
Minnesota Hospital Association

The Health Care **Leader**

a governance newsletter for Minnesota health care trustees

Thursday, Dec. 1, 2011

MHA Health Care Leader is a biannual newsletter produced by the Minnesota Hospital Association, 2550 University Ave. W., Suite 350-S., St. Paul, MN 55114-1900; Tel: (651) 641-1121; Fax: (651) 659-1477; www.mnhospitals.org

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*1 Super committee fails to reach an agreement

Automatic spending cuts to take effect in 2013

The Joint Select Committee on Deficit Reduction — commonly known as the “super committee” — failed to reach an agreement on a deficit reduction strategy by its Nov. 23 deadline.

The bipartisan 12-member committee was tasked with crafting a far-reaching plan to reduce the national deficit by at least \$1.2 trillion.

According to this summer’s Budget Control Act, the committee’s failure to reach an agreement means automatic spending cuts totaling \$1.2 trillion split between defense spending and non-defense programs will take effect in January 2013.

Under the trigger, reductions in Medicare payments to hospitals and to other providers would total 2 percent over nine years (2013 to 2021). The impact to Minnesota will be a loss of \$602.6 million over nine years.

Minnesota did not have a lawmaker on the super committee, but MHA staff weighed in with our delegation throughout the process urging them to reject proposals that cut Medicare and Medicaid funding for hospitals.

Specifically, MHA staff communicated the following messages:

Minnesota hospitals oppose any further reductions to payment for hospital services under Medicare and Medicaid for the following reasons:

- **The hospital field is already absorbing \$155 billion in reductions as a part of the Affordable Care Act, as well as state Medicaid cuts.** This figure does not include additional cuts imposed by regulations such as coding offsets under the Medicare inpatient prospective payment system. We urge lawmakers to look outside of both the hospital and health-care sector for new ideas that could achieve budget savings.
- **Federal programs already pay hospitals less than the costs of providing services.**
- **We do not support arbitrary triggers for cuts; we prefer targeted policy changes.** Minnesota hospitals are wary of formula-driven arbitrary budget targets that would result in across-the-board cuts to health care. This could further exacerbate the “cost-shift,” which would increase health-care costs to employers and other purchasers of private coverage.
- **It is important to protect the safety net.** Medicaid has been dramatically cut as states struggle to balance their budgets. Further cuts would threaten this program, which is a lifeline to so many. Provider assessments are used by most states to help finance their Medicaid programs. Curtailing this option will result in jeopardizing services to the poor and disabled. We support the following alternatives to Medicaid cuts:
 - applying Affordable Care Act models like accountable-care organizations, bundling, medical homes and pay-for-performance to Medicaid;

- coordinating care for dual-eligibles and those with chronic conditions;
 - increasing the use of generic drugs;
 - restructuring copayments; and
 - designing stronger tax incentives for long-term care.
- **There are other alternatives to Medicare cuts.** We also support the following alternatives for Medicare savings:
 - creating a better alternative to our current liability system;
 - junk food taxes;
 - increased Medicare beneficiary cost-sharing;
 - a tax cap on employer-provided health insurance benefits; and
 - adjusting the Medicare eligibility age.
 - **Minnesota's 79 Critical Access Hospitals (CAHs) face unique challenges.** CAHs are the health-care safety net and economic backbone of their communities. In addition to delivering quality health-care services, they are often the largest employer in the community. Because of their rural settings, however, CAHs operate with modest balance sheets and have more difficulty accessing capital to invest in new equipment and renovate aged facilities. Minnesota's CAHs also face difficulties in recruiting physicians and other important members of their workforce.

Congress previously recognized these vulnerabilities by creating policies and programs to protect stable access to care for rural residents, yet some lawmakers are now proposing sweeping cuts to these successful programs. We urge Congress to protect the CAH program, including rejecting any proposal that suggests new mileage requirements that could result in rural hospital closures.

- **Cuts to graduate medical education funding would jeopardize the ability of teaching hospitals to train the next generation of physicians.** Teaching hospitals serve a critical role in the nation's health-care system by training the next generation of health-care professionals and conducting life-saving medical research. However, in March 2011, the Medicare Payment Advisory Commission concluded that the overall Medicare margin was negative 0.6 percent in major teaching hospitals and negative 5.2 percent for all other teaching hospitals.

