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***1 Health care coverage for low-income Minnesotans takes center stage of special session**

By Mary Krinkie, Vice President of Government Relations, Minnesota Hospital Association

As I write this article for the trustees serving on the boards of Minnesota's 145 hospitals, the 2011 legislative session is coming to a close by its constitutionally mandated deadline of May 23. As has been the case for a number of years, Minnesota's governor and the parties controlling the Legislature are of different political philosophies, which makes the negotiation of a biennial state budget difficult. This situation is exacerbated by a \$5 billion budget shortfall, a populist DFL governor who wants increased income taxes on Minnesota's wealthiest residents and new Republican majorities in both the House and Senate that are far more conservative than their Republican predecessors. This combination is, as most capitol insiders predicted, a recipe for a special session.

Special sessions are nothing new in Minnesota. Since statehood, Minnesota has had 46 special sessions, with the first one in 1862 with Minnesota's Fourth Legislature. Some special sessions have shown to be very bipartisan in nature. That has been the case, for example, when lawmakers have met quickly to pass legislation addressing a natural disaster with tornado or flood relief. But getting to a budget "deal" in 2011 will likely prove to be difficult given the very real and heartfelt differences in political philosophies.

With an anticipated gubernatorial veto of the Health and Human Services Budget bill, health-care coverage for low-income Minnesotans is in the eye of the storm. Hospitals are caught in the political fray between Gov. Mark Dayton, who continues to express his support for the early Medicaid enrollment option, which is now expected to provide health-care coverage for nearly 105,000 low-income Minnesotans who earn less than 75 percent of the federal poverty guidelines, and Republican lawmakers, who are trying to address the budget shortfall without new revenues. This task is made even more difficult by holding 40 percent of the budget harmless, with no overall funding reductions in K-12 education.

The Omnibus Health and Human Services Bill (S.F. 760) cut a whopping \$1.6 billion from projected expenditures, of which an estimated \$1.2 billion would come out of Minnesota's health-care infrastructure. Most of this money is within the Medicaid program, so the impact to providers and patients will be nearly doubled with the loss of federal matching funds. Under the legislation, hospitals would be facing both significant cuts in direct payments and lost revenues associated with growing uncompensated care as thousands of individuals lose their health-care coverage. From the outset, MHA recognized that some cuts to hospitals would likely be inevitable. Our goal of providing health-care coverage for Minnesota's lowest income residents remains MHA's top priority, and that is broadly supported throughout the MHA membership, even if it comes at the expense of some direct cuts in hospital reimbursement rates.

Here in Minnesota, we are at the cusp of health-care payment and delivery reform. There is broad recognition that getting individuals into a health-care home, with aggressive care management, especially for those individuals who frequently and often inappropriately access care in the hospital emergency rooms, is one way to help bend the cost curve. But

getting these individuals to seek their care in a primary care setting will not easily happen if they have lost their health insurance. This approach is in the opposite direction of where we have been trying to head.

The Minnesota Department of Human Services has now estimated that approximately 138,000 individuals could lose their coverage under the provisions of S.F. 760. That figure comprises 105,000 adults without children in the Medicaid program who earn below 75 percent of the federal poverty guidelines (FPG); 20,000 adults without children in MinnesotaCare who earn below 125 percent of the FPG; and an additional 13,000 individuals and families eligible for but opting not to participate in the “Healthy Minnesota Contribution Program” (that is a newly proposed program under which the state provides a defined subsidy contribution to individuals to use for purchasing private insurance). Those opting not to participate most likely are doing so because their budgets are too strapped to afford the premiums, they have a pre-existing health condition, or simply because they are unable to navigate the purchase of private insurance.

If this approach of eliminating coverage prevails, it will inevitably lead to three things:

1. A reduced quality of health for those individuals directly affected by losing their health-care coverage, and potentially for the greater community who would be affected by cut backs in selected services;
2. Higher costs to the business community and individuals who purchase private insurance as providers are forced to cost shift what they can to other non-governmental payers;
3. A loss of jobs in our health-care work force.

