living in the United States illegally, even though the law is expected to reduce the number of uninsured. Hospitals expected to suffer most range from public ones in Manhattan and Brooklyn to rural outposts in Washington State, where a steady flow of farm workers migrate illegally. Hospitals in some states can request money from the emergency Medicaid program to treat illegal immigrants in rare instances, but the program has many restrictions, some hospital executives say.

From Hospitals Fear Cuts in Aid for Care to Illegal Immigrants
The New York Times (07/27/12) Bernstein, Nina
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HHS Issues New Operating Rules

The U.S. Department of Health and Human Services (HHS) on Aug. 7 released an interim final rule for making electronic healthcare claim payments and detailing claim payment adjustments. The operating rules expand upon industry-wide health electronic fund transfer (EFT) standards that HHS adopted this past January. HHS hopes the operating rules, together with the electronic remittance advice (ERA) operating rules announced Aug. 7, will save $9 billion in administrative costs over the next decade by reducing inefficient manual administrative processes for physician practices, hospitals and health plans. Operating rules include best business practices for transmitting electronic transactions.

From More Operating Rules to Come
Healthcare Finance News (08/07/12) Irving, Frank
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Most Hospital Adverse Events Not Reported to State Systems

According to a July study from the U.S. Department of Health and Human Services' Office of Inspector General (OIG), only 8 percent of adverse events in hospitals were reported as required. The District of Columbia and 25 states have adverse-event reporting systems, and of the 35 adverse events the OIG identified previously in these states, only three were submitted to a state reporting system. The report said, "For the remaining 31 events, hospitals had no record indicating that staff recognized the event had occurred. This suggests that the low rate of reporting to state adverse-event reporting systems is due largely to hospital staff not identifying incidents of harm as reportable events." About six of the 32 events contributed to patient death, according to the report. The OIG report found that many hospitals were unclear about what adverse outcomes were supposed to be shared through incident-reporting systems and expressed lingering fears of liability.

From Most Hospital Adverse Events Not Reported to State Systems
American Medical News (08/08/12) O'Reilly, Kevin B.
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