The Medicare program has long recognized its responsibility for funding its share of direct and indirect costs for training health-care professionals, yet some policymakers are proposing dramatic cuts to these programs. The nation is already facing a critical shortage of physicians. Reducing graduate medical education funding could hamper national efforts to improve access to care and may result in longer wait times for patients.

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

***2 Red Wing community preventative health program highlighted in January Trustee Conference sessions**

As we move forward with the changes of health-care reform, hospitals are becoming critical catalysts in their communities to move from today's interventional paradigm to one based on prediction and prevention. Two different sessions at MHA's January Trustee Conference will highlight a community preventative health program, initiated at Fairview Red Wing Medical Center, which is on the cutting-edge of this paradigm shift.

Phoenix-Arizona based author, physician and psychiatrist Carl Hammerschlag, who helped design and implement the program, will join Fairview Red Wing Medical Center President and Chief Executive Officer Scott Wordelman in presenting the sessions. A general session on Saturday, Jan. 7, "Healing Communities: The Future of Health Care," will highlight the program.

A second breakout session later that day will focus on how participants can implement similar programs in their communities by partnering with other community organizations. The breakout session is limited to 25 participants, so be sure to pre-register for this session right away if you'd like to participate.

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

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***3 Personalizing the hospital message**

By Mary Krinkie, MHA vice president of government relations

We usually talk about health care in the abstract, but it really is the most personal of all the services that we purchase. In March of 2008, hospitals began reporting patient satisfaction scores as part of the Hospital Consumer Assessment of Healthcare Providers and Systems. Patient experience with communication, pain management, cleanliness and overall satisfaction are now part of how Medicare pays for services. While this is certainly acknowledgment that health care is a personal experience, to make our communications more effective we have to make the communications more personal. The more personal the message, the more memorable it will be and the more meaningful our outreach will be with our various audiences.

As we look at issues for the upcoming 2012 legislative session, one of the challenges for hospital advocates and trustees is how we can take rather stale facts and turn them into personal messages that will resonate with public policymakers, community influencers and the public. Here are three examples of issues where our communications could be made more effective if we could make our messaging more personalized.

State budget shortfalls and preventing additional cuts in hospital payments

Hospitals have once again received significant budget cuts in the Medical Assistance program. A new 10-percent cut in the fee-for-service program puts the inpatient payment rate at 2002 costs minus 26 percent! In addition, we believe many of the cuts that were made in the Prepaid Medical Assistance Program (PMAP) will likely be passed along to providers in lower negotiated rates. These are the facts, but the message is not personalized nor is it memorable to our targeted audiences.

Specific and personalized messaging of this information is needed. What do payments this much below costs mean to hospitals? What would your hospital have been able to do if it had received the additional \$50,000 in payments or \$5 million in payments, depending on your volume of Medical Assistance patients? What cost-saving activities has your hospital already taken to make up for these reduced state payments? We have to do a better job of taking factual budget information and making it personal for your community.

Hospitals need more information and data to improve quality and help bend the cost curve.

New state savings have been “booked” with hospital admission, readmission and emergency room utilization targets. In order for hospitals to have a better chance at success in navigating these reforms and making the savings a reality, hospitals need greater access to utilization data. A more comprehensive sharing of utilization data would help hospitals with both quality improvement efforts and better care management services. One source of information that could be helpful to providers is the encounter-level data that health plans have already reported to the state, but the state is not currently allowed to share that information with providers.

This sounds fairly academic. So let’s try to personalize this. Is it fair for a hospital to be penalized for not meeting a readmissions target, when the hospital can’t determine if a discharged patient filled their follow-up prescription, or know if the patient was able to see a physician within 48 hours of emergency room services? This personal utilization data is the best tool to help providers deliver a better coordination of care. It needs to be timely, personalized information so that a provider can better serve its patients. Not aggregate, yearly reports that show trends.

Keeping the Minnesota Department of Health out of hospital community benefit activities.