No one benefits when health care becomes less accessible and more expensive. Over the course of the next several weeks or perhaps even months, hospital leaders and trustees must advocate for people who often can't advocate for themselves. Through our collective voices, we can help keep health coverage for 138,000 Minnesotans who might otherwise join the growing ranks of the uninsured. Throughout this special session, with an unknown duration, we hope hospital trustees will continue to let legislators know how important health-care coverage for low-income Minnesotans is for your hospital and your community. [^top](#)

***2 Minnesota hospitals' board members embrace certification**

Since its inception in January 2008, interest in the Minnesota Hospital Association's (MHA) board certification program has steadily grown. Currently, more than 300 board members from Minnesota hospitals are actively working toward certification. Twelve have already received certification and 11 more will receive certification at the upcoming MHA Summer Trustee Conference.

The hospital trustees that have received certification thus far are:

- Larry Anderson, United Hospital District, Blue Earth;
- Jane Aschnewitz, Perham Memorial Hospital and Home;
- Diane S. Cross, University of Minnesota Medical Center, Fairview, Minneapolis;
- William Erickson, RiverView Health, Crookston;
- Richard A. Helms, New River Medical Center, Monticello;
- Loren A. Morey, Lakewood Health System, Staples;
- Barbara Muesing, First Care Medical Services, Fosston;
- Steven L. Perkins, Sanford Hospital Luverne;
- Barbara Peterson, Lakewood Health System, Staples;
- Clay Peterson, St. Joseph's Area Health Services Inc., Park Rapids;
- Thomas W. Spence, Cook County North Shore Hospital, Grand Marais; and
- Emily Tholl, Lakewood Health System, Staples.

Another 11 trustees have recently completed certification requirements and will be recognized for that work at the conference this summer.

If you are currently working toward certification and would like to review your progress, contact [Christy Brager](#), MHA education specialist at (651) 659-1412.

For those considering beginning certification, information about board certification can also be found on MHA's TrusteePlace website at www.mnhospitals.org/index/trusteeplace under "Board Education Certification." [^top](#)

***3 Ryan named MHA Trustee of the Year**

Riverwood Healthcare Center board member honored for service

Each year, the Minnesota Hospital Association (MHA) honors a hospital or health system board member who has dedicated time and skill to the preservation of health care, via its Trustee of the Year Award. This year's winner is Michael Ryan, board member at Riverwood Healthcare Center in Aitkin.

For 20 years, from 1991 to 2010, Michael Ryan served on the Riverwood Healthcare Center Governing Board of Directors and provided the leadership necessary to support expansion and enhancement of quality health-care services for rural Aitkin County communities. Ryan joined the 11-member governing board in 1991 and served as chair from 1994 until he passed away in September 2010.

During his time on the board, Ryan oversaw major growth in local health-care services and in facility changes. Ryan was instrumental in building board consensus to move ahead with a \$20 million integrated hospital and clinic facility. Under Ryan's leadership on the Riverwood board, the number of facility practice and internal medicine practitioners grew from five to 20, and the number of surgeons, specialty physicians and other practitioners grew from three to 35. Ryan's board colleagues commended him for his ability to help the board confront difficult issues head-on in a climate of openness, respect and candor.

Ryan led Riverwood through many difficult challenges as well as outstanding

achievements in the growth and development of staff. His long-term commitment to sustaining and improving quality health care services for the largely rural population Riverwood serves is a lasting legacy that deserves recognition.

Ryan was posthumously honored with the award at MHA's Annual Awards Banquet May 6 at the Metropolitan Ballroom in suburban Minneapolis. [^top](#)

***4 State and national perspectives on health care's future to be provided at MHA Summer Trustee Conference**

State economist Tom Stinson to discuss health-care outlook for Minnesota; Health care consultant Marc Sauve to discuss national health-care trends

Minnesota state economist Tom Stinson, Ph.D., will present a session at the Minnesota Hospital Association Summer Trustee Conference on how predicted economic and demographic changes will change the outlook for Minnesota.

“State Economy: The New Normal” will briefly cover how Minnesota weathered the recession and what Stinson thinks the new economic reality will be for the state, and that reality's effect on the outlook for the health-care sector.

Following Stinson's session, Marc Sauve, a senior health-care strategist at the Nashville, Tennessee-based health-care consulting firm Gresham, Smith and Partners will discuss the mega trends that will affect the future of health-care delivery nationally.

In “The Future of Health Care in America,” Sauve will reveal the truth about our nation's fiscal health, the culprits of dollar-driven health care, and the biggest “Ponzi scheme” in U.S. history. He will also provide information on probable future scenarios and on aligning resources and leveraging opportunities for the transformation of care.

For more information or to register, download the conference brochure here [\[PDF\]](#). [^top](#)

***5 Implications of health care reform on small and rural facilities to be discussed during conference**

James D. Bentley, Ph.D., a speaker and health-care consultant from Silver Spring, Md., will present at the Minnesota Hospital Association's Summer Trustee Conference. He will discuss the implications of health-care reform on small and rural health-care facilities.

“Health Care Reform — Big Implications for Small Facilities” will explore the components of health-care reform that offer small and rural facilities incentives to improve patient access, coordinate care in their communities and assure uniformly high-quality patient care.

For more information or to register, download the conference brochure here [\[PDF\]](#). [^top](#)

*6 Minnesota hospital leaders visit congressional members during AHA's annual meeting

Minnesota hospital leaders, auxiliaries and Minnesota Hospital Association (MHA) staff members advocated on behalf of Minnesota hospitals April 10 – 13 in Washington, D.C. Face-to-face visits with Minnesota's congressional delegation were among the activities that occurred as part of the American Hospital Association (AHA) annual meeting.

A total of 23 MHA representatives participated in the program and corresponding "hill visits," which help keep hospital issues at the forefront of our delegation's minds, MHA President and Chief Executive Officer Lawrence J. Massa said.

"I appreciate the time MHA members took to travel to Washington, D.C. so our congressional leaders could hear first-hand the challenges hospitals face and the innovative solutions Minnesota hospitals and health systems find to meet those challenges," Massa said. "The meetings allow us to build upon our ongoing discussions and good relationships with our congressional offices."

During the congressional visits, attendees:

- expressed support for keeping federal health care reform legislation in place while we work to improve it;
- asked our delegation to continue to support new payment systems that move to a pay-for-value model;
 - asked our delegation to protect hospitals from being "double punished," or inundated with administrative burdens that do not improve patient care or increase accountability (Example: a provision in the value-based purchasing rule that would impose financial penalties for hospital-acquired conditions on top of financial penalties for those same conditions imposed in the federal reform bill);
 - asked our delegation to instruct the Centers for Medicare & Medicaid Services to adopt a default standard of general supervision for outpatient therapeutic services and then make case-by-case, evidence-based exceptions;
 - urged our delegation to continue to protect the critical-access hospital (CAH) program by exempting CAHs from the Independent Payment Advisory Board and allowing CAHs to continue claiming the full cost of provider taxes.



MHA board chair and CEO of Queen of Peace Hospital Mary Klimp was honored for receiving the AHA Grassroots Champion award at MHA's Healthcare Executives' Institute in March.

Annual meeting activity

MHA members also had the opportunity to attend various AHA annual meeting presentations. Addresses were given by political pundits Arianna Huffington, Tucker Carlson and Mika Brzezinski; Admiral Thad Allen, former commandant of the U.S. Coast Guard who was responsible for

overseeing the United States response to the recent oil spill in the Gulf of Mexico; and former Florida Gov. Jeb Bush.

AHA also held a special breakfast and ceremony to honor one outstanding individual nominated from each state who goes above and beyond to support hospital grassroots advocacy efforts. MHA was pleased to support Mary Klimp, chief executive officer of Queen of Peace Hospital in New Prague and MHA chair, as Minnesota's 2011 AHA Grassroots Champion.