The Minnesota Department of Health was successful at some behind-the-scenes legislative maneuvers when the state government shutdown ended last spring, giving the department the authority to prepare a plan to implement “evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and HMO collaboration plans.” The legislation goes on to say that the Department’s plan will be implemented by July 1, 2012 and does not require legislative approval.

Minnesota hospitals have supported public reporting of community benefit activity, and the Minnesota Hospital Association (MHA) has supported funding for the State Health Improvement Program (SHIP) grants, which is the funding to local public health agencies for anti-tobacco and anti-obesity initiatives. However, MHA is very concerned about the intrusion of a government entity attempting to direct or approve hospital community benefit activity. We strongly believe

community benefit activity should be determined at the local level. The new federal health-care reform law supports that belief, with a requirement that nonprofit hospitals conduct a community health needs assessment in collaboration with a wide variety of local stakeholders, to establish priorities for the community and to demonstrate progress toward addressing those needs through its reporting to the Internal Revenue Service. While addressing smoking cessation and reducing obesity may be priorities in some communities, there may be other priorities identified in the community needs assessment process that communities want to address.

Hospitals need to personalize and articulate what they are currently doing with their community benefit activities. Annual reports that are made to MHA may not show the depth and breadth of hospital activities. Trustees need to engage the local benefactors of hospital community benefit activities to speak out that they are concerned that their local hospital may have to step back from current activities, if new mandates are forthcoming. Once again, the more individualized you can make your communications about hospital community benefit activities with your local communities of interest, the better that communication will be.

Hospitals have many challenges as we head into 2012 — likely and significant cuts to Medicare provider payments coming from the super committee; the potential for yet another state budget shortfall; controversy and uncertainty around the Patient Protection and Affordable Care Act; and implementation of numerous payment reform demonstration projects at both the state and federal level, to name just a few. MHA will be involved in trying to provide general information to support and advocate for hospital concerns. Trustees need to see how this information can be personalized to your facilities in order to make the communications as effective as possible. [^top](#)

***4 Wendell Potter to speak at January Trustee Conference**

Author, media analyst and journalist Wendell Potter, APR, will present the closing session at the January Trustee Conference: “The New World of Health Care: What’s Really in it and How it Affects You.”

A true industry insider, and referred to as “the ideal whistleblower,” by Time magazine, Potter offers a unique perspective on the issues of health care. Potter regularly speaks out on the need for a fundamental overhaul of the health-care system, charging insurance companies with misleading advertising and other forms of miscommunication.

Following a 20-year career as a corporate public relations executive, Potter left his job as head of communications for one of the nation’s largest health insurers to try his hand at helping socially responsible organizations, including those advocating for meaningful health-care reform, achieve their goals. He has served as senior fellow on health care at the Center for Media and Democracy since May 2009.

Potter’s book, “Deadly Spin,” reveals the evolution of his journey, which he will share in this closing session.

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

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***5 Educational videos for board meetings now available**

Over the past year, and in response to member-requests, the Minnesota Hospital Association (MHA) has been preparing a series of short board education videos for you to provide at board meetings or to view individually. These videos are now available on MHA's website for your use.

Topics and speakers are listed below.

- **Board Fiduciary Duties**
Tom Schroeder, Faegre & Benson LLP
- **Board Self Evaluation — The Importance and Role of Self Evaluation**
James Platt, Fredrikson & Byron, P.A.
- **Community Commitment to Reducing Avoidable Readmissions Effectively (RARE) Campaign**
- **Creating Clinical Integration as True Health Delivery Reform — Understanding the Physician “Control/Participation” Continuum in Coordination of Care**
Perry Hanson, Wipfli LLP
- **Emerging Executive Compensation Topics to Watch**
Eric Gonzaga, Grant Thornton, LLP
- **Legal Issues for Hospitals**
Ben Peltier, vice president of legal services, Minnesota Hospital Association
- **Patient Safety: Adverse Health Events**
Tania Daniels, vice president of patient safety, Minnesota Hospital Association
- **Transforming Care at the Bedside (TCAB) Collaborative Introduction**
Rachel Jokela, patient safety/quality coordinator, Minnesota Hospital Association

The videos are available on MHA's TrusteePlace website under “board videos,” or click [here](#). They are designed as short introductions on specific health-care topics, to be shared during hospitals' board meetings or for individual use.

After viewing, if you find other topics that you'd like MHA to explore, please contact [Peggy Westby](#) at (651) 603-3518. MHA plans to update this list, and add additional videos at least once a year. [^top](#)

***6 Jesson to provide perspective on state health-care issues**

Minnesota Commissioner of Human Services Lucinda Jesson will share her experience as commissioner, to date, and provide insight into the state's health-care priorities at the January Trustee Conference.

During her session, "The State of Minnesota Health Care," Jesson will provide her perspective on how hospitals and the state government can work together to meet the needs of consumers, contain costs and improve the health of all Minnesotans.

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

***7 MHA's Board Certification program explained**

The Minnesota Hospital Association (MHA) has developed a special voluntary board education certification program designed to make a good board member great and a committed board member an exceptional asset. The certification program is a process of verifying an individual trustee's initiatives to improve personal health-care knowledge, leadership effectiveness and compliance with a variety of governance best practices. Certification is a viable way of assuring various stakeholders that Minnesota's hospitals hold themselves to high standards and are accountable for their governing performance.

Board members seeking certification earn at least 35 credits in component categories by attending MHA programs and conferences. A limited number of credits can also be earned for health-care governance education offered by outside organizations. The component categories include:

- Principles of Effective Governance;
- Strategic Planning and Positioning;
- Fiduciary Duties;
- Board Development and Self-Assessment;
- Quality and Patient Safety; and
- General.

Once a trustee has earned the appropriate amount of credit in each component category, he or she completes a form which shows that the basic standards for board involvement have been met.

The certification process has been designed for hospital trustees as part of a larger effort to hold Minnesota hospitals to a higher standard of accountability. By its use, participating hospitals are demonstrating a commitment to improve the performance of their boards. Participating hospitals are also encouraging trustees to pursue ongoing education, and they are educating trustees about their responsibility in serving their community. Certification also provides trustees with an opportunity to move beyond the basics of governance to a forward-thinking, strategic understanding of the health-care environment and how to move their hospitals' mission and vision to a new level.

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](#)

***8 Extended session for board chairs scheduled for Trustee Conference**

The January Trustee Conference will include a special, extended session for board chairs called "The High-Impact Board Chair: The Foundation of Governance Effectiveness."

The extended session is scheduled for Saturday, Jan. 7 from 1:30 – 4 p.m. During the session, health-care consultant and speaker Larry Walker will explore the unique responsibilities of the board chair, challenges to chair effectiveness, the importance of trust-based relationships, ways to ensure productive board meetings, and how to drive strategic thinking.

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

***9 AHA's Umbdenstock to speak at January Trustee Conference session**

Richard Umbdenstock, president and CEO of the American Hospital Association, will present on the federal health-care reform environment at MHA's January Trustee Conference.

Umbdenstock's session, "Reforming Health Care ... With Help from Washington or Without It," will assess the public and political environment for health reform and provide a comprehensive federal perspective on pending legislation. He'll outline the agenda that health-care facilities and their trustees must pursue on their own, with or without national legislation. Umbdenstock will discuss how that agenda will improve hospitals' performance and transparency and will help them achieve more effective, efficient and safer care and make their communities healthier.

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

***10 Patient-driven leadership**

By Brian Wong M.D., M.P.H., The Bedside Trust, LLC

The night before 40-year-old Edie was scheduled for a lobectomy, she sat up in her hospital bed knowing that sleep wouldn't come to her without the help of strong drugs. Only two weeks had passed since she went in for antibiotics for what she thought was a persistent bronchial infection. The next day, she was in front of an oncologist having an almost out-of-body,

real-life nightmare. After scans and more blood work, she was told she had non-small cell lung cancer and needed one of her five lobes removed as soon as possible.

They told her if they removed it right away, followed by chemotherapy, and the cancer hadn't metastasized, and if she avoided bleeding, infection, an air leak, or damage to her heart, lungs, or blood vessels in her chest, that she had a 60 to 70 percent chance at a normal life. Yes, she would lose lung capacity and live differently, but live nevertheless. She didn't know that the most dangerous part of the equation had gone on behind the scenes the day she left her oncologist's office in a daze.