MHA participants in the trip to Washington, D.C. were:

- Matt Anderson, vice president, regulatory and strategic affairs, MHA
- Richard Blair, board chair, Essentia Health, Duluth
- David Borgert, director, government relations, CentraCare Health System, St. Cloud
- Bradley Burris, chief executive officer, Pipestone County Medical Center
- Joanell Dyrstad, board of directors, Fairview Health Services, Red Wing
- Mary Edwards, vice president, public policy, Fairview Health Services, Minneapolis
- Ann Gibson, vice president, federal relations/work force, MHA
- Mary Klimp, chief executive officer, Queen of Peace Hospital, New Prague
- Prudence Knaak, Health Care Auxiliary of Minnesota, Rochester
- Ben Koppelman, St. Joseph's Area Health Services, Inc., Park Rapids
- Lauren Larsen, board member, Essentia Health, Duluth
- Michael Mahoney, vice president, government affairs, Essentia Health, Duluth
- Jen Mallard, director, federal government relations, Mayo Clinic Rochester, Washington, D.C.
- Lawrence J. Massa, president and CEO, MHA
- Cindy Morrison, vice president of health policy, Sanford Health South, Sioux Falls, S.D.
- Barbara Muesing, Health Care Auxiliary of Minnesota, Fosston
- Bill Nelson, chief executive officer, Mille Lacs Health System, Onamia
- David Nelson, president and CEO, St. Francis Healthcare Campus, Breckenridge
- Ben Peltier, vice president, legal services, MHA
- Peter Person, M.D., chief executive officer, Essentia Health, Duluth
- Terence Pladson, M.D., president and CEO, CentraCare Health System, St. Cloud
- Michael Rock, M.D., chief medical officer, Mayo Clinic Rochester
- Pat Rogowski, Health Care Auxiliary of Minnesota, Scandia

For more information contact [Ann Gibson](#), vice president of federal relations/work force for MHA, at (651) 603-3527. [^top](#)

***7 Risky business**

Digitizing data doesn't eliminate the risk of misuse or errors

- Health care organizations rank third among all industries in the number of data breaches that could lead to identity theft, representing 16 percent of all breaches.
- The Centers for Medicare and Medicaid Services reported to Congress that the national Medicare billing-error rate for fiscal year 2009 was 7.8 percent, or \$24.1 billion.
- In the period from 2006 to 2007, more than 1.5 million names were exposed during data breaches that occurred in hospitals alone.
- Medication-administration errors (which accounted for half of preventable, adverse drug events before computerized provider order entry) and monitoring errors did not decrease with computerized provider order entry.
- The impact of a lost or stolen device with patient data costs an average of \$90 per patient account if no encryption solution is in place.
- Health care IT professionals identified an internal breach of security as their primary concern regarding data security; 97 percent indicated that they have concerns about the security of the data at the organizations at which they work.
- More than 300,000 Americans were victims of medical identity theft in 2009, and it's on the rise.

Sources: Symantec Global Security Threat Report; Office of the Inspector General, U.S. Department of Health & Human Services; attrition.org; *Pediatrics* 119, No. 1 (2007); Gartner; 19th Annual HIMSS 2008 Leadership Survey; Federal Trade Commission.

From Trustee Magazine, February 2011 [^top](#)

***8 Home is where the heart is**

By Amy Nelson

As we move toward reform of the health care paradigm, there is a building momentum to keep patients in their homes whenever possible. Hospitals will have increased incentives to prevent re-hospitalizations. Hospital caregivers will be a critical linchpin in making home care an integral part of the care continuum, bridging the clinic-based care model and the actual world patients live in.

For all ages and many conditions

The primary population creating a demand for home care is seniors. As 78 million Baby Boomers approach retirement age, U.S. demographics are shifting significantly. Seniors 65 and older will soon constitute 20 percent of the population. And it's estimated that by the year 2020, 12 million older Americans will need long-term care.

In addition to the senior niche, home care serves people of all ages who are recovering from health challenges or are disabled, chronically ill or in need of end-of-life care. Their ongoing needs may be medical, nursing, therapeutic or just assistance with the basic activities of daily living. Home care ranges from a one-hour weekly visit to 24-hour care.

Children who would have years ago been institutionalized or remained in the hospital for long durations are now being successfully cared for at home. Stated Dr. John McNamara,

director of Children's Home Care & Hospice Program at Children's Hospitals and Clinics of Minnesota, based in Minneapolis, "We have sent over 400 children home with trachs and vents and find home care to be a very good alternative with fewer infections and low readmission rates. Even acute illnesses have been successfully cared for at home."

Chronic conditions that are being handled by home care nurses include tracheotomy, ventilator, g-tube, intravenous therapies and many cardiac issues. Cancer and transplant patients are also recuperating at home.

Recent advances in medical technology have increased the population of patients now treated at home. Common home medical interventions include: infusion therapies with central and peripheral lines, lab draws, parenteral and enteral nutrition, sleep diagnostic testing, respiratory assistive devices such as ventilators, bi-level, CPAP, oxygen monitoring, carbon dioxide monitoring, airway clearance equipment and techniques. The types of care now being handled at home are drastically different from care models even 10 years ago, and they will continue to evolve as technologies advance.

Hospital caregivers are more cognizant of the fact that skilled private-duty nurses and care managers working in the home regularly meet complex medical needs. All such nurse activities are signed off by MDs and patient plans of care are re-certified at a minimum every 60 days.

Types of home care

Home care is anywhere from 5-20 times less expensive than facility care. It also provides a one-on-one focus, which is difficult to obtain in hospitals or group facilities. There are four basic home care service options:

1. Personal care assistants provide assistance with activities of daily living such as dressing, bathing, feeding, getting to doctor appointments, etc. and are not licensed by the state. This type of care is typically paid for by Medical Assistance.
2. Private duty care — basically private pay care — provides assistance with non-medical needs such as shopping, cooking, transportation and companionship and involves household management services but no hands-on medical care. Some long-term care policies will cover such home care, but reimbursement terms and exclusion criteria vary.
3. Licensed home care agencies employ a variety of home health care professionals serving clients with skilled nursing care as well as home health aides. This type of care is typically paid for by private insurance, Medicare and Medicaid.
4. Medicare-certified skilled home care is typically received on an acute, intermittent basis following an illness, injury or change in disease status. Such services are physician-driven and reimbursement is contingent on the individual demonstrating progressive improvement while being homebound.

New technologies are making home care a more viable option today. Telehealth service management, electronic medical records and a variety of assistive technologies such as home sensors all improve service levels. A nurse using telehealth equipment can potentially make up to 15 visits a day rather than the standard five.

Who pays for home care?

Funding for home care is increasing as more people recognize its cost competitiveness. Many insurance companies now cover extended-hour nursing and care visits. A tracheotomy patient, for example, can be approved for 24 hours per day of care for one month and then weaned onto family care. Managed care companies, such as Medica, Health Partners, UCare and Blue Cross/Blue Shield, have come to understand that home care is both safe, efficient and provides the same level of care at a cost-effective rate.

Payment options for home care include self-pay, Medicare, Medicaid, Veterans Administration, community organizations, commercial health insurance companies, managed care organizations and workers' compensation.

A critical component

Now that state budget cuts are impacting health care, it's important that hospital caregivers consider what types of patient care are both cost effective and ultimately necessary. There is a need for more communication between physicians — not only family practice and gerontology doctors but also specialists like orthopedists and cardiologists — and their patients about the benefits of home care. Even the one step of discussing discharge planning, including home care options, at a patient's admission can make a big difference.

Home care is a critical component of collaborative care that needs to move from the periphery to the mainstream. Home is where families want their loved ones to be and it's where a high quality of life for patients can best be had.

[Amy Nelson](#) is founder, president and chief operating officer of Accurate Home Care, a home care services provider that serves a wide range of medically complex pediatric and adult clients in Minnesota, Iowa and Illinois. Nelson can be reached at (763) 633-3800.

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***9 Fact sheets on MHA federal policy priorities now online**

Documents outline initiatives and positions on patient safety and quality, Medicare and Medicaid financing and more

Fact sheets on Minnesota Hospital Association (MHA) federal policy priorities are now online. The documents can be found on the MHA website.