Jerri had been working for the oncologist for a grand total of five days. It wasn't a fun place to be. She knew she wouldn't last long, but she really wanted to save enough for the down payment on a car, so she figured she could keep it up for a few months.

Dr. H, the oncologist, was old school. His nurses walked around with laptops and the diagnostic equipment was state of the art, but he was a dinosaur who only worked with pens and charts. It was Jerri's job to translate his chart notes into digital documents so they could be sent via email to a hospital or lab when necessary. His writing was stereotypically physician, but she was pretty good at deciphering his scrawl.

But today, she struggled. His notes said that the patient needed immediate removal of one of her lung lobes, but the description of which lobe was overly messy and smeared. She knew it was the right lung, and could make out the letters "erior" at the end of the word, but the first few letters were illegible. She Googled "lung lobe" and found an image that showed the five lobes, and she realized that it was either the "inferior" or the "superior." She showed it to a nurse who couldn't make it out and told her to ask the boss.

Knowing that this guy yells at everyone, she wasn't thrilled. But she had little choice if she wanted to be driving a convertible Mustang this summer. So she knocked on his door, went in, and asked if he would take a look at the chart. He didn't bother to look up when he bellowed, "Get out of here and do your f***ing job."

"Please Dr. H, I just need you to look at one word I am having trouble with," She said.

"If you can't do your job, I'll find someone who can," Dr. H replied.

As she walked back to her workspace she kept seeing herself headed down the coast highway with the top down. She looked at the paper again and mentally flipped a coin in her head and typed in, "right inferior lobe." And that was that. She was sure someone else would check this out a number

of times before surgery. Plus, there was always the CT scan to refer to before surgery. But it didn't work out that way for Edie.

When the surgeon (an old colleague of the oncologist) walked into Edie's surgery he didn't check the scan. One of the nurses did and mentioned that the scan and the notes didn't seem to jibe. The surgeon told the nurse to leave scan interpretation up to the physicians and (again), "Just do your job or get out." When she persisted, he said, "I'll take Dr. H's charts over a nurse, every day of the week." And he began to cut.

After a good lobe was removed, and then a day later the cancerous lobe was removed, Edie was left with minimal lung capacity. She finished a course of chemotherapy, began respiratory therapy, and started to marginally improve. Three weeks passed and she contracted pneumonia. It was too much for her system and she died four weeks after the surgery.

On the surface, Edie's death is no mystery. When these "never events" happen, new initiatives usually follow. Our knee-jerk, Band-Aid reaction is to create a checklist. Though recent studies have shown the great effectiveness of using checklists, especially in surgery, this method isn't a solution to the entirety of the problem and only addresses operational deficiencies. It took me a long time to realize that a key root-cause of substandard patient safety, care, and unnecessary deaths is cultural, not operational, deficiencies. Lately, many articles and research studies are coming up with the same conclusions.

A recent qualitative study performed by 11 hospitals (158 hospital staff members) researched, "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?"^[1] Staff in high-performing hospitals found that the definitive difference between them and lower-scoring members was their ability to solve problems and learn as organizational teams. Working with a "non-punitive approach to problem-solving, which focused on learning rather than blaming," made all the difference. It led them to conclude that, "High performance may require long-term investment and concerted efforts to create an organizational culture that supports full engagement in quality, strong communication and coordination among groups, and the capacity for problem-solving and learning across the organization."

Dr. Pauline Chen's recent article, "What Makes a Hospital Great,"^[2] also determined that the only way to become a better hospital is through relational solutions. She quoted Elizabeth H. Bradley sharing, "It's how people communicate, the level of support and the organizational culture that trump any single intervention or any single strategy that hospitals frequently adopt." Dr. Chen also wrote, "The upside of such transparency is that hospitals all over the country are eager to improve their patient outcomes. The downside is that no one really knows how."

At The Bedside Trust, we are working with hospitals to implement a daily practice that discovers and treats the root cause of most of our problems. I started The Bedside Trust with another *physician* who is currently the CEO of a health-care system in Colorado. Since 2005 we've met with more than 3,500 physicians to find out what matters most to them when challenged with a difficult case. Overwhelmingly, they have yearned for true teamwork — to work beside team players who are respectful, responsive, understanding, and capable of safe conversations aimed at solving patient challenges together. They needed to be able to trust each other.

This led us back to the patients — we also asked what matters most to them. They also came back with “trust.” They want to trust their physicians, trust that everyone communicates, and trust that they are going to experience a healthy outcome. They need to believe in the people taking care of them. And the best way to build patient trust is to model it by equipping physicians, nurses, administrators, and staff members to work as trusted teams.

We’ve learned through experience that starting with the CEO and executive team best facilitates organization-wide buy-in for building and working as trusted teams. Although it is a leadership practice, such behaviors and benefits naturally trickle down through the entire organization, to create a community of patient-driven leaders. Everyone in a hospital begins to show up as proactive leaders in their job—and more importantly, begins looking past their jobs to realize their organizational roles.

Following this practice isn’t rocket science, nor does it add to a hospital’s already overflowing workload. Along with saving lives, hospitals that have adopted patient-driven leadership have shown us that building trusted teams affects all aspects of an organization from the top floor to the bottom line.

How would 40-year old Edie have fared if everyone involved in her case belonged to and embraced a trusted team? What if the oncologist and surgeon knew that one person couldn’t possibly be as smart as a group of people? What if every leader, physician, and staff member trusted their co-workers and simply took a moment to listen and learn before responding to a situation? You know the answers

¹ L. A. Curry, E. Spatz, E. Cherlin et al., "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?" *Annals of Internal Medicine*, 2011.

² Pauline W. Chen, M.D., “What Makes a Hospital Great,” *The New York Times*, 2011.

The Minnesota Hospital Association thanks Brian Wong M.D., M.P.H., CEO of The Bedside Trust, LLC, for contributing this article. He can be reached by phone at (206) 619-8088 or [via email](mailto:via). To learn more visit www.patientdrivenleadership.com. [^top](#)

***11 Training camp for rookie trustees — back by popular demand**

By popular demand, the Minnesota Hospital Association Trustee Council is bringing back the training camp for new and inexperienced trustees. Attendees of the previous two training camps in 2010 and 2011 found the session extremely helpful and requested that it be continued.

The session is scheduled for 8:30 a.m. – 2 p.m. Friday, Jan. 6 — just before the trustee conference begins. The camp will help newer trustees understand fundamental issues and expectations of health-care boards and trustees. It will also provide information about basic board and trustee roles and responsibilities.

The extended session will explore essential governance practice questions that every board member should know the answers to in order to consistently carry out effective and accountable trusteeship.

The training camp will explore fundamental governance responsibilities including:

- organizational vision;
- roles and responsibilities;
- policies and procedures;
- quality;
- communication;
- education and self-assessment; and
- relationships with other board members, the CEO, physicians, staff members and the community.

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

***12 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, nearly 350 board members from Minnesota hospitals are actively working toward certification. Twenty-four have already received certification, and 10 more will receive certification at the upcoming MHA January Trustee Conference.



Trustees recognized for certification at the 2011 July Trustee Conference pose with MHA's president Lorry Massa. Pictured from left: Mitchell Kilian, Linda Doerr, Don Bottemiller, Edwin Treml, Lorry Massa, Judith Bjerga, Richard Philabaum and Mike Werner.

The hospital trustees that received certification at our most recent conference in July include:

- Judith A. Bjerga, Lakewood Health System, Staples;
- Ed Borowiec, Cook Hospital & C&NC, Cook;
- Don Bottemiller, Tri-County Health Care, Wadena;
- Linda Doerr, New River Medical Center, Monticello;
- Brian Doyle, New River Medical Center, Monticello;
- Mitchell Kilian, Ridgeview Medical Center, Waconia;
- Chuck Koenigs, Swift County-Benson Hospital;
- James Morris, Mayo Clinic Health System - New Prague;
- Kathryn Olson, Cook County North Shore Hospital, Grand Marais;

- Richard Philabaum, Paynesville Area Health Care System;
- Edwin Treml, Sleepy Eye Medical Center; and
- Mike Werner, Ridgeview Medical Center, Waconia.