The documents were prepared for face-to-face meetings with Minnesota's congressional delegation during April's American Hospital Association annual meeting in Washington, D.C.

The briefs outline some of the association's initiatives and positions on the following issues: Medicare and Medicaid; small and rural hospitals; patient safety and quality; health care reform; regulatory relief; work force; and health information technology.

For more information contact [Ann Gibson](#), MHA's vice president of federal relations/work force, at (651) 603-3527. [^top](#)

***10 Trustees encouraged to participate in Minnesota Hospital PAC/American Hospital Association PAC Golf open**

The Minnesota Hospital Political Action Committee (PAC) and American Hospital Association PAC leaders encourage trustees to participate in the groups' premiere fundraising event on Tuesday, Aug. 16 at the Prestwick Golf Club in Woodbury.

The PAC golf open is a great opportunity to spend the day networking with hospital CEOs and top management team members while also raising money for the PAC. Trustees may participate for \$200.

Trustees who have already contributed \$200 or more are qualified to participate at no extra charge. However, they must register for the event with PAC staff.

Participating in the PAC helps support state and federal candidates that understand the important role hospitals play in their communities.

Those who are unable to attend the golf open are encouraged to consider contributing at lower club levels created exclusively for trustees. Under that arrangement, trustees may contribute \$25, \$50 or \$100 to be recognized as leading contributors to their hospital's PAC goal.

Of course, trustees may still participate at club levels set by the American Hospital Association PAC — those levels are \$350, \$500 or \$1,000. Contributors who give at those higher levels will receive additional acknowledgment in national materials.

The Minnesota Hospital PAC thanks the following trustees who had already contributed \$25 or more as of May 6:

Ben Franklin Club – trustees who gave \$1,000 or more

James Morris, Queen of Peace, New Prague

Chairman's Circle – trustees who gave \$500 or more

Joanell Dyrstad, Fairview Health Services, Minneapolis

Capitol Club – trustees who gave \$350 or more

Mark Dwyer, M.D., Sanford Bemidji

Jodie Torkelson, Sanford Medical Center Thief River Falls

Gold Level – trustees who gave \$100 or more

Larry Anderson, United Hospital District, Blue Earth

Dixon Bond, Northfield Hospital

Diane Cross, University of Minnesota Medical Center, Fairview, Minneapolis

J. Kevin Croston, North Memorial Health Care, Robbinsdale

Loren Morey, Lakewood Health System, Staples

Barbara Muesing, Essentia Health Fosston
Clayton Peterson, St. Joseph Area Health Services, Inc., Park Rapids
Brett Reese, Northfield Hospital
Kathy Sterk, Fairview University Medical Center – Mesabi, Hibbing
Dean Thompson, Sanford Bemidji
Rodney Will, Sanford Bemidji

Silver Level – trustees who gave \$50 or more

Charles Austin, Northfield Hospital
Tom Hruby, Sanford Bemidji
Glen Lindseth, Sanford Bemidji
Michelle Muench, M.D., Northfield Hospital
Steve Rogness, Sanford Bemidji
Judy Roy, Sanford Bemidji
James Schlichting, Northfield Hospital
Mary Theurer, Lakewood Health System, Staples
E. Paul Wicht, Lakewood Health System, Staples

Bronze Level – trustees who gave \$25 or more

Bev Bales, Douglas County Hospital, Alexandria
Chad Broadwell, Sanford Medical Center Thief River Falls
Kari Howe, Sanford Bemidji
Barbara Peterson, Lakewood Health System, Staples

Trustees who gave up to \$25

Jan Bonebright, Redwood Area Hospital, Redwood Falls
Colleen Hoffman, Sanford Medical Center Thief River Falls
Leonard Medrud, Redwood Area Hospital, Redwood Falls
Peter Smith, Redwood Area Hospital, Redwood Falls

For more information about the Minnesota Hospital PAC, contact [Ann Gibson](#), Minnesota Hospital Association (MHA) vice president of federal relations and work force; [Mary Krinkie](#), MHA vice president of government relations; or [Carol Eshelman](#), Minnesota Hospital PAC coordinator, at (651) 641-1121. [^top](#)

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