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

***13 Trustees strengthen the hospital community's political voice by contributing to the Minnesota Hospital PAC**

The Minnesota Hospital Political Action Committee (PAC) is fortunate to have the growing support of hospital trustees. Trustees play an important role in helping to ensure Minnesota hospitals have a strong voice in the political process.

Participation in the political process can take many forms. Financially supporting candidates who resonate with the hospital message is an important component of our advocacy strategy. The Minnesota Hospital PAC works to inform elected officials on how their decisions affect the lives of the patients we serve.

The PAC will continue to provide an opportunity for hospital leaders and trustees to get to know some of our new legislators and help our existing champions that need our support.

The deadline to contribute to the 2011 Minnesota Hospital PAC is Friday, Dec. 2. Any contributions that are received after Dec. 2 will be attributed to your facilities' 2012 PAC goal. The 2012 fundraising campaign will begin promptly in January.

Minnesota Hospital PAC leaders would like to thank the following trustees that had contributed by Nov. 4:

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

Andrea Kmetz-Sheehy, Children's Hospitals and Clinics of Minnesota, Minneapolis/St. Paul

James Morris, Mayo Clinic Health System – New Prague

Chairman's Circle – trustees giving \$500 or more

Joanell Dyrstad, Fairview Health Services, Minneapolis

Capitol Club – trustees giving \$350 or more

Mark Dwyer, M.D., Sanford Bemidji

Jodie Torkelson, Sanford Medical Center Thief River Falls

Gold Level – trustees giving \$100 or more

Larry Anderson, United Hospital District, Blue Earth

Russell Becker, Children's Hospitals and Clinics of Minnesota, Minneapolis/St. Paul

Dixon Bond, Northfield Hospital

Diane Cross, University of Minnesota Medical Center, Fairview, Minneapolis
J. Kevin Croston, North Memorial Health Care, Robbinsdale
John Diehl, Gillette Children's Specialty Healthcare, St. Paul
Gregory Goven, Children's Hospitals and Clinics of Minnesota, Minneapolis/St. Paul
Steve Laraway, St. Cloud Hospital
William Mennis, M.D., Lakewood Health System, Staples
Richard Migliori, M.D., Children's Hospitals and Clinics of Minnesota, Minneapolis/
St. Paul
Loren Morey, Lakewood Health System, Staples
Barbara Muesing, Essentia Health Fosston
Clayton Peterson, St. Joseph's 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 giving \$50 or more

Charles Austin, Northfield Hospital
Karl Bloomquist, Douglas County Hospital, Alexandria
James Herzog, Owatonna Hospital
Tom Hruby, Sanford Bemidji
Robert Jensen, FirstLight Health System, Mora
Marty Johnson, Sanford Medical Center Thief River Falls
Paul Kent, FirstLight Health System, Mora
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
Mark Thune, Sanford Medical Center Thief River Falls
E. Paul Wicht, Lakewood Health System, Staples

Bronze Level – trustees giving \$25 or more

Bev Bales, Douglas County Hospital, Alexandria
Chad Broadwell, Sanford Medical Center Thief River Falls
Alfred Fresonke, Perham Health
Katherine Hemmelgarn, Perham Health
Kari Howe, Sanford Bemidji
Chuck Koenigs, Perham Health
Jerry Kunza, Perham Health
Barbara Peterson, Lakewood Health System, Staples
Gail Quittschrieber, Perham Health

Trustees giving up to \$25

Jan Bonebright, Redwood Area Hospital, Redwood Falls
Eldon Fluck, Redwood Area Hospital, Redwood Falls
Colleen Hoffman, Sanford Medical Center Thief River Falls

Leonard Medrud, Redwood Area Hospital, Redwood Falls
Bev Reynolds, Redwood Area Hospital Redwood Falls
Peter Smith, Redwood Area Hospital, Redwood Falls
Martha Widmer, Redwood Area Hospital, Redwood Falls

For more information contact [Carol Eshelman](#), MHA PAC coordinator, at (651) 603-3539; [Ann Gibson](#), MHA vice president of federal relations and workforce, at (651) 603-3527; or [Mary Krinkie](#), MHA vice president of government relations, at (651) 659-1465. [^top](#)

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